

## REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Asa C. Lockhart, MD, MBA, Chair.

### 1. END-OF-LIFE CARE (RESOLUTION 101-NOV-20)

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS  
IN LIEU OF RESOLUTION 101-NOV-20  
REMAINDER OF REPORT FILED  
*See Policy TBD***

At the November 2020 Special Meeting, the House of Delegates referred Resolution 101, “End of Life Care Payment,” which was sponsored by the New York Delegation. Resolution 101-Nov-20 directed the American Medical Association (AMA) to petition the Centers for Medicare & Medicaid Services (CMS) to allow hospice patients to cover the cost of housing (room and board) as a patient in a nursing home or assisted living facility, and to advocate that patients be allowed to use their skilled nursing home benefit while receiving hospice services. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report provides overviews of Medicare’s hospice and skilled nursing benefits, differentiates between hospice and palliative care, summarizes AMA policy and makes policy recommendations.

#### BACKGROUND

Except under very limited circumstances, Medicare’s hospice benefit does not pay for room and board for its enrollees including those in nursing, skilled nursing, or assisted living facilities, where many Medicare enrollees spend the end of their lives. People who pay out of pocket for stays at these facilities may elect hospice if qualified, and if there is an agreement between the facility and a hospice.<sup>1</sup> Medicaid pays for room and board for its dually eligible enrollees who qualify for hospice if the facility has an agreement with a hospice. However, patients using Medicare’s skilled nursing facility (SNF) benefit post-hospitalization typically cannot elect hospice under current program rules. An exception would be for patients enrolled in hospice who need skilled care for a condition unrelated to their terminal illness. For example, if a cancer patient in hospice falls and breaks a hip, Medicare may pay for care in a SNF that the patient needs to recover from the hip injury.<sup>2</sup>

Post-acute care services, including skilled nursing and rehabilitation, are commonly used by Medicare patients in the last months of life. Nearly one quarter of hospitalized Medicare patients are discharged from a hospital to a facility, usually a SNF, for post-acute care.<sup>3</sup> Because Medicare typically does not pay for concurrent coverage of hospice services and SNF care, some patients who could benefit from hospice instead elect Medicare’s SNF benefit so that their room and board costs are paid for. It is a common challenge at hospital discharge to find post-acute placements for seriously ill patients who may have limited life expectancies, require more care and assistance than can be provided at home, and cannot afford the costs of nursing care or stays at a long-term care facility out of pocket. Because Medicare covers room and board under the SNF benefit, this can become the preferred option for patients deemed eligible for the benefit, even though SNFs are designed to provide rehabilitative, not palliative, care and some SNF services may not be consistent with appropriate end-of-life care.

A frequently cited study from 2012 found that one-third of Medicare patients received SNF care during the last six months of life and nine percent died in a SNF, many within 30 days of admission.<sup>4</sup> More recent Centers for Disease Control and Prevention data reveal that, in 2016, nearly 30 percent of decedents 65 and over died at home, 28 percent died in the hospital, another 25 percent died in a facility that provides patient care (e.g., a nursing home, SNF, or long-term care facility), and 8.5 percent died in a hospice facility.<sup>5</sup> Research has suggested that of the large numbers of patients enrolled in the SNF benefit at the end of their lives, many would have elected hospice if they had not needed room and board coverage.<sup>6</sup> A 2018 *Health Affairs* blog describes this conundrum as follows:

Either you get to receive restorative care in a nursing facility or end-of-life care at home. Unfortunately, this approach fails to meet the needs of real-world patients and families. If our current model persists, we will continue to cause patients and families to fall into a gap at some of the most tender moments in their family life cycle.<sup>7</sup>

Patients at the end of life who are too sick to benefit from skilled care, but are unable to return home, often remain hospitalized until death because there is no appropriate, affordable community placement available. Patients who need around-the-clock nursing care often end up in nursing facilities, including SNFs. Some Medicare enrollees cycle between hospital stays and nursing facilities in the last months of life, even when rehabilitation is unlikely to be successful. Many end-of-life patients remain at home with family members who become responsible for providing the care they need, including assistance with activities of daily living (ADL) services.

### *Medicare's Skilled Nursing Facility Benefit*

Covered SNF services include post-hospital extended care services for which benefits are provided under Medicare Part A and include nursing care; bed and board in connection with furnishing of such nursing care; physical or occupational therapy and/or speech-language pathology services; medical social services; drugs, biologicals, supplies, appliances, and equipment; and other services necessary to the health of the patients.<sup>8</sup> Medicare does not cover SNF services for patients who only need custodial services (e.g., assistance with ADL such as bathing and dressing) but not skilled nursing benefits.

Medicare will cover skilled nursing under the SNF benefit if patients have a qualifying three-day hospital stay and documented daily skilled care needs, although CMS waived SNF three-day stay and discharge requirements during the public health emergency so that hospitals could focus on COVID-19 care. Care in a SNF is generally covered if it is documented that the patient requires daily skilled services that must be performed by or under the supervision of a professional and can only be provided to an inpatient at a SNF. Services must be reasonable and necessary for the treatment of a patient's illness or injury and consistent with the individual's medical needs and medical practice standards. According to the Medicare benefits manual, coverage does not depend on the patient's potential for improvement from the nursing care and/or therapy, but rather on the patient's need for skilled care.<sup>9</sup> Nonetheless, patients need to be able to participate in daily therapy services to be eligible for the SNF benefit and some seriously ill patients receiving hospice care cannot do so.

Medicare will cover up to 100 days of SNF care but only pays 100 percent of the costs for the first 20 days. At day 21, patients must begin paying a copay (\$185.50 per day in 2021) through day 100 of a covered stay.<sup>10</sup> SNF services are costly; in 2019, Medicare's median payment per day was \$498 and its median payment per stay was \$18,559. Medicare spending on SNF services in 2019—when almost 1.5 million Medicare patients used the SNF benefit—was \$27.8 billion.<sup>11</sup> In addition to providing post-acute care, most SNFs are also certified to provide long-term care (nursing home care) that is not covered by Medicare.

### *Medicare's Hospice Benefit*

More than 1.6 million Medicare patients received hospice services in 2019 at a total cost of \$20.9 billion.<sup>12</sup> Medicare spending on hospice has increased substantially in recent years and was \$15.1 billion in 2014, a figure cited by the Council in its most recent report on the program ([Council on Medical Service Report 4-I-16, Concurrent Hospice and Curative Care](#)). The literature on hospice costs to the Medicare program has been mixed, with some studies showing cost savings among hospice patients who are in the last one or two months of life. A MedPAC-commissioned analysis suggests that hospice produces savings for some patients, including cancer patients, but has not decreased net Medicare spending.<sup>13</sup>

The hospice benefit was introduced to the Medicare program in 1983 to provide a range of palliative and support services provided primarily in the home. To be eligible to elect hospice care under Medicare, patients must be certified as having a life expectancy of six months or less if the terminal illness runs its normal course; patients can be recertified for additional periods if they remain terminal.<sup>14</sup> Room and board costs in a nursing facility are not covered unless the patient qualifies for a short inpatient hospice or a respite stay. Covered hospice services include nursing care, medical social services, physician services, counseling and bereavement services, medical equipment and supplies (including prescription drugs), and other services included in a patient's individualized care plan. Skilled therapy services, such as physical, speech and occupational therapy are covered if they are deemed reasonable and necessary to manage symptoms or help maintain patient functioning. Under the supervision of a hospice nurse, hospice aides may provide

personal care and some homemaker services that are deemed necessary to maintain a safe and sanitary environment in areas of the home used by the patient.<sup>15</sup>

Medicare pays for hospice care using per diem payment categories encompassing four levels of care: (1) routine home care, for which Medicare pays \$199 per day for the first 60 days and \$157 per day thereafter; (2) general inpatient care, paid \$1,046 per day; (3) continuous home care, paid at a rate of \$60 per hour; and (4) inpatient respite care, for which Medicare pays \$461 per day (payment rates are for fiscal year 2021).<sup>16</sup> General inpatient care is provided around the clock in an inpatient facility (e.g., a hospice inpatient unit or SNF), usually for pain or symptom control which cannot be managed in other settings. It is intended to be short-term and, once symptoms stabilize, patients may be returned to their residences. Continuous home care consists mainly of nursing care provided on a continuous basis; this level of care is available only during brief periods of crisis and as needed to maintain the patient at home.<sup>17</sup> Inpatient respite care is provided in an approved facility on a short-term basis for respite. Service intensity add-on payments are made when hospice provides direct patient care by a registered nurse or social worker during patients' last seven days of life.

When Congress established Medicare's hospice benefit, it established two caps on payments to hospices—known as the inpatient cap and the aggregate cap—to ensure that hospice costs do not exceed the costs of conventional care. The inpatient cap limits the share of general and respite inpatient days that a hospice can provide to 20 percent of its total patient care days. Although this cap is rarely exceeded, the aggregate cap, which limits total aggregate payments any individual hospice can receive in a year (\$30,684 in 2021), is exceeded by an estimated 16 percent of all hospices.<sup>18</sup>

Hospice use among Medicare enrollees has been incrementally increasing in recent years, such that 51.6 percent of enrollees who died in 2019 had used hospice services, up from 25 percent in 2000.<sup>19</sup> In 2018, a majority of hospice care days were provided at private residences, followed by assisted living facilities and nursing facilities, including SNFs.<sup>20</sup> Most care provided by hospice is routine home care, which accounted for 98 percent of Medicare-covered hospice days in 2019<sup>21</sup> and is in line with polls showing that seven in ten people would prefer to die at home.<sup>22</sup> Hospices vary and, even within the routine home level of care, the frequency and type of hospice visits and type and intensity of services may differ by patient and across hospices. While more people are turning to hospice at the end of life, families and the caregivers they hire provide much of the care and assistance with ADL services that home hospice patients often require.

### *Palliative Care*

Palliative medicine focuses on reducing suffering, improving a patient's quality of life, and supporting patients with serious illness and their families. Palliative care can be provided alongside other medical treatments regardless of whether the patient can be cured and can be initiated early in one's disease course. Hospice is a type of palliative care for people who likely have six or fewer months to live and are willing to forego curative treatments for their terminal illness. Not all palliative care is hospice, although hospice care is always palliative.

The philosophies underlying hospice and palliative care are similar; however, care location, timing and eligibility often differ. At its core, palliative care is designed to assess, prevent and manage physical and psychological symptoms, address spiritual concerns, and focus on communications that establish patient goals of care and assist patients with medical decision-making about treatment options. Whereas hospice care is most commonly provided to patients in their homes, long-term care facilities, or wherever patients reside, non-hospice palliative care is frequently provided in hospitals or community settings such as cancer centers, clinics and nursing homes. Patients can receive palliative care while continuing curative treatment at any stage of their illnesses, and many studies have shown that early palliative care interventions improve quality of life and increase patient and family satisfaction. As suggested by Policy H-85.951, it is important for physicians to be familiar with hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.

### *Medicare Advantage Plans and Hospice*

Traditional Medicare has historically covered services related to a terminal illness under the hospice benefit even for patients enrolled in Medicare Advantage (MA) plans, meaning that fee-for-service Medicare has generally been responsible for coverage of most services while the MA plan is responsible for certain supplemental benefits. In 2021, CMS began testing the inclusion of hospice within the MA benefits package through the hospice component of the

Value-Based Insurance Design (VBID) Model.<sup>23</sup> MA plans participating in the demonstration are permitted to offer palliative care as well as supplemental benefits such as meals, transportation, and in-home supports. The demonstration has started small; for example, Humana is offering the hospice benefit to enrollees in a handful of metropolitan areas. Humana's benefit allows transitional concurrent care and offers in-home respite care.<sup>24</sup>

### *Disparities in End-of-Life Care*

Despite increases in the use of both hospice and palliative services in this country, racial disparities in end-of-life care persist, and communities of color remain underserved. Black and Latino people are more likely to die in a hospital and be treated more intensively at the end of life than Whites.<sup>25</sup> Black Americans are less likely to utilize hospice than Whites and have more emergency department visits and hospitalizations in the last six months of life.<sup>26</sup> While some have posited that differences in trust of health systems and patient preferences contribute to existing disparities,<sup>27</sup> more research and efforts to understand and reduce these disparities, and address cultural competence in end-of-life care, are needed.

