REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Medicaid Reform
(Resolution 809-I-19)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2019 Interim Meeting, the House of Delegates referred Resolution 809, "AMA Principles of Medicaid Reform," which was sponsored by the Utah Delegation. Resolution 809-I-19 asked the American Medical Association (AMA) to support a series of principles and to pursue action to improve the federal requirements for Medicaid programs based on the AMA's Medicaid reform principles. The Council agrees with the intent of the principles proposed in referred Resolution 809-I-19. As demonstrated in the appended crosswalk, the Council analyzed each of the 14 principles and found them to be largely addressed by AMA policy.

AMA Medicaid reform efforts are guided by some 70 AMA policies that have been deliberated over the years by the Council and in the House of Delegates. The Council believes these policies provide the right direction for continued federal and state advocacy efforts and recommends reaffirmation of the following principles:

- Medicaid's role as a safety net must be supported and sustained (Policy H-290.986).
- Medicaid reform should be undertaken within the AMA's broader health insurance reform efforts, which support individually purchased and owned health insurance coverage as the preferred option (Policy H-165.920).
- State efforts to expand Medicaid eligibility as authorized by the Affordable Care Act (ACA) should be supported (Policy D-290.979), and states that newly expand eligibility should receive three years of 100 percent federal funding (Policy H-290.965).
- State waivers should be supported, provided they promote improved access to quality medical care; are properly funded; have sufficient provider payment levels to secure adequate access; and do not coerce physicians into participating (Policy H-290.987).
- Caps on federal Medicaid funding should be opposed (Policies H-290.963 and D-165.966).
- Medicaid should pay physicians a minimum of 100 percent of Medicare rates (Policies H-385.921 and H-290.976).

The Council also considered the need for new policy in the context of the 2019 novel coronavirus (COVID-19) pandemic and the ensuing demands on patients, physicians, and state Medicaid programs. The dual health and economic crises triggered by the pandemic have resulted in unparalleled financial uncertainty for millions of Americans, including physicians serving Medicaid patients. To help safeguard Medicaid funding, the Council recommends new policy supporting increases in states' Federal Medical Assistance Percentage (FMAP) during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5, November 2020

Subject: Medicaid Reform
(Resolution 809-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

At the 2019 Interim Meeting, the House of Delegates referred Resolution 809, "AMA Principles of Medicaid Reform," which was sponsored by the Utah Delegation. Resolution 809-I-19 asked the American Medical Association (AMA) to support a series of principles and to pursue action to improve the federal requirements for Medicaid programs based on the AMA's Medicaid reform principles. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2020 Interim Meeting.

This report provides an overview of Medicaid expansion, waivers and financing; describes the impact of the 2019 novel coronavirus (COVID-19) pandemic; highlights Medicaid's role in addressing disparities in health coverage and access to care; summarizes relevant AMA policy; and makes policy recommendations. A crosswalk comparing each of the 14 principles proposed in Resolution 809-I-19 with current AMA policy is appended.

BACKGROUND

In response to referred Resolution 809-I-19, the Council reviewed approximately 70 AMA policies that guide AMA's federal and state Medicaid advocacy and found that the principles proposed in the resolution are largely addressed by existing policy. At the onset of COVID-19, the Council broadened its analysis to consider the need for new AMA policy in the context of the pandemic and the ensuing demands on physicians, state Medicaid programs, and the health care system.

Medicaid is the largest health insurance program in the US; the leading payer of births, mental health services and long-term care;[1] and an indispensable safety net for low-income and vulnerable populations. As a countercyclical program, Medicaid spending increases during economic downturns as job losses mount, incomes fall, and more people enroll in the program. Enrollment growth occurs just as states, bringing in less tax revenue, experience budget shortfalls that put pressure on state spending, including Medicaid spending. In the current downturn, Medicaid programs are central to state efforts to care for low-income COVID-19 patients and also provide coverage to the newly unemployed and uninsured. Accordingly, the impact of the pandemic on state Medicaid programs could be extraordinary.

