Whereas, Medicaid is a state/federal program that pays for healthcare services for low-income pregnant women and adults with and without children, children, individuals who are elderly or have a disability, parents and women with breast or cervical cancer, and

Whereas, Some low-income individuals eligible for Medicaid may qualify for private health insurance funded by Medicaid; and

Whereas, Spending on Medicaid is about one-tenth of the federal budget, $630 million in 2018; and

Whereas, The average annual growth in Medicaid spending is 5.5 percent, exceeding that of private health insurance; and

Whereas, Medicaid member obligations do not always encourage use of the most appropriate care and avenues of care; and

Whereas, Medicaid reimbursement does not always support the most effective and efficient interaction between clinicians and patients; and

Whereas, Some Medicaid policies regarding enrollment qualification and leaving the program encourage patients to behave in ways that are not in the patients’ best interest (e.g., Medicaid spend-down); and

Whereas, Physician-directed oversight of access, quality, and cost can greatly improve Medicaid; and

Whereas, Unnecessary and burdensome administrative requirements on clinicians could be evaluated and reduced; therefore be it
RESOLVED, That our American Medical Association support the following principles of Medicaid reform:

1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.
3. Create the best coverage at the lowest possible cost.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.
7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.
8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.
10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.
12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.
13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time).
14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it further

RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA’s principles of Medicaid reform (Directive to Take Action)

Fiscal Note: not yet determined.

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