### RELEVANT AMA POLICY

The AMA has long supported the goals of hospice and palliative care. Policy H-70.915 supports improved payments for health care practices caring for dying patients and encourages research into the needs of dying patients and how they could be better served by the health care system. Policy H-85.951, which was established through Council Report 4-I-16, (1) supports continued study and pilot testing by CMS of a variety of models for providing and paying for concurrent hospice, palliative and curative care; (2) encourages CMS to identify ways to optimize patient access to palliative care, and to provide appropriate coverage and payment for these services; and (3) encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures and to refer seriously ill patients accordingly.

Policy H-85.966 maintains that the use of hospice should provide the patient and family with appropriate support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying disease. Policy H-85.955 approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment; supports changes to the Medicaid program to allow provision of concurrent life-prolonging and palliative care; and supports broadening eligibility beyond six-month prognoses under Medicaid and Medicare hospice benefits. Policy D-155.995 supports greater evaluation of the use of disease management, case management, pay-for-performance, and end-of-life care programs for high-cost patients.

The AMA also has substantial policy on long-term care (LTC), including the financing of long-term services and supports (Policy H-280.945). Policy H-280.991 states that programs to finance LTC should cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual, and coordinate benefits across different LTC financing programs. Policy H-210.994 similarly supports the provision of LTC services in the least restrictive setting by affirming support of home health care as an alternative to nursing home or institutional care.

Policy H-290.982 supports: increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, and respite care; allowing states to use long-term care eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility; buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new LTC infrastructures and to encourage expansion of LTC financing to middle-income families who need assistance.

Policy D-280.985 directs the AMA to work to identify additional mechanisms by which patients' out-of-pocket costs for SNF care can be fairly covered. Under Policy H-280.947, the AMA continues to advocate for elimination of the three-day stay rule and requirements related to inpatient hospitalization as a prerequisite before Medicare patients are eligible for SNF or LTC placement.

## DISCUSSION

The 2015 Institute of Medicine (IOM) report, *Dying in America*, found that “significant problems remain in providing end-of-life care for Americans that is high quality and compassionate and preserves their choice while being affordable and sustainable.”<sup>28</sup> The IOM report further highlighted the need for policy changes to support high-quality end-of-life care by stating:

A major reorientation and restructuring of Medicare, Medicaid, and other health care delivery programs is needed to craft a system of care designed to ensure quality and address the central needs of all people nearing the end of life and their families. Current financial incentives and a lack of more appropriate alternatives drive a reliance on the riskiest and most costly care settings. These incentives should be changed, and positive alternatives should be further developed.

In addition, many of the most urgent needs of these patients and their families are not medical per se and require the design and implementation of affordable support service programs that rigorously target the highest-risk patients and families, and tailor services to specific family needs as they evolve over time.<sup>29</sup>

The sentiment of the IOM report is relevant to the concerns raised by referred Resolution 101-Nov-20 regarding end-of-life care, for patients who may benefit from custodial nursing care but are prohibited under current rules from electing Medicare’s SNF and hospice benefits at the same time for the same condition. The Council’s work on long-term services and supports and home and community-based services has highlighted the challenges of caring for our aging population and identifying affordable and politically viable solutions that meet the care needs of many seniors. Council on Medical Service Report 4, which is also being considered at this meeting, recommends new AMA policy on the hospital at home model, which we believe could benefit some patients at the end of life.

Medicare’s hospice benefit helps large numbers of patients and families, but it does not cover room and board for more than a small number of enrollees who qualify for short-term inpatient hospice, or a brief respite stay. Continuous home care that includes nursing and supportive care in one’s residence is allowable under Medicare’s hospice benefit but only during brief periods of crisis. Although routine home care makes up 98 percent of Medicare-covered hospice days, it is critical that general inpatient care, continuous home care, and respite inpatient care are available to hospice patients as their conditions change and their needs evolve.

The Council recognizes the ongoing need for custodial or continuous care, and ADL services, among many end-of-life patients and the importance of discharging these patients to appropriate settings—preferably where the patient resides—with necessary, affordable supports. The Council believes that hospice is well-suited to provide supportive care services as part of routine home care, as needed (since it already does so), and that the provision of such services as determined by patient need may improve quality of life and prevent utilization of higher intensity care. Accordingly, the Council recommends supporting Medicare coverage of and payment for supportive care services, including assistance with activities of daily living, as needed, under the hospice benefit.

The Council recognizes that a new room and board coverage benefit for hospice enrollees could significantly add to the costs of Medicare, a program already making headlines for its trust fund sustainability issues. The Council further recognizes that Medicare’s SNF and hospice benefits were not designed to work in tandem and differ in many respects, including their mission and goals, eligibility criteria, and duration of allowable services. SNFs are intended to provide rehabilitative—not palliative—services, some of which may not be needed at the end of life. Despite these differences, some similar services are provided by both SNFs and hospices, including skilled nursing, nursing aides, equipment, supplies and prescription drugs. A concurrent model would need to be carefully designed to prevent duplication of services, ensure administrative coordination and proper payment, and address site-neutral care. Although the Council does not recommend concurrent hospice and SNF care under the Medicare program, we believe the costs and benefits of care models incorporating elements of SNF and hospice are worthy of further study, especially given that COVID-19 may have impacted location preferences of hospice services. Accordingly, the Council recommends support for study and pilot testing by CMS of care models that allow concurrent use of Medicare’s hospice and SNF benefits.

Because of financial incentives and coverage gaps within Medicare, the Council expects that many patients will continue to be discharged to SNFs in the last months of life, and some will die there, especially as the elderly population grows and the SNF benefit continues to be utilized for its room and board coverage. Consistent with AMA policy supportive of coverage and payment for palliative care, the Council recommends supporting increased access

to palliative care services by Medicare patients in SNF. Finally, the Council acknowledges the breadth of existing AMA policy on hospice, palliative, and end-of-life care, and recommends reaffirmation of Policies H-85.966 and H-70.915.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 101-Nov-20, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit.
2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition.
3. That our AMA support increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.
4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease.
5. That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient.

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## 2. ACCESS TO HEALTH PLAN INFORMATION REGARDING LOWER-COST PRESCRIPTION OPTIONS (RESOLUTION 213-NOV-20)

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS  
IN LIEU OF RESOLUTION 213-NOV-20  
REMAINDER OF REPORT FILED  
*See Policies TBD***

At the November 2020 Meeting, the House of Delegates referred Resolution 213, “Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary,” which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. Reference committee testimony at the meeting was mixed regarding Resolution 213. While testimony supported the intent of Resolution 213, testimony also expressed concern that Resolution 213 could lead to unintended consequences of creating unnecessary administrative burdens on physicians, confusion for patients, and potential pharmacy scope of practice expansion. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology (HIT) solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.

### BACKGROUND

Patients are directly impacted by high prescription drug prices when they are still in the deductible period of their insurance plans, when the drugs prescribed are not covered by their insurance, when a nonpreferred formulary status for a particular drug leads to a higher patient cost-share, when Medicare Part D beneficiaries are in the “donut hole,” or when patients are uninsured. As the number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise, more patients may struggle with prescription affordability challenges. Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians

consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until patients attempt to purchase their drugs at the pharmacy that the selected pharmaceuticals are unaffordable for the patient.

Pharmacists play an important role in identifying instances of prescription drug prices impairing access to care. Critically, a pharmacist may be the first, and potentially only health care professional, who knows that a patient has declined a prescribed medication due to cost. The prescribing physician should be informed when a patient declines to fill a prescription as soon as possible, but as noted in testimony on Resolution 213-NOV-20, requiring pharmacists to communicate to the prescriber a lower-cost medication option can be problematic. Ideally, patient out-of-pocket costs associated with prescription options would be easily available through the electronic systems used by physicians and pharmacists, but that information is not currently universally available. In the absence of a technology tool, the only way to know which medications are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or call the insurance plan or PBM. Clearly, such a process is burdensome for everyone. Since the ultimate decision regarding which medication is most appropriate for a patient is made directly between physicians and patients, requiring pharmacists to research patients' formularies and discuss their research with the physician unnecessarily adds burden to both physicians and pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may increase confusion among patients and scope of practice concerns as patients seek prescription guidance from their pharmacists. Rather than imposing burdensome new legal requirements on pharmacists, the goal of improved prescription drug price transparency at the point of prescribing could be accomplished via improved HIT.

#### PRICE TRANSPARENCY AT POINT OF PRESCRIBING AND REAL-TIME PRESCRIPTION BENEFIT TECHNOLOGY

To empower informed joint decision-making, patients and physicians must have a way to obtain real-time, patient-specific prescription drug coverage information at the point of prescribing in physicians' electronic health records (EHRs).<sup>1</sup> Having access to accurate, current information about a patient's prescription benefit will enable physicians and patients to evaluate drug costs and consider possible alternative therapies when selecting a medication regimen. Drug price transparency at the point of care has the potential to reduce drug costs for patients (and public and private payers). Additionally, provision of such data within the e-prescribing workflow will ensure physician awareness of utilization management requirements, such as prior authorization requirements, step therapy protocols, and quantity limitations at the point of prescribing. Transparency of patient out-of-pocket costs and coverage restrictions in EHRs can therefore help mitigate medication nonadherence and treatment abandonment. Finally, by leveraging a technology solution embedded into existing EHRs, neither patients, physicians, pharmacists, nor payers would be burdened with the time-consuming process of manually cross-checking current formularies and potential medication alternatives. This technology solution currently exists in proprietary form, and a standardized version is on the horizon.

Real-Time Prescription Benefit (RTPB) technology, also known as Real-Time Benefit Tool (RTBT) technology in federal regulatory language, is a prescription drug decision-making tool that embeds real-time, patient-specific benefit information in the e-prescribing workflow.<sup>2</sup> RTPB tools allow prescribers to access accurate, patient-specific coverage and benefit information, including the expected out-of-pocket cost, for a chosen medication and pharmacy. RTPB tools also present prescribers with utilization management restrictions and plan-preferred alternative medication options, which may be more cost-effective for the patient.<sup>3</sup> RTPB tools represent a significant improvement over the drug formulary information otherwise incorporated into EHRs and e-prescribing. Existing drug formulary information is often inaccurate, outdated, and generally unreliable due to delayed updates and lack of patient specificity. The significant limitations in drug formulary information embedded into EHRs have caused some physicians to distrust (and consequently ignore) the formulary data currently available in EHRs.

Several proprietary RTPB tools are already being used by some physicians and health systems, but the proprietary nature of these tools limits their impact. Currently, physicians' ability to access RTPB information for a specific patient depends on whether there is a business relationship between the physician practice's RTPB tool software provider and the patient's drug plan. For example, Surescripts is collaborating with several EHR companies and leveraging information from the PBMs CVS Health and Express Scripts to provide RTPB tools for the patients and physicians in their network.<sup>4</sup> Similarly, OptumRx and UnitedHealthcare are collaborating to provide a similar tool,



specifically for their enrollees.<sup>5</sup> Accordingly, some physicians may have access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit information across all prescription drug plans, and tools do not yet integrate with all EHRs/e-prescribing systems. To achieve that level of universal access and transparency, a non-proprietary RTPB standard is required.