In March 2020, Medicaid and Children's Health Insurance Program (CHIP) covered nearly 71 million people (just over 64 million people were enrolled in Medicaid while an additional 6.7 million were enrolled in CHIP) and over half (51 percent) of total enrollees were children.[2] Notably, prior to the pandemic Medicaid provided coverage to more than 20 percent of low-wage workers.[3] As initial unemployment claims surged nationwide, early forecasts predicted that the economic crisis would trigger large-scale Medicaid enrollment increases. A model by Health

Management Associates, for example, estimated that enrollment could increase by 11 to 23 million people,[4] while the Kaiser Family Foundation projected that over half (12.7 million) of the nearly 27 million individuals who could lose employer-sponsored insurance would become eligible for Medicaid.[5] Three months into the pandemic, the Georgetown University Center for Children and Families found enrollment increases of five percent on average in the 22 states being tracked as well as significant variability across states.[6] National enrollment figures for May 2020, the most recent available at the time this report was written, indicate that 73.5 million individuals were enrolled in Medicaid and CHIP, an increase of approximately 2.5 million from March.[7] The modest increase was at least partially attributed to the ability of furloughed workers to keep employer-sponsored coverage and the fact that, early in the pandemic, fewer people were seeking medical care. The situation is evolving and while enrollment growth over time is uncertain, many states are anticipating and/or already experiencing significant increases in Medicaid applications.

Although Medicaid enrollment and spending increased during the 2002 and 2009 recessions and following Affordable Care Act (ACA) implementation, growth in Medicaid spending per enrollee has generally been less than that of private insurance spending,[8] in part because payment rates are significantly lower than rates paid by Medicare and private insurance for comparable services. Inadequate Medicaid payment rates often do not cover the full cost of patient care and have been associated with lower physician participation in Medicaid, which in turn negatively impacts patient access to care.[9] Delayed payments and administrative burdens also steer some providers away from participating in the program.

The greatest share (almost two-thirds) of all Medicaid spending goes toward the care of elderly and disabled persons, while a far smaller percentage (approximately 14 percent in 2017) pays for the Medicaid expansion population, which is financed primarily with federal dollars.[10] Spending varies by state as do eligibility, coverage and payment policies, so one state's Medicaid program can look very different from another. Notably, disparities in eligibility and coverage are most pronounced between states that have and have not expanded Medicaid under the ACA.

MEDICAID EXPANSION

The Supreme Court ruling—in *National Federation of Independent Business v. Sebelius*—that Medicaid expansion was optional allowed states to decline the opportunity to expand coverage to individuals with incomes up to 133 percent (138 percent including the ACA's five percentage point income disregard) of the federal poverty level (FPL). At the time this report was written, all but 12 states (AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, WY) had chosen to expand Medicaid,[11] although Missouri, Nebraska and Oklahoma had not yet implemented their Medicaid expansions. Wisconsin covers adults up to 100 percent of the FPL, thereby bridging the gap between Medicaid and premium tax credit eligibility without receiving the enhanced federal match. Section 1115 waivers have been used by states to try to customize the scope and structure of expansion plans in ways that would not otherwise be permitted under federal rules. Although a handful of states have sought partial expansions that cover individuals at 100 instead of 133 percent (138 percent including the income disregard) of the FPL and allow them to receive the enhanced federal match associated with full expansion, the Centers for Medicare & Medicaid Services (CMS) has not approved these requests.

Since 2013, more than 14 million people have enrolled in Medicaid under the ACA expansion.[12] Council on Medical Service Report 5-I-14, Medicaid Expansion Options and Alternatives, expressed concern for individuals left in what is known as the coverage gap of earning too much to qualify for Medicaid in their states but too little (less than 100 percent of the FPL) to qualify for premium subsidies to purchase health insurance through ACA marketplaces. Expansion states have

eliminated the coverage gap but, nationally, prior to the pandemic, an estimated 2.3 million uninsured adults fell into the gap in non-expansion states, a number that is sure to grow. Nine out of 10 of these individuals live in southern states, with one third residing in Texas and another 17 percent in Florida.[13]

Policymakers in states that have not expanded Medicaid have voiced concerns about increasing the government's role in health care and are wary of the fiscal impacts associated with expansion (Medicaid expansion was 100 percent federally financed through 2016 and has phased down to 90 percent in 2020). In a 2016 report on Medicaid expansion, the Council expressed concerns about the enormous federal investment in Medicaid expansion, as well as massive enrollment increases which led some states like California to further reduce payment rates to providers. Additionally, the Council noted in its report that initial reviews of the impact of Medicaid expansion on coverage, quality and outcomes were somewhat mixed.

