Partnership for Medicaid

MEDICAID POLICY OPTIONS SUMMARY

SEPTEMBER 2012

THE PARTNERSHIP FOR MEDICAID – a nonpartisan, nationwide coalition of safety net providers, health plans, counties, and labor – offers the following recommendations to legislators and the administration for strengthening and improving the Medicaid program.

Long Term Services and Supports (LTSS)

Options for Financing

- Reform public and private long-term care financing to better support high-quality care delivery and to expand consumer choices.
- Enable and encourage personal responsibility in planning for LTSS needs.
- Facilitate and support integration and coordination between Medicare and Medicaid.
- Support quality and efficiency in both Medicaid and private LTSS.

Choice and Access to the LTSS Continuum

- Foster the proliferation of person-centered service models and empower individuals to choose and shape the array of services and service setting most appropriate to their needs and preferences.
- Ensure people have access to and may move seamlessly among all levels of services and all settings as their needs and preferences change.
- Recognize family caregiving and the role of family caregivers.

Supportive Housing

- Direct the Department of Housing and Urban Development (HUD) to collaborate with the Centers for Medicare & Medicaid Services to target the highest-cost, homeless Medicaid beneficiaries for supportive housing programs.
- Extend HUD mortgage insurance to supportive housing programs, as is currently allowed for hospitals and skilled nursing facilities.

Coordinating Care

Care Coordination for Chronic Conditions

- Expand care coordination for all patients, especially those with chronic conditions, and strengthen linkages among preventive, primary, acute, and LTSS. These efforts should include the following:
    - Enrolling beneficiaries with chronic conditions in programs that coordinate care by providing services including drugs, care management, and ongoing health condition monitoring
    - State initiatives under the new Medicaid Health Homes option
    - New Medicaid accountable care organization (ACO) models including a pediatric ACO model
    - Innovative managed care arrangements
    - Shared savings models involving state Medicaid agencies, hospitals, and health plans in order to reduce the use of emergency departments

- Combine care coordination activities with risk adjustment and payment mechanisms to counter adverse risk selection and ensure adequate provider and plan reimbursement.

Care Coordination for Pregnant Women

- Implement "pregnancy medical homes," drawing on the successes of the North Carolina Department of Medicaid's model – a program that is expected to save the state $10 million within its second year of implementation.

Improving Quality

Simplify and Align Enrollment Periods for Health Coverage

- Give states the option to establish a 12-month continuous eligibility period for all Medicaid enrollees, and potentially a longer eligibility period for categories of enrollees who are unlikely to have their eligibility status change, such as seniors and dual eligibles.
- Improve retention in the Medicaid program as a cost-effective way to reduce the number of uninsured people, make their health insurance coverage more secure, and improve health care quality measurement and beneficiary health.

Develop Comparable Data About the Quality of Medicaid Services

- Encourage reporting of comparable quality measures for all Medicaid enrollees. Quality reporting changes should be implemented in a way that does not add administrative burden to already stretched providers.
- Standardize quality measures across all payers to the greatest extent possible to reduce the reporting burden on providers.

Caring for Dual Eligibles

Integrating Care for Duals

- Ensure dual eligibles have access to an appropriate array of providers to meet their multiple and complex needs.
- Support the Office of Medicare-Medicaid Integration – known as the "Duals Office" – which seeks to improve alignment between the two programs.
- Provide adequate reimbursement to ensure program effectiveness and access and quality for dual eligibles.
    - Rates in fee-for-service, capitated, risk-based, and hybrid approaches must reflect the depth and breadth of services required for this unique population.
    - If a state elects to use managed care to cover dual eligibles, adequate rates must be accompanied by risk and payment adjustments to counter adverse risk selection.