To test the hypothesized benefits of a standard RTPB tool, a research team at Johns Hopkins Medicine recently studied the impact of an RTPB tool integrated into the EHR at their institution.<sup>6</sup> The study found that the RTPB tool reduced physician prior authorization burden, achieved patient cost savings, and facilitated improved medication adherence. Specifically, the cost and day-supply information provided by the RTPB tool frequently led physicians and patients to choose a 3-month supply of medication instead of a 1-month supply, as many PBMs discount the copay on 3-month supplies, making the 3-month supply more cost effective. This has important health outcomes implications, as medication adherence increases with longer day-supply of prescriptions.<sup>7</sup> The most common changes in drug selection involved switching to alternatives with minimal clinical, but notable financial, significance. In addition, the information provided by the RTPB tool was able to guide prescribers in choosing medication alternatives without prior authorization requirements, and to convert from an agent covered with restrictions to one covered without restrictions, or to convert from an agent not covered to one covered with restrictions. These features reduced administrative burden on prescribers and increased the likelihood of patients being able to obtain their medication without delay. The study found patient cost savings of up to \$2,370 when a prescription was switched from a retail to mail order pharmacy. The average patient out-of-pocket cost savings due to changes in prescription was approximately \$21. Essential to building physician trust in the tool, the study found that the price estimates provided by the RTPB tool were accurate in 98 percent of the orders. The research team emphasized that webinars and in-person meetings were held to promote increased adoption and appropriate use of the RTPB tool, and since going live with the tool, they observed a significant increase in awareness from prescribers about the tool.

CMS intensified the need for standardized RTPB technology with its May 2019 final rule requiring that each Medicare Part D plan adopt one or more RTBTs that are capable of integrating with at least one EHR or e-prescribing system by January 1, 2021.<sup>8</sup> While this mandate could potentially help accelerate physician practices' access to RTPB tools, the CMS rule is significantly limited. The CMS rule allows Medicare Part D plans to support a single RTBT that is required to integrate with only one physician EHR/e-prescribing system. As such, physicians and their EHR vendors could presumably need to support a different RTBT for every Medicare Part D plan in order to have access to prescription benefit information for every Medicare patient treated by the practice. This would be an overwhelming, expensive, and burdensome proposition for vendors and physicians and would likely discourage adoption of this technology. Alternatively, since CMS is only requiring *one* RTBT capable of integrating with at least *one* e-prescribing system or EHR, some physicians may find that they have RTPB information for some, but not all, of their patients. Such incomplete access to RTPB information may lead to greater confusion and frustration, both among physicians and patients. An RTPB standard is needed to progress beyond the current proprietary and incomplete RTPB technology landscape and allow all physicians access through any EHR to any patient's specific benefit information.

The National Council for Prescription Drug Programs (NCPDP) has been developing an electronic standard for RTPB technology since 2014.<sup>9</sup> The NCPDP's Real Time Prescription Benefit Standard Task Group (RTPB Task Group) is responsible for developing the RTPB standard,<sup>10</sup> and the AMA has participated in the RTPB Task Group since its inception. At its August 2021 Virtual Interim Work Group meeting, the RTPB Task Group agreed to recommend that CMS recognize, via the federal rulemaking process, the RTPB standard that has been developed by NCPDP.<sup>11</sup> It is anticipated that the RTPB standard will have an implementation time-period of 2 years following the publication of a final rule.

As articulated in Resolution 213-NOV-20, currently it can be impossible for insured patients and their physicians to know at the point of prescribing what a prescribed drug will cost the patient. A standardized RTPB tool embedded into physicians' EHRs will close the current information gap among insurance plans, PBMs, pharmacies, patients and their physicians. The universality of a standardized RTPB tool is expected to significantly improve interoperability, expand transparency, increase prescription drug adherence, and promote informed communication and trust between patients and their physicians.<sup>12</sup>

#### ENHANCED PHYSICIAN EDUCATION REGARDING APPLICATION OF RTPB TECHNOLOGY

The Council commends the resolution sponsors for highlighting the critical problem of cost-related non-adherence and prescription abandonment and the urgent need for tools that will enhance communication among physicians and

pharmacists on behalf of patients. Resolution 213-NOV-20 also illustrates that RTPB technology is not currently a top-of-mind solution for the majority of physicians. The AMA's 2020 Physician Practice Benchmark Survey (2020 Benchmark Survey), which is a nationally representative survey of US physicians who provide patient care, and which included an explanation of RTPB technology, found that only 35.7 percent of physicians had heard of RTPB technology prior to taking the survey.<sup>13</sup> Moreover, among that portion of the physician population who had heard of RTPB technology, only about 55 percent of those physicians had access to RTPB technology. This may be due to the proprietary nature of the currently available RTPB tools. However, the physicians who have access to RTPB technology overwhelmingly choose to take advantage of the tool. In fact, the 2020 Benchmark Survey found that physicians who have access to RTPB tools are over four times as likely to use the RTPB technology available to them than not. Accordingly, not only is there an urgent need for a standard RTPB tool that will provide all physicians access to all patients' specific benefit information at the point of prescribing, but there is also an urgent need to help the approximately 64 percent of physicians who are unfamiliar with RTPB technology understand the tool's significant value so that they will be prepared to optimally utilize RTPB technology, once it is available to them.

#### ADDITIONAL TOOLS TO FILL PRESCRIPTION DRUG COST INFORMATION GAPS

The Council recognizes that RTPB technology is not a panacea that can solve the much broader problem of prescription drug cost transparency in all contexts. As the "Benefit" element of the RTPB name implies, RTPB tools will only increase point of prescribing price transparency for insured patients. Yet, out-of-pocket prescription drug cost transparency is essential for all patients. Some patients are uninsured or underinsured, and formulary status may not be relevant to these patients. Some local pharmacies may charge lower retail prices for certain prescription drugs than others, and there may be prescription discount programs available for some medications (e.g., directly through manufacturers or through drug discount aggregator websites, such as GoodRx). Clearly, there is an urgent need for ongoing HIT innovation to enhance prescription drug price transparency in all contexts, and the AMA continues to advocate for improvements.

While the health care industry awaits implementation of a standard RTPB tool to provide price transparency for insured patients and awaits additional future tools to provide optimal prescription out-of-pocket cost information at the point of prescribing for all patients, physicians may want to further explore how tools within their current EHR systems could be used to mitigate concerns about prescription abandonment. Among the features that are legally required to be included in all EHR software are tools that facilitate communication between pharmacies and prescribers, and these tools could be used to help identify and respond to patients who encounter cost barriers when attempting to fill their prescriptions. For example, the "RxFill transaction" can be used to communicate between a pharmacy and a prescriber, informing a prescriber whether a specific prescription was dispensed (or partially dispensed) to a patient.<sup>14</sup> Accordingly, if a physician is notified that a patient has never picked up an essential medication, the physician can follow-up with the patient to determine why the prescription was abandoned and if an alternative medication is appropriate. Physicians can choose to receive RxFill notifications for certain patients who are prescribed certain medications (e.g., insulin for patients with diabetes), but not for others (e.g., prescriptions for seasonal allergy medication). EHRs may allow physicians to further customize how and when they are notified. Similarly, physicians can communicate electronically with pharmacies to discuss prescription options. If a patient declines a drug, pharmacies can use the "RxChangeRequest Transaction" to send prescribers options regarding potential alternatives to originally prescribed medications.<sup>15</sup> For example, pharmacists may suggest a generic alternative to a brand-name drug, or they may suggest another drug that is available at a cheaper price. Upon receiving an RxChangeRequest, a prescriber can respond with an "RxChangeResponse transaction" to either approve or decline the RxChangeRequest, and the prescriber is able to provide additional comments in the response.<sup>16</sup> Importantly, both EHR vendor implementation and pharmacy information systems technology implementation of these e-prescribing tools varies. Physicians who believe that the use of RxFill and/or RxChangeRequest and RxChangeResponse could support their practice are encouraged to seek additional information from their EHR vendor and local pharmacies.

Physicians can also encourage their patients to utilize currently available consumer-facing prescription drug price transparency tools. For example, when shopping for a Medicare plan, Medicare patients can look-up the cost of their prescription medications under various Medicare plan options.<sup>17</sup> There are a variety of drug discount programs, including drug discount aggregator websites, that allow patients to compare prescription drug prices and obtain coupons that can be used at local pharmacies. Drug discount aggregator websites allow patients to view and compare prices of brand name and generic versions of prescription drugs and provide coupons that patients may choose to use when filling their prescriptions. These coupons can be especially helpful and straightforward for patients who do not have insurance coverage for prescription drugs, but because medications purchased using a coupon may not

automatically be counted towards insured patients' deductibles, they may not always provide overall cost-savings for insured patients.<sup>18</sup> A federal regulation finalized in 2020 provides insured patients with greater out-of-pocket cost transparency beginning in 2023.<sup>19</sup> The Transparency in Coverage final rule requires most individual and group health plans to make available to participants, beneficiaries and enrollees personalized out-of-pocket cost information for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request.<sup>20</sup> This will allow patients to obtain real-time, accurate out-of-pocket cost estimates that they can share with their physicians as they engage in joint decision-making and care planning. In addition to providing greater real-time cost transparency for patients and their physicians, starting in 2022, the Transparency in Coverage final rule will require disclosure of in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.<sup>21</sup> Researchers and third-party developers and innovators can use this data to create private sector solutions to achieve greater price transparency.<sup>22</sup>

## AMA POLICY AND ADVOCACY

Long-standing AMA policy supports ongoing advocacy for the development of HIT tools, such as an RTPB standard, that enhance prescription drug price transparency. Policy H-450.938 states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. In addition, the policy calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy H-110.990 supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can jointly decide on treatment. Recent Policy H-125.974 states that our AMA will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and CMS to work with physician and hospital organizations, and HIT developers, in identifying RTPB implementations and published standards that provide real-time information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. This policy also states that the AMA will advocate to the ONC and CMS that any policies requiring HIT developers to integrate RTPB within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. Moreover, the policy establishes that the AMA will support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Additionally, AMA policy and advocacy promote open communication between pharmacists and physicians when issues of prescription unaffordability arise and increased price transparency at the pharmacy. Policy H-285.965 urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary. Moreover, Policy H-110.991 advocates for greater prescription drug price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the patient's copay be listed on prescription receipts, (2) pursuing legislation that would require pharmacies to inform patients of the cash price as well as the formulary price of any medication prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that would prohibit pharmacies from disclosing when a patient's copay is higher than the drug's cash price (so called "gag clauses"). The AMA developed model legislation consistent with Policy H-110.991, similar bills have been enacted in several states, and federal legislation was enacted to prohibit gag clauses in Medicare, Medicare Advantage,<sup>23</sup> group, and individual health insurance plans.<sup>24</sup> Related, in response to Policy H-110.987, the AMA developed model state legislation entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year" which addresses the issue of timely prescription decision support and would authorize a pilot study to integrate transparency data at the point of care, with information such as medicines' formulary status, cost-sharing tier, patient out-of-pocket cost, and coverage restrictions being integrated into EHRs or e-prescribing systems.

The AMA continues to advocate extensively in support of an RTPB standard. Since 2014, the AMA has been actively engaged in the development of the NCPDP RTPB standard to ensure that any mandated standard will meet the needs of physician end-users and their patients. The AMA serves as a member of the NCPDP's RTPB Task Group which is comprised of stakeholders from across the health care industry, including organized medicine, hospitals, payers, HIT vendors, and pharmaceutical/life sciences companies. NCPDP has quarterly workgroup meetings, and the RTPB Task

Group meets weekly to discuss and continue developing the RTPB standard. Collectively, the RTPB Task Group is committed to the goal of developing and publishing an RTPB standard that will meet the needs of and benefit every sector of the health care industry and that will be readily adopted by CMS.