The effects of Medicaid expansion have been widely studied since the Council's last report on the topic in 2016, when data on the impact of the expansion were not yet conclusive. Evidence from a number of studies has since shown that Medicaid expansion is associated with increased access to care, decreased mortality, increased financial well-being, and improved self-reported health.[14,15,16] Enrollees have been found to be more likely to obtain primary and preventive care, be diagnosed and treated for chronic conditions, and have access to prescription medications.[17] Expansion states have experienced greater reductions in their uninsured populations,[18] with coverage gains playing a significant role in addressing the opioid epidemic. Evidence also points to a narrowing of disparities in coverage among people of different races and ethnicities, most notably in expansion states.[19]

Studies of economic measures have also shown that Medicaid expansion may offset costs in other areas (such as uncompensated care) and that it spurs economic activity and may even generate savings for states.[20] Nevertheless, the main arguments against expansion focus on costs and fiscal accountability. Prior to the pandemic, total Medicaid spending had grown to nearly $600 billion[21] with the federal share reaching over $400 billion.[22] Medicaid is the third largest domestic federal program and one of the largest budget items in most states, and has been projected to be a trillion-dollar program by 2026.[23] In 2018, Medicaid accounted for 16.4 percent of national health care spending.[24]

WAIVERS

In states reluctant to expand Medicaid eligibility as designed in the ACA, Section 1115 waivers may provide a workable alternative. Waivers permit states to put aside certain Medicaid requirements to test and evaluate a novel delivery model or provide services not typically covered. Expanding Medicaid is one of the ways that the US Department of Health and Human Services (HHS) has permitted states to employ demonstration waivers. States have also sought waivers that would allow them to charge premiums, require contributions to health savings accounts, require enrollment in private plans, incentivize healthy behaviors, impose work requirements as a condition of eligibility, impose closed prescription formularies, implement lock-out periods, use funds for inpatient substance use and/or mental health services, and use funds for social determinants of health interventions.[25,26] While supportive of state flexibility via Medicaid waivers, AMA policy also underscores the need for safeguards to protect low-income patients and sustain Medicaid's role as an indispensable safety net.

Section 1115 waivers have been around for decades and are frequently used by Administrations to implement domestic priorities. In early 2020, CMS announced the Healthy Adults Opportunity

(HAO) initiative, inviting states to apply for Section 1115 waivers under which states would agree to limited federal financing without being bound to many existing programmatic and oversight requirements.[27] Under the HAO initiative, states agreeing to an aggregate or per-capita cap financing model for adult Medicaid expansion populations would be granted a menu of flexibilities that could be attractive to some states, although state interest in HAO waivers has been limited.

AMA policy opposing caps on federal Medicaid funding was reaffirmed in Council on Medical Service Report 5-I-17. Accordingly, the AMA urged CMS to reject Oklahoma's HAO Section 1115 demonstration application to implement a per capita cap model, the only state application to be submitted under the HAO initiative that has since been withdrawn. The AMA believes that per capita caps artificially limit the growth of Medicaid expenditures, and may hinder a state's ability to address the health care needs of its vulnerable citizens and respond to public health emergencies.

