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.