During recent testimony at the Congressional Hearing, “Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain,” the AMA emphasized the challenges patients and physicians encounter due their inability to access patient-specific formulary and cost-sharing information at the point of care.<sup>25</sup> The AMA has also recently submitted written comments to CMS<sup>26</sup> and presented to the ONC Health Information Technology Advisory Committee (HITAC) Intersection of Clinical and Administrative Data Task Force (ICAD) strongly supporting an RTPB standard. Additionally, the AMA recently submitted comments to CMS that highlighted the importance of physicians having access to real-time, patient-specific prescription drug coverage information at the point of prescribing in physicians’ EHRs, supported CMS’ efforts to expedite industry implementation of RTBT, and recommended that CMS require plans to support a single RTBT standard, when made available.<sup>27</sup>

Finally, in 2016, the AMA launched a grassroots campaign and website, [TruthinRx.org](http://TruthinRx.org), the goal of which is to address the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs. [TruthinRx.org](http://TruthinRx.org) provides a platform through which individuals can sign petitions to members of Congress and template letters that website visitors can customize and directly send to their US Senators and US Representatives, calling on them to support increased transparency in prescription drug prices. Coordinated with AMA model legislation, and state and national engagement, [TruthinRx.org](http://TruthinRx.org) is updated to reflect advances in AMA policy and pharmaceutical industry activities.

## DISCUSSION

Resolution 213-NOV-20 highlighted physicians’ need for patient-specific, real-time formulary and cost-sharing information, and an RTPB standard would fill that need. A standardized RTPB tool integrated into EHR systems will allow physicians to have real-time access, at the point of prescribing, to a current report of whether a specific medication is on a specific patient’s prescription formulary. A standardized RTPB tool will provide patient-specific out-of-pocket cost for a selected medication at that patient’s designated primary pharmacy, and it will alert physicians to applicable utilization management restrictions. A standardized RTPB tool will present physicians with options of alternative medications that are covered by a patient’s insurance plan, and this will empower physicians and patients to decide together, before the patient leaves the examination room, whether the medication is not only clinically, but also financially, well-suited for the patient. If the medication is unaffordable, the physician can pull up this same information for other medications equally clinically appropriate for the specific patient, and it will allow physicians to see the drug discount program prices for the queried pharmacy. Accordingly, the Council recommends that the AMA continue to zealously advocate for the development, publication, adoption, and mandated use of standardized RTPB tools with minimal burden on physicians. In addition, the Council recognizes that many practicing physicians have not been made aware of how a standard RTPB tool will enhance their practice, or how HIT tools already available within their EHR and/or e-prescribing systems can enhance communication between physicians and pharmacists. For this reason, the Council recommends that the AMA develop and disseminate educational materials that will empower physicians to leverage these HIT tools to enhance their practices.

The Council recognizes that the question of whether a particular prescription drug is on a patient’s insurance formulary is just one component of the much larger prescription drug affordability challenge. The AMA will continue to advocate for technology tools to efficiently address the broad range of prescription price transparency and affordability challenges unrelated to insurance benefits. For these reasons, the Council recommends amending Policy H-110.990 to specifically call for the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient’s medical condition. Related, the Council recommends amending Policy H-125.974 which supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools, and advocates that regulators work with physician and hospital organizations, and HIT developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. The Council recommends adding to this strong policy to also specify that the AMA will advocate that regulators include proven and established real-time pharmacy benefit criterion within EHR certification programs and that integration of RTPB tools within HIT be accomplished

without disruption to EHR usability and minimal to no cost to physicians and hospitals. Finally, the Council recommends reaffirming Policy H-450.990 which calls for physician access to the best available cost data at the point of decision-making.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 213-NOV-20 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient.
2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals.
3. That our AMA develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment.
4. That our AMA amend Policy H-110.990 by addition and deletion, as follows:

Our AMA: ...

2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; ~~and~~

3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and

4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information

5. That our AMA amend Policy H-125.974 by addition and deletion as follows:

Our AMA will: ...

(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;

(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;

~~(5)~~ will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without minimal disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and...

6. That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates that cost data be delivered in a reasonable and useable manner by third-party payers and purchasers. The policy also calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making.

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#### APPENDIX - Policy Recommended for Amendment or Reaffirmation

##### H-110.990, Cost Sharing Arrangements for Prescription Drugs

###### Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13 Reaffirmed in lieu of: Res. 205, A-17 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: CMS Rep. 07, A-18)

##### H-125.974, Continuity of Care for Patients Discharged from Hospital Settings

###### Our AMA:

- (1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
- (2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
- (3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
- (4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
- (5) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals; and
- (6) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. (CMS Rep. 2, A-21)

##### H-450.938, Value-Based Decision-Making in the Health Care System

###### PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmation: I-17 Reaffirmed: CMS Rep. 06, A-19)



### **3. COVERING THE REMAINING UNINSURED (RESOLUTION 123-JUN-21)**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS  
IN LIEU OF RESOLUTION 123-JUN-21  
REMAINDER OF REPORT FILED  
*See Policies TBD***

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The nation has witnessed record enrollment in Affordable Care Act (ACA) coverage, via coverage offered on ACA marketplaces and under the Medicaid expansion, as well as through the Special Open Enrollment Period that recently ended. Resulting from the ARPA, a significant proportion of the uninsured is now eligible for ACA financial assistance, either in the form of premium tax credits to purchase marketplace coverage, or Medicaid. However, some segments of the uninsured population continue to be left behind, with potential negative effects on their health outcomes and financial security, as well as systemwide impacts resulting from how their care is provided and financed. After reviewing American Medical Association (AMA) policy as well as health reform legislation and regulation at the state and federal levels, the Council concluded that new and innovative AMA policy is needed targeting select segments of the uninsured population.

Subsequently, at the June 2021 Special Meeting of the House of Delegates, Resolution 123, Medicare Eligibility at Age 60, was referred. Introduced by the Medical Student Section, Resolution 123 asked that our AMA advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

This report provides background on the ACA improvements included in the ARPA; outlines the AMA proposal for reform; analyzes the need for new AMA policy to improve the coverage rates for each segment of the post-ARPA uninsured; examines the uninsured population ages 60 to 64 and evaluates potential pathways to increase coverage to this population, including lowering the Medicare eligibility age; and presents policy recommendations.

#### **BUILDING UPON THE ACA: THE AMERICAN RESCUE PLAN ACT**

The ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the federal poverty level (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, the ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL (\$51,040 for an individual and \$104,800 for a family of four based on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent (i.e., 60 percent of benefit costs covered) or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Also consistent with Policy H-165.824, ARPA increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

Individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. The only change ARPA made to cost-sharing reduction eligibility and generosity was targeted to those receiving unemployment compensation. Individuals receiving unemployment compensation in 2021 who qualify for exchange coverage and enroll in a silver plan—regardless of income—are eligible for substantial cost-sharing reductions.

At the time that this report was written, 38 states and the District of Columbia had adopted the Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.<sup>1</sup> ARPA included new incentives for states to implement Medicaid expansions. States that have not yet expanded Medicaid are now eligible for a five-percentage-point increase in their traditional Federal Medical Assistance Percentage Rate (FMAP) for two years if they newly implement the Medicaid expansion, applicable to a large share of their Medicaid population and spending. In the near term, the new five-percentage-point increase would be in addition to the current 6.2-percentage-point increase in the match rate provided under the



Families First Coronavirus Response Act (FFCRA) pursuant to the COVID-19 public health emergency. Importantly, states that newly expand would also receive a 90 percent federal match for the expansion population.

#### THE AMA PROPOSAL FOR REFORM

Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the ACA, the AMA proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage environment. The AMA proposal for reform focuses on expanding health insurance coverage to four main population targets:

1. Individuals eligible for ACA's premium tax credits who remain uninsured (11 million);
2. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) who remain uninsured (7.3 million);
3. People who remain uninsured who are ineligible for ACA's premium tax credits due to an offer of "affordable" employer-sponsored coverage (3.5 million); and
4. People with low incomes who remain uninsured and are ineligible for Medicaid (2.2 million).<sup>2</sup>

By appropriately targeting the provision of coverage to the uninsured population, the AMA proposal for reform has aimed to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Premium tax credits would be available to individuals without an offer of "affordable" employer coverage, with no upper income limit (Policy H-165.824).
- Individuals currently caught in the "family glitch" and unable to afford coverage offered through their employers for their families would become eligible for ACA financial assistance based on the premium for family coverage of their employer plan (Policy H-165.828). Currently, in determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. As a result, the "family glitch" leaves many workers and their families ineligible to receive premium and cost-sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they would likely have to pay well over 9.83 percent of their income for family coverage.
- To help employees currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income (Policy H-165.828).
- The generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan (Policy H-165.824).
- Young adults facing high premiums would be eligible for "enhanced" tax credits based on income (Policy H-165.824).
- Eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
- The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact their ability to access and afford the care they need (Policy H-165.824).
- A permanent federal reinsurance program would be established, to address the impact of high-cost patients on premiums (Policy H-165.842).
- State initiatives to expand their Medicaid programs will continue to be supported. To incentivize expansion decisions, states that newly expand Medicaid would still be eligible for three years of full federal funding (Policies D-290.979 and H-290.965).
- Public options would be explored as potential pathways to provide health insurance coverage to uninsured individuals who fall into the "coverage gap" at no or nominal cost, provided that they meet the standards outlined in Policy H-165.823.
- To maximize coverage rates, the AMA would support the auto-enrollment of individuals who qualify for zero-premium marketplace coverage or Medicaid/CHIP in health insurance coverage, and continue to support the use of individual mandate penalties at the state and federal levels (Policies H-165.823, H-165.824 and H-165.848).
- To improve coverage rates of individuals eligible for either ACA financial assistance or Medicaid/CHIP but who remain uninsured, the AMA would support investments in outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982).
- States would continue to have the ability to test different innovations to cover the uninsured, provided such experimentations: a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care; b) ensure and maximize patient choice of physician and private health plan; and c) include reforms that eliminate denials for pre-existing conditions (Policy D-165.942).

## NEED FOR NEW AMA POLICY TO ADDRESS THE POST-ARPA UNINSURED: FILLING IN URGENT POLICY GAPS

While the exact number of the uninsured is in flux due to the COVID-19 pandemic and resulting changes in employment and eligibility for either ACA premium assistance or Medicaid, Kaiser Family Foundation (KFF) released estimates that offer a profile of the post-ARPA uninsured. Of note, these estimates are based on 2019 American Community Survey data; the time delay may affect overall numbers, but these estimates are still expected to provide a representative overview of the uninsured population. Overall, KFF estimates that 28.9 million nonelderly individuals are uninsured.<sup>3</sup> The Council has analyzed the remaining uninsured post-ARPA to assess whether new AMA policy is needed targeting select segments of the remaining uninsured. The Council's analysis concluded that how to best cover three segments of the uninsured population is currently not sufficiently addressed in AMA policy and AMA's plan to cover the uninsured: the uninsured who are ineligible for ACA financial assistance due to falling into ACA's coverage gap, the uninsured who are ineligible for ACA financial assistance due to immigration status, and the uninsured ineligible for ACA financial assistance due to having an offer of affordable employer coverage. Critically, without the implementation of policy solutions for these populations, many will be left without any affordable coverage options.