Although waivers imposing work requirements have been encouraged by the current Administration, they have been repeatedly struck down in court. The AMA opposes work requirements as a condition of Medicaid eligibility (Policy H-290.961) because of the potential for continuity of care interruptions when patients subject to the requirements churn in and out of the program, experiencing periods of being uninsured. Work requirements can cause otherwise eligible enrollees to lose coverage, as it did in Arkansas, the only state that has fully implemented such eligibility restrictions. Research has demonstrated that work requirements in Arkansas did not increase rates of employment and that nearly 17,000 people lost coverage in the initial months after the requirements were implemented.[28]

COVID-19 Waivers and Other Temporary Changes

Under guidance issued to state Medicaid directors in March 2020, CMS began considering new COVID-19 Section 1115 waivers. Unlike traditional waivers, CMS is not requiring states to submit budget neutrality calculations for the special waivers, which focus primarily on home and community-based services for the long-term care population. At the time this report was written, six states had CMS-approved Section 1115 waivers to address COVID-19. States can also apply for special Section 1135 waivers that are only authorized during public health emergencies. CMS has approved Section 1135 waivers—focusing on provider enrollment, prior authorizations, appeals, long-term services and supports and state plan processes—for all states.[29]

Temporary changes have also been approved by CMS for 49 states through Medicaid disaster relief state plan amendments (SPAs). At the time this report was written, 31 states had increased state plan payment rates using SPAs, 20 states had waived or extended prescription drug prior authorization requirements, 18 states had expanded coverage for testing and testing-related services to uninsured individuals, and 14 states had eliminated deductibles and other cost-sharing.[30] States have also taken a range of administrative actions in response to COVID-19, including issuing guidance to expand Medicaid telehealth coverage (49 states), instituting payment parity for some telehealth services (43 states), and waiving or lowering telehealth cost-sharing (20 states).[31] The AMA is monitoring Medicaid waivers and state administrative actions and providing assistance to state medical associations upon request.

FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP) INCREASE

Under Medicaid's joint financing model, CMS matches each state's Medicaid expenditures according to the federal medical assistance percentage (FMAP), which varies by state and is inversely related to a state's per capita income. Prior to the pandemic, the 2020 Medicaid FMAP ranged from the minimum 50 percent in 12 states to 77 percent in Mississippi.[32]

A temporary 6.2 percentage point increase in federal Medicaid matching funds was provided to states by the Families First Coronavirus Response Act (PL 116-127) to help them shoulder the costs of increased Medicaid enrollment and services, including COVID-19 testing and treatment. As a condition for receiving these funds, states must provide continuous eligibility through the emergency period and are not permitted to restrict eligibility or make it more difficult to apply for Medicaid.

The temporary 6.2 percentage point increase in the FMAP was an important first step to help states continue serving the tens of millions of Americans enrolled in Medicaid. However, it is unlikely to make up for state budget shortfalls and, at the time this report was written, Medicaid cuts were under consideration in several states. A six percent cut had been made to Nevada's Medicaid program—to be largely taken out of provider payment rates and some optional benefits—and Colorado's Medicaid program had been cut by one percent. Increasing the FMAP is widely recognized as a quick and easy way to provide fiscal relief to states during economic downturns and incentivize them to maintain current Medicaid levels and services. Further enhancements to the 6.2 percentage point increase in the FMAP enjoy broad support from a range of national medical specialty societies and other stakeholders, including the AMA.

NARROWING DISPARITIES IN HEALTH COVERAGE AND ACCESS TO CARE

Although the impact of COVID-19 on our nation, its people and our health care system is continuing to unfold, one feature is unmistakably clear. The pandemic is disproportionately impacting minoritized and marginalized populations, particularly Black, Latino and Native American communities that in many places are testing positive, being hospitalized, and dying from COVID-19 at much higher rates.[33] One in four deaths from the virus have been among Black Americans, who are also more likely than White Americans to have lost income because of the pandemic.[34] COVID-19 has highlighted longstanding health inequities that disproportionately affect many communities of color—including higher rates of chronic diseases, lower access to health care, and lack of or inadequate health insurance. The current crisis underscores the importance of addressing racial and ethnic disparities in health insurance coverage and access to health care and the need to better understand the role of social determinants of health (SDOH), which can negatively affect health outcomes among people of color. Medicaid initiatives addressing SDOH are described in Council on Medical Service Report 11-I-20, Health Insurance Benefits Addressing SDOH. Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA (see the AMA's Plan to Cover the Uninsured). The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.[35]

Studies have shown that coverage expansions implemented under the ACA have reduced racial disparities in both health insurance coverage and access to care but that significant disparities remain.[36,37] The percentage of uninsured Black adults decreased from 24.4 percent in 2013 to 14.4 percent in 2018 while the uninsured rates of Latino adults fell from 40.2 percent to 24.9 percent and uninsured rates of White adults decreased from 14.5 percent to 8.6 percent during the same time period.[38] Notably, coverage disparities narrowed most significantly in states that expanded Medicaid.[39]

Disparities in access to care, as measured by two indicators—foregoing care due to cost and not having a usual source of care—also decreased in all states since 2013, and more so in expansion states.[40] Although Medicaid expansion under the ACA has played a key role in reducing disparities in health insurance coverage and access to care, almost half of Black adults live in states that have

not expanded the program. Black adults in these states who would be eligible for Medicaid if the state had expanded the program are likely to instead fall into the coverage gap. Expansion of Medicaid across the 12 states that have not yet opted to do so may narrow the gaps in coverage and access to care in those states, although disparities will likely remain.

RELEVANT AMA POLICY

AMA policy maintains that Medicaid reform should be undertaken in conjunction with broader health insurance reform (Policy H-290.982) and supports Medicaid's role as a safety net for the nation's most vulnerable populations (Policy H-290.986). AMA policy on covering the uninsured and expanding choice is largely based on recommendations developed by the Council over the years. Although AMA policy supports and advocates that individually purchased and owned health insurance coverage is the preferred option (Policy H-165.920), Policy H-290.974 states that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid/CHIP. Policy D-290.979 states that, at the invitation of state medical societies, the AMA will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the ACA (138 percent FPL including the income disregard). Policy H-290.965, established by Council on Medical Service Report 2-A-16, supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and maintaining federal funding for Medicaid expansion populations at 90 percent beyond 2020.

Policy H-165.855 supports states having the option to provide coverage to nonelderly and nondisabled Medicaid populations within the current Medicaid program or using premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients. AMA policy further encourages the development of coverage options, notably through state demonstration waivers, for low-income adults in the coverage gap (Policies H-290.966, D-165.966, and H-290.987). Policy H-290.966 advocates for CMS to exercise broad authority in approving state demonstration waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. Policy H-290.987 asserts that Section 1115 waivers should meet certain criteria before being approved by HHS, including that the waivers: assist in promoting the Medicaid Act's objective of improving access to quality medical care; are properly funded; have sufficient provider payment levels to secure adequate access; and do not coerce physicians into participating. AMA policy opposes caps on federal Medicaid funding (Policies H-290.963 and D-165.966). AMA policy also opposes lock-out provisions that block Medicaid patients from the program for lengthy periods (Policy H-290.960) and tying work requirements to Medicaid eligibility (Policy H-290.961). Policy H-290.982 supports modest cost-sharing for non-emergent, non-preventive services as a means of expanding coverage to uninsured individuals while Policy H-170.963 advocates that Medicaid and other publicly funded programs incentivize voluntary healthy behaviors.

Policy H-160.913 recognizes the potential value of Medicaid patient-centered medical home models. Streamlined application and enrollment processes are supported by Policy H-290.982, while Policy D-290.985 encourages sufficient federal and state funding for Medicaid/CHIP to support enrollment and the provision of necessary services. Policy H-290.984 opposes mandatory enrollment in managed care plans. The AMA advocates for the same policies for Medicaid managed care that are advocated for private managed care plans, as well as criteria for federal and state oversight of Medicaid managed care plans that are delineated in Policy H-290.985. Network

adequacy elements are outlined in Policy H-285.908, and Policy H-320.908 addresses prior authorization.