### *Uninsured Ineligible for ACA Financial Assistance Due to Falling into ACA's Coverage Gap*

Resulting from states not implementing the Medicaid expansion provided for under the ACA, more than two million of the nonelderly uninsured find themselves in the coverage gap—not eligible for Medicaid, and not eligible for premium tax credits because they reside in states that did not expand Medicaid.<sup>4</sup> Approximately 60 percent of individuals who fall into the coverage gap are people of color. Three of four individuals who fall into the coverage gap reside in four states—Florida, Georgia, North Carolina and Texas.<sup>5</sup> Of note, an additional 1.8 million uninsured adults in non-expansion states with incomes between 100 and 133 percent FPL are currently eligible for premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage but would become eligible for Medicaid if their state implemented the Medicaid expansion.<sup>6</sup>

Medicaid eligibility for adults in states that did not expand their Medicaid programs is quite limited. The median limit for parents in these states is 40 percent FPL. Childless adults—regardless of income—remain ineligible for Medicaid in nearly all states that did not expand their Medicaid programs. Significantly, childless adults make up more than three of four individuals who fall into the coverage gap. Overall, approximately half of individuals who fall into the coverage gap have incomes under 50 percent FPL, which amounts to \$6,440 per year for an individual, or \$537 per month.<sup>7</sup>

Approximately two-thirds of individuals in the coverage gap are in working families, with half working themselves.<sup>8</sup> Overall, individuals who fall in the coverage gap are in households in which workers earn low wages, work part-time, or are not consistently employed. Without access to Medicaid or heavily subsidized marketplace coverage, the uninsured in the coverage gap simply do not have access to affordable coverage options. For example, in 2021, the national average unsubsidized premium for a 40-year-old non-smoker seeking coverage on ACA marketplaces was \$436 per month for the lowest-cost silver plan and \$328 per month for a bronze plan. This is equivalent to roughly 80 percent of income for those at the lower income range of the coverage gap (below 40 percent FPL), and nearly a third of income for those with incomes closer to the poverty line.<sup>9</sup>

### Assessment of the Need for New AMA Policy

Policy D-290.979 states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. Policy H-290.965 supports states that newly expand Medicaid being made eligible for three years of full federal funding. Policy H-290.966 encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap; encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations; and encourages the Centers for Medicare & Medicaid Services (CMS) to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such 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. Policies H-165.920 and H-165.865 advocate for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits. Policy H-165.855 encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance. Policy H-165.823 states that any public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility—at no or nominal cost.

At the time that this report was written, there were three main pathways to provide coverage to the uninsured who fall into the coverage gap. One strategy, as past COVID-19 relief bill provisions aimed to do, would be to provide more incentives to states to adopt ACA's Medicaid expansion. The Council notes that, at this juncture, it is unclear whether additional financial incentives would cause any additional states to expand Medicaid. Another strategy would be to extend eligibility for premium tax credits and cost-sharing reductions to individuals with incomes below the poverty line, the current floor for eligibility. Lastly, the establishment of a federal Medicaid-like program or another type of public option has been discussed to cover those individuals who fall in the coverage gap in non-expansion states. While the AMA has policy relevant to each of the leading legislative approaches to provide individuals in the coverage gap with a source of health insurance coverage, the Council believes that new policy is needed to

address the affordability of coverage offered under any federal approach to provide coverage to this population, as well as the impacts of any intervention on states that have already expanded Medicaid. The Council believes that there is a need for new policy to ensure that any federal approach targeted at the uninsured who fall in the coverage gap makes health insurance coverage available to this population at no or nominal cost, with significant cost-sharing protections. In addition, the Council believes that it is critical for any federal approach to address the coverage gap protect against current expansion states from dropping their Medicaid expansions.

#### *Uninsured Ineligible for ACA Financial Assistance Due to Immigration Status*

Almost four million of the nonelderly uninsured are ineligible for ACA financial assistance due to their immigration status.<sup>10</sup> Overall, lawfully present and undocumented immigrants were significantly more likely to be uninsured than citizens in 2019. Among the nonelderly population, 25 percent of lawfully present immigrants and 46 percent of undocumented immigrants were uninsured, compared to nine percent of citizens. Critically, noncitizen children are more likely to be uninsured than citizen children.<sup>11</sup>

The higher uninsured rate among noncitizens is partially rooted in eligibility restrictions for Medicaid, CHIP and ACA marketplace coverage. Currently, many qualified non-citizens, including many lawfully permanent residents or green card holders, face a five-year waiting period after receiving qualified immigration status before becoming eligible for Medicaid and CHIP. Populations exempt from the five-year waiting period include refugees, asylees and lawfully permanent residents who used to be refugees or asylees. States currently have the option to eliminate the five-year waiting period for lawfully present children and pregnant women without a qualified immigration status. At the time this report was written, 35 states have extended coverage to affected children, with half of states having done so for impacted pregnant women.<sup>12</sup>

An alternative to coverage for lawfully present immigrants who are affected by the five-year waiting period or do not have a qualified immigration status is to seek coverage on ACA marketplaces and receive subsidies for coverage. These lawfully present immigrants with incomes below the poverty line are eligible to receive premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage even if they are ineligible for Medicaid based on their immigration status. Lawfully present immigrants with incomes between 100 and 400 percent of FPL are eligible for premium tax credits and cost-sharing reductions to purchase coverage if they are not eligible for other coverage.

However, undocumented immigrants are not eligible to purchase coverage through the ACA marketplaces, even if they pay the full cost because they are not eligible for subsidies. In addition, they are not eligible to enroll in Medicaid or CHIP. These eligibility restrictions for Medicaid, CHIP and marketplace coverage also extend to individuals with Deferred Action for Childhood Arrivals (DACA) status, as they are not considered lawfully present and remain ineligible for coverage options, according to rules issued by CMS. With these restrictions in place, some states and localities have established programs to provide coverage to certain groups of immigrants regardless of immigration status, without the use of federal funds.

#### Assessment of the Need for New AMA Policy

Policy H-290.983 opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. Policy H-440.903 directs the AMA to actively lobby federal and state governments to restore and maintain funding for public health care benefits for all lawfully present immigrants. Policy H-350.957 advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. Policy H-440.876 opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and opposes proof of citizenship as a condition of providing health care. Policy D-440.985 states that our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

The Council believes that existing policy sufficiently addresses the need to provide health insurance coverage to lawfully present immigrants and has enabled the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/CHIP. The Council is cognizant that proper knowledge surrounding eligibility for benefits is key to eligible immigrants enrolling in Medicaid, CHIP or marketplace coverage. The Council believes that existing policy addressing outreach and enrollment assistance for Medicaid/CHIP coverage, and financial assistance to purchase marketplace coverage, is sufficient to address this barrier to enrollment in coverage. However, there remains a gap in AMA policy that provides an avenue for undocumented immigrants and DACA recipients to access coverage options. There is a need for AMA policy in support of allowing undocumented immigrants and DACA recipients to purchase unsubsidized coverage on ACA marketplaces, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. Without that guarantee in place, fear of immigration enforcement could preclude a segment of the immigrant population from enrolling in coverage. AMA policy also may be needed to address state and local initiatives to provide coverage to immigrants regardless of their immigration status; existing policy only addresses the reimbursement for the care provided to undocumented immigrants.

*Uninsured Ineligible for ACA Financial Assistance Due to Having an Affordable Offer of Employer Coverage*

Approximately 3.5 million of the nonelderly uninsured are ineligible for ACA's premium tax credits because they have an "affordable" offer of employer-sponsored insurance coverage.<sup>13</sup> To be considered "affordable," employer coverage must have an actuarial value of at least 60 percent and the employee share of the premium must be less than 9.83 percent of income in 2021. Notably, following the enactment of ARPA into law, inconsistencies now exist between the definition of affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the percentage of income at which premiums are capped for individuals with the highest incomes eligible for subsidized marketplace coverage. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. But employer coverage with an employee share of the premium less than 9.83 percent of income is considered to be "affordable."

In determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. Defining the affordability of employer coverage based on the premium contribution for employee-only coverage, and not family-based coverage, is rooted in ambiguity within the ACA as to how affordability is defined for family members of employees offered employer-sponsored coverage. As a result, the Joint Committee on Taxation interpreted the law to base the definition of employer-sponsored coverage solely on the cost of employee-only coverage; this interpretation was ultimately adopted in regulations issued by the Internal Revenue Service. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. The average employee contribution for self-only coverage was estimated to be \$1,243 in 2020, while the average contribution for family coverage was estimated to be \$5,588.<sup>14</sup>

The "family glitch" leaves many families of workers ineligible to receive premium and cost-sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they would likely have to pay well over 9.83 percent of their income for family coverage. Overall, 5.1 million individuals fall into ACA's family glitch, more than half of whom are children. Of this number, 4.4 million are currently covered by an employer plan, 315,000 are enrolled in unsubsidized individual market coverage, and 451,000 are uninsured.<sup>15</sup> A study from 2016 estimated that, on average, families who fall into the family glitch spent 15.8 percent of their incomes on employer-sponsored coverage.<sup>16</sup>

Assessment of the Need for New AMA Policy

Policy H-165.828 supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the ACA. Existing AMA policy, therefore, does not take into consideration the inconsistency between the definition of affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the percentage of income at which premiums are capped for individuals with the highest incomes eligible for subsidized marketplace coverage. The Council believes that this inconsistency should be rectified.

Policy H-165.828 also supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. However, current discussions surrounding fixing ACA's family glitch are exploring a different solution to fixing the glitch, which would in effect decouple the worker from their family in determining eligibility for premium tax credits to purchase coverage. As such, a spouse and/or child in a family offered "affordable" employee-only coverage but unaffordable family coverage would become eligible for premium subsidies to purchase marketplace coverage. The worker, meanwhile, would remain only eligible for the employee-only employer-sponsored coverage, not premium subsidies to purchase coverage on the ACA marketplaces. Because employees would not be newly eligible for premium tax credits, there would be no impact on liability for employers under the employer mandate, as the mandate is only applicable if an employee receives subsidies, not their family members.

Under this option, the family would be covered by at least two different health plans and would be responsible for the premiums associated with each plan, including that associated with the employee-only employer-sponsored coverage as well as that associated with the marketplace plan. Accordingly, not all families would necessarily be better off switching from their employer-sponsored family plan. However, many families would be better off, even those that may still need to pay more than 9.83 percent of their income for coverage of their entire family between employer-sponsored and marketplace plan premiums. It has been estimated that families switching from their employer plans would save approximately \$400 per person in premiums on average, with families with incomes below 200 percent FPL saving \$580 per person. Overall, while some currently covered by employer-sponsored coverage would transition to marketplace or Medicaid/CHIP coverage under this approach to fixing the family glitch, it also has been projected to cover nearly 200,000 uninsured individuals impacted by ACA's family glitch.<sup>17</sup>

POST-ARPA UNINSURED POPULATIONS FOR WHOM AMA POLICY IS SUFFICIENT: LOOKING AHEAD

The Council's analysis concluded that AMA policy sufficiently addresses how best to cover three segments of the post-ARPA uninsured population: the uninsured eligible for ACA premium tax credits, the uninsured eligible for Medicaid, and the uninsured who have an affordable ACA marketplace plan available to them without the need for any subsidy. That being said, the Council

underscores the need for AMA policy to be implemented to cover these populations, ranging from ramping up outreach and enrollment assistance, to making additional improvements to ACA's premium tax credits and cost-sharing subsidies, to implementing auto-enrollment for those eligible for zero-premium marketplace plans or Medicaid.

#### *Uninsured Eligible for ACA Premium Tax Credits*

Eleven million of the nonelderly uninsured are eligible for premium tax credits, at least six million of whom are eligible for zero-premium marketplace plans.<sup>18</sup> Of those individuals eligible for zero-premium marketplace plans, approximately 1.3 million have incomes below 150 percent FPL (\$19,140 for an individual and \$39,300 for a family of four based on 2020 federal poverty guidelines) and are eligible for zero-premium silver plans with cost-sharing reductions that result in their deductibles being reduced to an average of \$177 and thus resembling platinum-level coverage<sup>19</sup> (90 percent of benefit costs covered). Individuals receiving unemployment compensation in 2021 who qualify for exchange coverage and enroll in a silver plan—regardless of income—are also eligible for substantial cost-sharing reductions that also cause their coverage to resemble that of a platinum plan. Even with the additional premium assistance provided for in the ARPA, a segment of the uninsured eligible for premium tax credits may not see the benefit in getting covered if they cannot afford their deductibles, copayments, and other cost-sharing responsibilities.