Longstanding AMA policy advocates that Medicaid should pay physicians at minimum 100 percent of Medicare rates (Policies H-385.921 and H-290.976). Policy H-290.965 supports: increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings; strict oversight by CMS to ensure that states are setting and maintaining Medicaid rate structures at levels to ensure there is sufficient physician participation; and a mechanism for physicians to challenge payment rates directly to CMS. The AMA opposes cuts in Medicaid and Medicare budgets that may reduce patient access to care and undermine care quality under Policy H-330.932, which also supports expansion of these budgets to adjust for cost of living, population growth, and the cost of new technologies. Policy D-290.979 advocates for increases in Medicaid payments to physicians as well as improvements and innovations in Medicaid that will reduce administrative burdens and deliver health care more effectively. Provider taxes are opposed under Policy H-385.925.

AMA policy supports the creation of basic national standards of uniform eligibility for Medicaid (Policy H-290.997), continuous eligibility (Policy H-165.832), and presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person sought medical care (Policy H-165.855). Principles regarding Basic Health Programs are outlined in Policy H-165.832. AMA policy supports expanded Medicaid coverage for management and treatment of substance abuse disorders (Policy H-290.962) and for twelve months postpartum (Policy D-290.974). Policies H-290.983 and H-440.903 support Medicaid benefits for legal immigrants.

The AMA has several policies focusing on health inequities and reducing racial and ethnic disparities in health care, including Policies D-350.995, D-350.996, H-185.943 and H-65.963. Policy H-350.974 prioritizes the elimination of racial and ethnic disparities in health care through various approaches, including ensuring greater access to health care; encourages the development of measures that identify socioeconomic and racial/ethnic disparities in quality; and supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Under Policy H-180.944, health equity is a goal toward which our AMA will work by: advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. Policies H-65.960, H-160.896 and D-385.952 address SDOH.

AMA ADVOCACY

Because Medicaid patients too often face barriers to care, the AMA works diligently at the state and federal levels to improve Medicaid programs, expand coverage options, and make it easier for physicians to see Medicaid patients. Since the ACA was enacted, AMA advocacy on Medicaid reform has been guided by AMA policy, highlighted in the AMA's Plan to Cover the Uninsured, which seeks to extend the reach of coverage to the remaining uninsured, including individuals eligible for Medicaid/CHIP and adults who fall into the coverage gap. Consistent with AMA policy, the AMA continues to advocate for Medicaid expansion and three years of 100 percent federal funding for states that newly expand. The AMA also supports investments in Medicaid/CHIP outreach and enrollment activities and opposes work requirements. Council on Medical Service Report 1, November 2020, Options to Maximize Coverage under the AMA Proposal for Reform, recommends establishing new AMA policy on auto-enrollment in health insurance as a means of maximizing coverage of the uninsured who are eligible for Medicaid/CHIP or zero-premium marketplace coverage. Importantly, the AMA—along with other

physician organizations—has argued against striking down the ACA (and Medicaid expansion) in an amicus brief filed in the case of *Texas v. California* that is before the US Supreme Court.

The AMA has long encouraged policymakers to work together to identify realistic coverage options for low-income people and believes it is important for states to develop and test new Medicaid models that best meet the needs of low-income and vulnerable populations. AMA advocacy emphasizes that Medicaid reform efforts must ensure that the program remains viable and effective, and that financing changes should not undermine coverage gains that have been made under the ACA. To expand access to care, the AMA works with state-level stakeholders to advocate in favor of fully funding the Medicaid program, increasing participation with policies to streamline enrollment, ensuring fair audit procedures and improving managed care programs. The AMA comments regularly on federal and state proposals regarding Medicaid financing, access to care and managed care, and monitors state actions to expand Medicaid eligibility and seek waivers to Medicaid requirements from CMS.

In response to the COVID-19 pandemic, the AMA has also:

- Successfully sought temporary expansion of Medicaid eligibility to uninsured individuals for COVID-19 testing.
- Urged states to eliminate Medicaid cost-sharing for COVID-19-related care, simplify Medicaid enrollment and renewal processes, and eliminate barriers to Medicaid coverage such as work requirements.
- Called on the Administration to promote health equity by collecting and releasing demographic data to help address any potential race, sex and age disparities during the pandemic.
- Submitted a written statement to Congress on the disproportionate impact of COVID-19 on people of color.
- Urged Congress to enhance federal financing for the Medicaid program by at least 12 percentage points and to keep any increased FMAP in place until states' economic recovery is secure and stable.

Because low Medicaid payment rates have been shown to impact patient access to care, the AMA has for many years advocated at the federal and state levels that physicians be provided fair and adequate Medicaid payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA has advocated that CMS ensure that states are maintaining Medicaid rate structures at levels that ensure there is sufficient physician participation, so that Medicaid patients can get care in a timely manner. In response to COVID-19, the AMA pressed HHS to distribute funds to assist practices and facilities treating Medicaid patients, which were operating on thin margins even before the pandemic. When initial payments from the Provider Relief Fund were not reaching Medicaid practices, the AMA urged CMS to authorize such payments, warning that without immediate financial assistance, the safety net that these Medicaid practices provide may not survive, endangering a vital part of the health care infrastructure.

DISCUSSION

Because Medicaid is an important—and often the only—source of consistent coverage for low-income children, adults, pregnant women, people with substance use disorders, and the elderly and disabled, the Council recognizes that the roughly 70 policies that provide the foundation for AMA Medicaid advocacy require periodic review. Accordingly, the Council appreciates the compilation of principles proposed in referred Resolution 809-I-19 which were reviewed individually for consistency with AMA policy. As demonstrated in the appended crosswalk, the proposed principles are largely addressed in AMA policy.

The Council points out that the first principle proposed in referred Resolution 809-I-19, which calls for the provision of access to care that is "the most cost-effective and efficient," could be problematic in the context of lower-cost retail clinics. In a 2017 report, the Council expressed concerns that the retail clinic model may have the effect of fragmenting care delivery by potentially undermining the medical home and the patient-physician relationship. Regarding Principle #5 of the resolution, the Council acknowledges that AMA policy does not "establish specialty-specific quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care." After discussing this language, the Council concluded that new policy delineating specific quality metrics is not warranted. On the contrary, the Council is concerned that additional metrics on top of existing quality measures could be detrimental to physicians by exacerbating administrative burdens.

The sponsor of the resolution could not have anticipated that the Council's deliberations would coincide with COVID-19-induced health and economic crises that have placed extraordinary demands on state and federal budgets and state Medicaid programs. The pandemic has had an unparalleled impact on our nation and its people, leading to massive job losses, financial uncertainty, and reduced health care coverage and access. A recent report estimates that half of the nearly 27 million people who could lose their employer-sponsored health insurance will be eligible for Medicaid.[41] Although the totality of Medicaid enrollment growth stemming from the pandemic remains uncertain, many millions of the newly uninsured are likely to turn to Medicaid, especially in expansion states where most low-income adults will be eligible. In non-expansion states, many of the same adults will not be Medicaid eligible and will instead fall into the coverage gap.

Physician practices have also been hit hard by COVID-19 as they struggle to meet the needs of their patients while incurring new costs related to personal protective equipment and supplies and confronting ongoing revenue shortages from deferred patient visits. Practices and facilities serving Medicaid patients operated on thin margins prior to the pandemic and will be particularly vulnerable to state Medicaid cuts. While the FMAP increase provided in the Families First Act was an important first step, it will not be sufficient to overcome projected state budget shortfalls and stave off state Medicaid cuts. To help safeguard Medicaid funding, which will help physicians and patients, the Council recommends new policy supporting increases in states' FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

The Council believes that foundational AMA policies supporting various aspects of Medicaid reform remain sound and provide the right direction for continued AMA federal and state advocacy. Accordingly, the Council recommends reaffirming that:

- Medicaid's role as a safety net must be supported and sustained (Policy H-290.986).
- Medicaid reform should be undertaken within the AMA's broader health insurance reform efforts, which support individually purchased and owned health insurance coverage as the preferred option (Policy H-165.920).
- State efforts to expand Medicaid eligibility as authorized by the Affordable Care Act (ACA) should be supported (Policy D-290.979), and states that newly expand eligibility should receive three years of 100 percent federal funding (Policy H-290.965).
- State waivers should be supported, provided they promote improved access to quality medical care; are properly funded; have sufficient provider payment levels to secure adequate access; and do not coerce physicians into participating (Policy H-290.987).
- Caps on federal Medicaid funding should be opposed (Policies H-290.963 and D-165.966).
- Medicaid should pay physicians a minimum of 100 percent of Medicare rates (Policies H-385.921 and H-290.976).