#### Assessment of the Need for New AMA Policy

Under Policy H-165.824, (1) there would be adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) the generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan; (3) young adults facing high premiums would be eligible for “enhanced” tax credits based on income; (4) eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll; (5) the size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact their ability to access and afford the care they need; and (6) the subsidy “cliff” would be eliminated. Policy H-165.823 highlights the potential for auto-enrollment as a strategy to cover the more than six million individuals eligible for zero-premium marketplace plans who remain uninsured.

As such, the Council believes that existing AMA policy is sufficient to address how best to cover uninsured individuals eligible for premium tax credits. Policy H-165.823 would provide a pathway for the six million uninsured individuals eligible for zero-premium coverage to become insured. Policy H-165.824 would enable the AMA to not only advocate to make the ARPA enhancements—improved premium tax credit generosity and ACA subsidy cliff elimination—permanent, but would support advocacy efforts to take additional steps to make premiums more affordable for the uninsured who are subsidy-eligible, as well as tackle barriers posed by deductibles and cost-sharing requirements. The policy also recognizes that uninsured individuals eligible for premium tax credits can only enroll in subsidized coverage if they are aware that they are eligible, which is why outreach efforts are so critical.

#### *Uninsured Eligible for Medicaid*

More than seven million of the nonelderly uninsured are eligible for Medicaid/CHIP, which includes adults in the Medicaid expansion population and populations eligible for Medicaid/CHIP under pre-ACA rules but who have not enrolled.<sup>20</sup> The reasons for this group remaining uninsured remain multifaceted, ranging from not being aware of their eligibility for coverage, to perceived stigma associated with public coverage, to facing barriers to enrollment, including those which are administrative or technical in nature.

#### Assessment of the Need for New AMA Policy

To improve coverage rates of individuals eligible for Medicaid/CHIP but who remain uninsured, AMA policy supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). Policy H-165.823 states that individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/CHIP.

As such, the Council believes that existing AMA policy is sufficient to address how best to cover uninsured individuals eligible for Medicaid. Policy H-165.823 would provide a mechanism through which the uninsured who are Medicaid-eligible would be able to gain coverage via auto-enrollment. Until auto-enrollment for Medicaid-eligible individuals is able to be implemented, investments in outreach and enrollment assistance activities will be essential to get this segment of the uninsured covered.

#### *Uninsured Who Have an Affordable Marketplace Plan Available to Them*

More than one million of the nonelderly uninsured have an affordable ACA marketplace plan available to them with an unsubsidized benchmark premium that is less than 8.5 percent of their household income without a premium tax credit, making them ineligible for ACA financial assistance.<sup>21</sup> Of note, this segment of the uninsured has higher incomes, but removing ACA's subsidy cliff still does not make them eligible for premium assistance.

### Assessment of the Need for New AMA Policy

Policy H-165.824 supports lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan. Policy H-165.848 supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.

The Council notes that a segment of this population could potentially become eligible for premium tax credits if the cap on premiums as a percentage of income were lowered even further than what the ARPA accomplished. That being said, using a policy “stick” to get this population covered may be necessary, including a state and/or federal individual mandate penalty. Accordingly, the Council believes that existing AMA policy is sufficient to address how best to cover this segment of the uninsured population.

### COVERING THE UNINSURED AGES 60 TO 64

Following the referral of Resolution 123 at the June 2021 Special Meeting of the House of Delegates, the Council examined the segment of the uninsured ages 60 to 64 to ascertain what improvements, if any, need to be made to AMA’s proposal for reform to ensure that this population has a pathway to coverage, and to assess the merits of lowering the Medicare eligibility age to age 60. Of the 20.8 million individuals ages 60 to 64 in the US, 56.3 percent are enrolled in employer-sponsored coverage, 14.5 percent are enrolled in Medicaid, 11.3 percent are enrolled in non-group coverage, 10.1 percent are enrolled in other public coverage (e.g., Medicare and military coverage), and 7.8 percent are uninsured.<sup>22</sup>

Of the uninsured ages 60 to 64, nearly half are eligible for premium tax credits. Further, nearly 20 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven percent are ineligible for ACA financial assistance due to immigration status.<sup>23</sup>

### *Assessment of the Need for New AMA Policy*

The Council notes that the earlier sections of this report address how existing AMA policy pertains to each segment of the uninsured population ages 60 to 64. For the uninsured eligible for premium tax credits, making premium tax credit assistance more generous, and expanding eligibility for and improving the generosity of cost-sharing subsidies, will be highly beneficial. The Council understands that when this population is able to enroll in ACA marketplace coverage, affordable cost-sharing levels will be critical so they will be able to access the care they need. The Council believes that subsidized ACA marketplace coverage with improved cost-sharing assistance is the preferable option to cover this segment of the uninsured population ages 60 to 64, especially considering that most current traditional Medicare beneficiaries are enrolled in supplemental insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more comprehensive cost-sharing protections than what is offered in the traditional Medicare program. Subsidized ACA marketplace assistance would also become available to some of the uninsured ages 60-64 currently ineligible due to having an affordable offer of employer coverage under current AMA policy, as well as recommendations for new policy proposed in this report.

For uninsured individuals ages 60 to 64 who are eligible for zero-premium marketplace coverage, as well as the 20 percent of the uninsured eligible for Medicaid, the Council believes that auto-enrollment again can be used as a mechanism to provide health insurance to these individuals at no cost to them. Existing AMA policy, and recommendations for new policy in this report, applicable to the uninsured who fall in the coverage gap, and ineligible for ACA financial assistance due to immigration status, would also pertain to those ages 60 to 64.

The Council also recognizes the role Policy H-330.896 plays in improving the consistency between Medicare and Social Security eligibility. The policy supports restructuring Medicare’s age-eligibility requirements and incentives to match the Social Security schedule of benefits. However, lowering the age to become eligible for Medicare from 65 to 60 is not consistent with the intent of Policy H-330.896, and is projected to have unintended consequences.

While lowering the age of Medicare eligibility to 60 could cover many of the uninsured in the 60-64 age bracket, the Council believes that the AMA proposal for reform, as well as the recommendations of this report, provide a better pathway to get this age cohort of the uninsured covered without causing significant health system changes and potential negative impacts to physicians, hospitals, and other entities. For example, lowering the age of Medicare eligibility to 60 has been projected by KFF to also have the potential to shift nearly 12 million individuals with employer coverage and 2.4 million with non-group coverage into Medicare.<sup>24</sup> Such a shift would notably impact the payer mix of physician practices. At the same time, only one-third of the approximately 1.6 million uninsured in this age cohort remains ineligible for premium tax credits to purchase marketplace coverage, or Medicaid, because they do not qualify for ACA financial assistance due to an affordable offer of employer coverage, falling into the coverage gap, or due to immigration status. Accordingly, the Council believes that the AMA proposal for reform can cover this population without the unwanted policy tradeoffs that lowering the Medicare eligibility age would present.

The Council recognizes that there are equity considerations associated with each alternative to cover the uninsured ages 60 to 64, and those associated with lowering the Medicare eligibility age must be examined. While lowering the Medicare eligibility age to 60 would open the door to Medicare to individuals aged 60-64, doing so would notably eliminate subsidized marketplace coverage

eligibility for these individuals, potentially increasing their cost of coverage. They still would, however, be able to choose to remain on their employer-sponsored coverage. In light of the premium tax credit enhancements included in the ARPA, lower-income individuals currently enrolled in a marketplace plan may have the potential to face higher premiums in traditional Medicare. In addition, considering that half of the uninsured ages 60 to 64 are eligible for premium tax credits, the Council believes that they should not lose access to the most affordable coverage pathway available to them—critical for those with the lowest incomes. Avalere found that current marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries.<sup>25</sup> Accordingly, the Council believes that improving the generosity of premium tax credits and cost-sharing reductions, and making cost-sharing reductions available to more people, as outlined in AMA policy, provides low-income uninsured ages 60 to 64 with a more preferable choice of coverage option than lowering the Medicare eligibility age to 60.

Overall, lowering the Medicare eligibility age to 60 has been projected to cost \$200 billion over ten years.<sup>26</sup> The aforementioned shift in coverage from employer coverage to Medicare shifts a large share in health spending to the federal budget. While certain proposals to date reiterate that lowering the Medicare eligibility age to 60 would be funded by general revenues, they would still need a pay-for. Proposals to lower the Medicare eligibility age to 60 could also threaten the fiscal stability of the Medicare Trust Fund. Notably, the Council emphasizes that the AMA proposal for reform would not only have a smaller fiscal footprint over a ten-year period, but also would not negatively impact the Medicare Trust Fund. The potential for other unintended consequences of lowering the Medicare eligibility age must be assessed, including on graduate medical education (GME).

Finally, the Council is highly concerned that lowering the Medicare eligibility age to 60 would negatively impact the payer mix of physician practices. It is expected that lowering the Medicare eligibility age to 60 would lower the revenues for physicians, hospitals, and other providers delivering care to the 60-64 age cohort. Physician and hospital payment rates from private plans tend to be higher than those paid by Medicare, with the difference between the two increasing over time.<sup>27</sup>

## DISCUSSION

The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order to cover the remaining uninsured. The enactment of the ARPA into law has provided a preview as to what ACA improvements, many of which reflect the AMA proposal for reform, can accomplish. The Council underscores that Policy H-165.824 supports making the ARPA changes to the ACA permanent—increasing the generosity of premium tax credits as well as eliminating ACA’s subsidy “cliff.” However, the Council is cognizant that more needs to be done to cover the uninsured eligible for premium tax credits and Medicaid, as well as the uninsured already eligible for an affordable ACA marketplace plan without any subsidy. Policy H-165.823, by outlining the potential for auto-enrollment for the segment of the uninsured eligible for coverage options that would be of no cost to them after the application of any subsidies, provides a coverage pathway for the 7.3 million uninsured individuals eligible for Medicaid/CHIP and the six million eligible for zero-premium marketplace coverage. Until auto-enrollment is enacted for these populations, the Council believes that outreach and enrollment assistance efforts will be absolutely critical, so individuals are aware that they are eligible for premium tax credits or Medicaid/CHIP and receive any necessary assistance to enroll in coverage. Outreach and enrollment assistance efforts are also vital to facilitate the enrollment of immigrants eligible for ACA financial assistance in health insurance coverage.

Policy H-165.824 also contains highly important provisions to improve the affordability of not only the premiums for individuals who remain uninsured despite being eligible for premium tax credits as well as those who already have access to an affordable marketplace plan, but also deductibles and other cost-sharing obligations. A component of the uninsured may not see the benefit to enrolling in coverage if they know they will not be able to afford the cost-sharing responsibilities of the plan in which they can enroll. In addition, uninsured individuals already eligible for affordable ACA marketplace coverage without any subsidy may need the “stick” of an individual mandate penalty to get coverage, advocated for in Policies H-165.848 and Policy H-165.824.

However, the Council sees an opportunity to further maximize coverage rates and improve coverage affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for ACA financial assistance due to falling into the coverage gap, immigration status, or having an affordable offer of employer coverage. The Council is highly concerned about the more than two million uninsured who fall into ACA’s coverage gap. It has been the hope of the Council that, following existing AMA policy, the states that have not yet expanded their Medicaid programs would do so, and enjoy the associated significant, positive financial incentives. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council underscores that Policies H-165.838 and H-165.823 recommended for reaffirmation collectively constitute a critical baseline for any federal approach to cover the uninsured who fall in the coverage gap to meet. In addition, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, and protect against current expansion states from dropping their Medicaid expansions. These new policies, as well as existing policy outlining standards that any public option to expand health insurance coverage must meet, supersede Policy H-290.966, which is recommended to be rescinded.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/CHIP. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for

undocumented immigrants and DACA recipients, but to recognize state and local efforts to provide coverage to immigrants regardless of immigration status. In implementing initiatives to improve the coverage rates of immigrants, the Council believes it is critical that entities overseeing these programs do not collect and/or report data regarding enrollee immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an “affordable” employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA’s “family glitch,” to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. Current AMA policy and these recommendations strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions. The Council still believes there is a role for Policy H-330.896, which supports restructuring age-eligibility requirements and incentives of Medicare to match the Social Security schedule of benefits. The Council finds lowering the Medicare eligibility age to 60 has multiple downsides:

- Individuals ages 60 to 64 would lose access to health plan choices, including subsidized ACA marketplace coverage.
- As current ACA marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries, lower-income individuals currently enrolled in a marketplace plan may have the potential to face higher premiums in traditional Medicare.
- The level of benefits under Medicare differs from options currently available to individuals ages 60 to 64, underscoring why most current, traditional Medicare beneficiaries are also enrolled in supplemental insurance.
- The projected crowd-out of millions of individuals from employer-sponsored and other private coverage to Medicare has the potential to negatively impact the payer mix of physician practices and hospitals.
- Physician and hospital payment rates from private plans tend to be higher than those paid by Medicare, with the difference between the two increasing over time.

The Council believes its recommendations address gaps in AMA policy with respect to covering the uninsured—including those ages 60 to 64—necessary to ensure that our patients are able to secure affordable and meaningful coverage and access the care that they need. There is now an opportunity to build upon the ACA and ARPA to cover more of the uninsured. The Council affirms that our AMA is well-positioned to move forward in its advocacy efforts in support of coverage of the uninsured, guided by policy and its resulting plan to cover the uninsured, which will include the recommendations of this report.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 123-J-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility—make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.
2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
3. That our AMA support extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.
5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations.
6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:
  - a. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an



employee's premium contribution is affordable to ~~that which applies to the exemption from the individual mandate of the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.~~

- b. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage with respect to the cost of family based or employee only coverage and household income. ...
7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion.
8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding.
9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet.
10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; (3) state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; (4) eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-sharing reductions; and (7) increasing the size of cost-sharing reductions.
12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities.
13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.
14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report.
15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits.

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#### 4. FINANCING OF HOME AND COMMUNITY-BASED SERVICES

*Reference committee hearing: see report of Reference Committee G.*

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED**

*See Policies TBD*

The COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as long-term care (LTC) facilities and the weaknesses in the nation’s system of caring for older adults and individuals with disabilities and limitations. It is estimated that about eight percent of people living in LTC facilities have died of COVID-19, a percentage that is considered an undercount.<sup>1</sup> In particular, nursing home deaths are believed to account for about one-third of total COVID-19 deaths. This grim reality has highlighted the need for a better system of caring for these older and disabled populations. The Council recognizes that COVID-19 pandemic has created an opportunity to review the current LTC system and to build upon the American Medical Association’s (AMA’s) current body of LTC policy to recommend fundamental reforms, specifically reforms strengthening the nation’s system of home and community-based services (HCBS).

This report, initiated by the Council, provides an overview of LTC needs in the United States (US), highlights the myriad ways that HCBS is funded, outlines current HCBS legislative proposals, summarizes relevant AMA policy, and recommends policy to create a stronger foundation and financing structure for HCBS.

## BACKGROUND

The US is undergoing a population shift. By 2040, about one in five Americans will be 65 or older. By 2050, those over age 85 are projected to more than triple.<sup>2</sup> According to the US Department of Health and Human Services (HHS), 70 percent of seniors reaching age 65 are expected to require some type of LTC assistance in their lifetime.<sup>3</sup> LTC includes both medical and non-medical care, such as assistance with activities of daily living (ADLs). ADLs include a range of activities such as help with bathing, dressing, meal preparation, medication management, help with housekeeping, and transportation.

Hundreds of thousands of older and disabled individuals live in institutionalized care settings not because they need the level of specialized medical care provided in those settings, but because Medicaid payment rules make that the only option with daily care that they can afford. The current long-term services and supports (LTSS) financing structure and incentives generally favor expensive institutional care settings like skilled nursing facilities over less expensive and usually more desirable care settings like adult day care and home care. The average annual cost for a nursing home room is \$105,850. Alternatively, the average annual cost for a full-time home health aide is about \$48,000, and the cost of adult day care is about \$17,000.<sup>4,5</sup> However, under the Medicaid statute, states must cover institutional LTSS services, but covering HCBS like home health aides and adult day care is optional.<sup>6</sup> Therefore, Medicaid coverage for services in the home or community varies by state with some states not offering HCBS altogether. According to Congressional Budget Office projections, federal LTSS expenditures under Medicaid are projected to reach \$113 billion per year by 2025 compared with the \$74 billion spent in 2014.<sup>7</sup>

Many residents in institutional facilities only need assistance with ADLs, and many would prefer to be living in their own communities. Seventy-six percent of people aged 50 and older would prefer to remain in their home for as long as possible, and 90 percent would prefer to age in place either in their homes or community settings such as adult day care centers.<sup>8</sup> Access to HCBS has emerged as an alternative to institutionalized care settings to help older Americans and those with disabilities live independently while receiving assistance with daily needs.

Medicaid beneficiaries with LTSS needs account for 6.4 percent of the Medicaid population but 45.6 percent of Medicaid expenditures.<sup>9</sup> Exacerbating the financial challenge of providing LTSS care to an aging population is a significant birth decline. The latest US census revealed that the US has one of the slowest rates of population growth in decades. The decline is largely due to declining immigration and a declining birthrate, which means there will continue to be fewer workers to support the aging population.<sup>10</sup> Today, there are 2.8 workers per Medicare beneficiary. However, that number is expected to decline to 2.3 workers by 2030.<sup>11</sup> This demographic shift puts a substantial strain on state and federal budgets and causes great instability in the programs on which the elderly and disabled rely. Therefore, it is critical to explore financially stable alternatives to providing LTSS to this population. In keeping people out of more expensive institutions and in the community, HCBS provides one method to stabilize LTSS funding.

## MECHANISMS TO PROVIDE HCBS FINANCING AND SERVICES

### *Section 1915(c) and Section 1115 Waivers*

For the last 40 years, states have used waivers to provide HCBS to Medicaid beneficiaries. Nearly all HCBS beneficiaries receive services through an optional authority. Section 1915(c) of the Social Security Act authorizes a waiver program allowing states to meet the care needs of their populations through LTSS in their homes or communities rather than in an institutional care setting. Section 1115 waivers give states the option to waive certain Medicaid requirements and allow states to use Medicaid funds for pilot or demonstration projects.<sup>12</sup> For example, states can target waivers to areas of the state where need is the greatest. States can also make waiver services available to certain groups of people who are at risk of institutionalization, such as those with a particular diagnosis. States can provide Medicaid to people who would otherwise only be eligible for coverage in an institutional setting. Using their waiver authority, states are permitted to offer a variety of services. Therefore, states can use waivers to provide a combination of standard medical and non-medical services. Services may include case management, home health aides, personal care, adult day care centers, and respite care. Moreover, states can implement other types of services that may assist in diverting or transitioning individuals from institutional care settings.<sup>13,14</sup>

Nearly all states and DC offer services through HCBS waivers. However, states continue to face an arduous federal waiver process. Obtaining a waiver generally requires negotiations between states and the federal government. There

currently are more than 300 HCBS waiver programs in effect nationwide. Relying upon such a patchwork system makes the availability of HCBS services highly dependent on the state in which a beneficiary resides.<sup>15</sup>

#### *State Plan Amendments*

A Medicaid state plan is an agreement between the state and the federal government detailing how the state administers its Medicaid program. In it, the state attests that it will follow federal rules and may claim federal matching funds for its Medicaid program activities. Additionally, the state plan outlines who will be covered under its activities, what services will be provided, payment methodologies for providers, and the state's administrative activities.<sup>16</sup>

States can amend their plans through a state plan amendment (SPA). States can submit a proposed SPA to Centers for Medicare & Medicaid Services (CMS) for review and approval. Over the years, Congress has enacted several SPAs designed to make it easier for states to expand HCBS. Using an SPA, states can provide Medicaid to people who would otherwise only be eligible for coverage in an institutional setting. States can also target services to individuals with particular needs, risk factors, or those with a specific disease or condition.<sup>17</sup>

#### *Money Follows the Person*

Medicaid's Money Follows the Person (MFP) demonstration has been in place since 2008. The initiative's intent is to rebalance Medicaid's bias for institutional care and seek to move seniors and people with disabilities from institutions and into the community. The program uses enhanced federal matching funds to incentivize states to operationalize the program. Since its inception, the MFP program has helped more than 100,000 individuals transition from institutional to community care settings. Notably, the national MFP program evaluation found that enrollees experienced significant increases in quality-of-life measures after transitioning back to their communities. The evaluation also found that some individuals would not have made the transition away from institutional care if not for MFP. The program also helped states control spending, which is attributed to the fact that HCBS typically costs less than institutional care. The evaluation found that state Medicaid programs saved about \$978 million during the first year after transition for MFP enrollees.<sup>18</sup> The availability of the program relies on federal funding reauthorization, which is set to expire in 2023.<sup>19</sup>

#### *Federal Medical Assistance Percentages*

The Federal Medical Assistance Percentages (FMAPs) are used to determine the federal share for most Medicaid health care services.<sup>20</sup> It is calculated by a formula that is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes compared to the national average.<sup>21</sup> For example, the FMAP rate in Mississippi is 84.51 percent while the rate in Massachusetts is 56.2 percent.<sup>22</sup>

The FMAP is critical to the provision of Medicaid services in states. Medicaid accounts for nearly 30 percent of state budgets, and state budgets are particularly constrained due to the economic strain of the COVID-19 pandemic. State budgets require Medicaid predictability and limiting the number of beneficiaries and services allows states to accurately estimate HCBS expenditures.<sup>23</sup> Absent increased federal matching funds, states are unlikely to expand HCBS services and eligibility despite significant unmet need.

## WORKFORCE

A key barrier to meaningful expansion of HCBS is an unstable workforce. States regularly mention workforce shortages as an obstacle to expanding HCBS, and the shortages have only been exacerbated by the COVID-19 pandemic. Currently, there are about 4.5 million direct care workers (DCWs) providing care to older adults and individuals with disabilities. Between 2019 and 2029, the Bureau of Labor Statistics estimates a 1.9 million increase in family caregiving jobs, which represents a 37 percent increase in over 10 years. The expected increased demand for DCWs is more than any other occupation in the economy.<sup>24</sup>

The current workforce is primarily comprised of women of color who earn low wages and do not receive employee benefits such as paid leave, health care, job training, or advancement opportunities. On average, DCWs make about \$16,200 per year. Despite their valuable work, one in eight DCWs lives in poverty.<sup>25</sup> Due to these suboptimal benefits and demanding working conditions, DCW turnover is about 60-80 percent annually.<sup>26</sup>

Additionally, the current workforce lacks standardization, which could provide beneficiaries with more consistent and reliable care. The federal government currently requires nursing home and home health aides to undergo 75 hours of training before they can provide care, and some states do not require personal care aides certified through Medicaid to be trained at all.<sup>27</sup> Moreover, certification often costs DCWs hundreds of dollars, and three-quarters of the workforce earn less than the average state living wage. The financial obstacle requirements exemplify the lack of consideration and value placed on a critical workforce.

As of 2018, Medicare's conditions of participation formally recognize home health aides as members of the interdisciplinary care team who are expected to report on a beneficiary's change in condition. Despite this responsibility, little has been done to help integrate aides into care teams. This lack of team integration is unfortunate because home health aides could demonstrate value on care team models including post-acute home care, hospital at home, and ambulatory case management.