As it has during past deliberations, the Council discussed the potential for bifurcating the Medicaid program which would remove the long-term care function that accounts for two-thirds of the program's spending. Due to concerns regarding the complexity, feasibility, and potential unintended consequences of bifurcation, the Council does not recommend utilizing AMA resources to engage in advocacy on bifurcation. The Council also notes that financing for long-term services and supports was addressed in a 2018 Council report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 809-I-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (New HOD Policy)

2. That our AMA reaffirm Policy H-290.986, which supports the Medicaid program's role as a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL) including the income disregard)] as authorized by the ACA. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and maintaining federal funding for Medicaid expansion populations at 90 percent beyond 2020. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-290.966, which supports state Medicaid waivers, provided they promote improving access to quality medical care; are properly funded; have sufficient provider payment levels; and do not coerce physicians into participating. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-290.963, which opposes caps on federal Medicaid funding. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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Appendix: Crosswalk of Resolution 809-I-19 with AMA Policy

The following table outlines the fourteen principles proposed in Resolution 809-I-19 and relevant AMA policy:

Resolution 809-I-19 Proposed Principle	Relevant AMA Policy and Council Analysis
1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.	Access to care is addressed in numerous policies, including Policies H-290.965 and H-290.997. Policy H-290.989 urges that Medicaid reform be undertaken in conjunction with broader health insurance reform to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.	A preference for enrollment in private insurance is embedded throughout policy, including Policies H-165.920, H-165.855 and H-290.982.
3. Create the best coverage at the lowest possible cost.	Policy H-165.846 supports principles for guiding the evaluation and adequacy of health insurance coverage.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.	Policy H-170.963 advocates that Medicaid and other publicly funded health insurance programs incentivize voluntary healthy behaviors among their participants which may decrease the cost of their medical care to the tax-paying public.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.	Policy H-290.982 calls for CMS to develop better measurement, monitoring and accountability systems and indices within Medicaid to assess program effectiveness. Policy D-350.974 encourages the development of measures that identify socioeconomic and racial/ethnic disparities in quality.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.	Policy D-290.977 advocated that the ACA's Medicaid primary care payment increases continue past 2014 in a manner that does not negatively impact payment for any other physicians. Policy H-290.965 advocates for robust access to specialty 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.	Fair and adequate physician payment by Medicaid that should be a minimum of 100 percent of Medicare rates is supported by Policies H-290.965, H-290.989, H-290.997, H-330.932, and H-385.921. Policy H-480.946 supports coverage of and payment for telemedicine services while Policy D-480.969 supports coverage parity for telemedicine services.

8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.	Policy H-290.985 advocates that the availability of off-hours, walk-in primary care and other criteria be used in the oversight and evaluation of Medicaid managed care plans. Policy H-385.940 advocates for fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services. Examples of CPT codes for after-hours care include 99050 and 99051.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.	Parameters related to prior authorization relief in Medicaid plans are outlined in Policy H-320.938. Policy D-320.981 outlines protections related to step therapy.
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.	Policy H-280.991 suggests policy directions for the financing of long-term care and encourages private sector coverage. As stated above (under #2), the preference for enrollment in private insurance is embedded throughout policy.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.	The AMA strongly opposes the use of provider taxes or fees to fund health care programs such as Medicaid (Policy H-385.925).
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.	Policy H-290.975 supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients.
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).	Policy H-385.944 supports payment for E&M services and procedures performed on the same day, where consistent with CPT guidelines.
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.	Policy H-320.938 supports prior authorization relief for Medicaid and Medicaid managed care plans and outlines parameters for such relief. The AMA supports improvements in Medicaid that will reduce administrative burdens under Policy D-290.979.