#### FEDERAL AGENCIES AND HOME AND COMMUNITY-BASED SERVICES

The current administration of HCBS services relies on five federal agencies. The agencies include the CMS, the Administration on Aging, the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture. Collectively, the agencies fund multiple programs that aid the elderly population with services like nutrition assistance, in-home care, affordable housing, and transportation.<sup>28</sup>

The Older Americans Act of 1965 requires HHS's Administration on Aging to facilitate cross-agency collaboration to administer HCBS. However, a recent US Government Accountability Office (GAO) report found that the five agencies operate largely independently of one another with minimal collaboration.<sup>29</sup> The GAO's report studied interagency collaboration and found that, though cross-agency collaboration is important for federal efforts, limited resources and competing priorities can preclude cooperation.

#### HOSPITAL AT HOME

Several countries pay for delivering services equivalent to hospital inpatient care to patients in their own homes. These "hospital at home" services have been successful in allowing patients with specific conditions that qualify for inpatient care to receive services in the home and avoid the risks associated with inpatient admission. Patients with conditions such as congestive heart failure, chronic obstructive pulmonary disease, and cellulitis are often candidates for the model. Patients must be sick enough to be hospitalized but stable enough to be treated at home. The at-home care is provided by visiting physicians, nurses, and other clinical staff. The services are more intensive than can be supported through traditional home health care payments. The care model has been shown to reduce costs, improve patient outcomes, and enhance the patient experience.<sup>30</sup>

Although some hospitals in the US have been delivering hospital at home care and some Medicare Advantage plans are paying for it, the service is difficult to sustain or expand without payment from Medicare because a minimum number of patients need to participate for the service to be cost-effective. The Physician-Focused Payment Model Technical Advisory Committee has recommended two different "hospital at home" payment models to HHS, but neither has been implemented to date.<sup>31</sup>

The pandemic has highlighted the flaws of institutionalized care and accelerated the availability of hospital at home. During the pandemic, CMS has allowed hospitals to deliver services in non-traditional settings, and it pressed many private insurers to do the same. The CMS program, the Acute Hospital Care at Home Program, gives participating hospitals the ability to reduce inpatient volume by treating certain acute care patients at home using a telehealth platform that allows for daily check-ins and monitoring. Telehealth has been successfully employed in the care model to help transition patients away from institutional care settings, and the technology has greatly assisted physicians and patients at a time when maintaining physical distance is critical to health and safety. The Brigham and Women's Hospital was one hospital to take advantage of CMS's program. A 95-day study took place evaluating the model, which cared for 65 acutely ill patients. Throughout the study, the hospital at home program was staffed by one physician, one or two nurses, and one mobile integrated health paramedic. The study showed that the program cost a fraction of the cost of caring for patients in the hospital and that such programs can serve as complements to traditional hospital-based care.<sup>32</sup> However, it is unclear whether CMS's Hospital Care at Home Program will be extended after the COVID-19 public health emergency ends.

In May 2021, Mayo Clinic and Kaiser Permanente announced that they were teaming up to scale the hospital at home model. The two health care giants join a growing list of hospitals around the country that have implemented this model of care. It is estimated that 30 percent of hospitalized patients can benefit from the hospital at home model.<sup>33,34</sup>

#### AMA POLICY

Policy H-280.945 was established with the adoption of CMS Report 5-A-18 on the financing of LTSS. The policy states that our AMA supports policies that standardize and simplify private long-term care insurance (LTCI) to achieve increased coverage and improved affordability; supports adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees; supports allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI; and supports innovations in LTCI product design, including the insurance of HCBS and the marketing of LTC products with health insurance, life insurance and annuities. The policy also supports expanding LTSS benefits by permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as a separate insurance policy and Medicare Advantage plans offering LTSS in their benefit packages. In addition, the policy supports permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit and supports a back-end public catastrophic LTCI program. Particularly salient to this report, the policy also supports incentivizing states to expand the availability of and access to home and community-based services and calls for better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

Policy H-280.991 addresses financing of LTC and outlines relevant principles and policy proposals for LTC. It states that programs to finance LTC should cover needed services in a timely and coordinated manner in the least restrictive setting appropriate to the health care needs of the individual and coordinate benefits across different LTC financing programs. The policy suggests providing coverage for the medical components of LTC through Medicaid for all individuals with income below 100 percent of the poverty level and providing sliding scale subsidies for the purchase of LTCI coverage for individuals with income between 100-200 percent of the poverty level. Policy H-290.958 supports increases in states' FMAPs or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Policy H-280.991 supports tax incentives and employer-based LTC coverage to help fund LTC including creating tax incentives to allow individuals to prospectively finance the cost of LTC coverage and encouraging employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage and allow tax-free withdrawals from Individual Retirement Accounts and Employee Trusts for payment of LTCI premiums and expenses. Additionally, the policy supports the use of a tax deduction or credit to encourage family caregiving. Policy H-280.991 states that consumer information programs should be expanded to emphasize the need for funding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to provide an environment within their states that permit innovative LTC financing and delivery arrangements and assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high-quality care. Additionally, consistent with other AMA policy on state-based innovation, Policy H-280.991 supports health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs.

Policy H-290.982 supports allowing states to use LTC eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment that account for impairments caused by cognitive and mental disorders and measures of medically related LTC needs. The policy supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits and supports providing grants to states to develop new LTC infrastructure and to encourage expansion of LTC financing to middle-income families who need assistance.

#### CURRENT HCBS PROPOSALS

In Spring 2021, the Biden Administration announced a \$400 billion plan to expand Medicaid HCBS and support home care workers as part of his American Jobs Plan infrastructure package. The plan does not increase funding for non-

Medicaid programs critical to living at home, and it does not help middle-income Americans who make too little to pay for LTCI but earn too much to qualify for Medicaid. However, the plan proposes extending and expanding the MFP program.

Subsequently, in June 2021, a bipartisan congressional team introduced the Better Care Better Jobs Act, which would expand HCBS. The legislation formed the basis of President Biden's \$400 billion plan to expand HCBS access. A main provision of the bill calls to permanently increase the FMAP by 10 percent. To receive the increase, states would have to address payment rates to promote the recruitment and retention of DCWs.<sup>35</sup> Another key provision would make the MFP program permanent.

However, in late June 2021, President Biden agreed to forego his \$400 billion plan to expand HCBS as a concession to reach a deal with congressional leaders on a broader infrastructure bill. Nonetheless, a scaled-back iteration of the \$400 billion plan may be incorporated into the \$3.5 trillion 2022 domestic spending reconciliation bill that will be considered in Fall 2021, and provisions of the Better Care Better Jobs Act are anticipated to be included.

## DISCUSSION

As the US population ages, beneficiary preferences evolve, and demographic shifts continue, HCBS provides a desirable and cost-effective way of delivering LTSS to seniors and those with disabilities. State Medicaid programs will confront increasing pressure to meet the LTSS needs of an aging population. Meanwhile, the COVID-19 pandemic has exposed the vulnerabilities of institutionalized care settings such as nursing homes and represents an opportunity to expand HCBS. The Council believes the AMA should seize this moment to establish fundamental policy to address the fractured LTSS system through a multi-pronged approach. The Council notes that this important issue is relevant to Council on Medical Service Report 1-NOV-21, which specifically addresses end of life payment. Notably, CMS Report 1-NOV-21 recommends supporting Medicare coverage of supportive care services, including assistance with activities of daily living, under Medicare's hospice benefit, and appropriate payment for those services.

Acknowledging the AMA's existing policy on LTSS and laying the foundation for new recommendations, the Council recommends reaffirming Policy H-280.945. The policy provides a comprehensive set of principles to improve the financing of LTSS and supports incentivizing states to expand the availability of and access to HCBS. Recognizing the importance of federal matching funds to the continuation and expansion of LTSS services, the Council also recommends reaffirming Policy H-290.958 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.

Moreover, the Council recommends that states simplify their state plan options and Medicaid waivers to allow states additional flexibility to offer HCBS. By streamlining the current patchwork system of HCBS waivers and SPAs, states could promote infrastructure development, increase administrative efficiency, improve budget predictability, and better care for beneficiaries. The Council believes that continued use of CMS waiver templates is a positive step forward. Streamlining state plan options and waivers can help eliminate Medicaid's bias for institutional care and provide states the flexibility to offer services that better meet the needs of their populations.

The Council also recommends that Medicaid's MFP program, set to expire in 2023, be extended or made permanent. Doing so would enable states to expand the settings that qualify as community care settings, create broader eligibility pathways, and offer new HCBS benefits. The program has demonstrated that it saves state Medicaid programs money and provides increased and sustained enrollee quality-of-life. The Council believes that the program has made important contributions to the rebalancing of LTSS away from institutional settings and into community settings and believes that these state efforts should be continued with the requisite support.

Investing in the HCBS workforce is critical to meeting the needs of an aging population and modernizing the LTSS system. To address the needs of this aging population and to support the needed caregivers, the Council recommends supporting federal funding for payment rates that promote access and greater utilization of HCBS. The Council also recommends supporting policies that help to train, retain, and develop the HCBS workforce. Steps must be taken to professionalize the HCBS workforce. The Council notes that the training and skills required will vary yet workforce standardization is critical. For example, the skills required to care for a hospital at home patient will differ from the skills required to care for an adult needing basic ADL assistance. HCBS workforce reforms would help build a pipeline of workers while stabilizing the workforce and improving quality of care. Ultimately, HCBS and LTSS reforms will

only be effective if the supporting workforce is invested in and valued. Increased federal funding for payment and policy changes to promote the workforce will help serve the needs of individuals in the most appropriate care settings.

The Council believes that strategic coordination between the five federal agencies that fund and implement HCBS activities could ensure that resources are being used efficiently and effectively for not only the government but also for beneficiaries. Accordingly, the Council recommends supporting cross-agency and federal-state strategies that can help avoid disconnects among HCBS programs and streamline funding and the provision of services. To further streamline programs, the Council recommends that HCBS programs track protocols and outcomes. Doing so could help make meaningful comparisons across states and identify best practices. It can also help promote quality care and ensure that care is aligned with patient goals.

Finally, the hospital at home model is an important component of the shift away from institutionalized care and has been successful in allowing patients with particular conditions to remain in their homes and avoid risks associated with inpatient admission and care. Accordingly, the Council recommends that CMS and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria.

HCBS presents a compelling shift away from institutionalized care. Not only is there currently an unmet need for HCBS, but also, this need is expected to increase with a growing elderly population. States and the federal government should be encouraged to develop and expand HCBS offerings as lower-cost and more preferred alternatives to providing institutional care.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS).
2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce.
3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS.
4. That our AMA support that Medicaid's Money Follows the Person demonstration program be extended or made permanent.
5. That our AMA support cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services.
6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices.
7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs.
8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit.
9. That our AMA reaffirm Policy H-290.958 which supports 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.

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## 5. INTEGRATING CARE FOR INDIVIDUALS DUALY ELIGIBLE FOR MEDICARE AND MEDICAID

*Reference committee hearing: see report of Reference Committee A.*

### HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

*See Policies TBD*

[Council on Medical Service Report 5-Nov-20](#), Medicaid Reform, addressed the Medicaid program generally without specifically addressing coverage and payment for care of individuals dually eligible for Medicare and Medicaid. Delivery of care and financing reform for the dual eligible population was the topic of [Council on Medical Service Report 5-A-13](#), when several state demonstrations designed to better integrate care were just getting started. Evidence from a variety of integrated models tested over the intervening years is now available to inform new American Medical Association (AMA) policy on integrated benefits for this predominantly low-income, medically complex population. Although many dually eligible individuals live with some combination of chronic conditions, mental illness, substance use disorder, and cognitive and/or physical disabilities, this is an extremely heterogeneous group. Because they tend to be high-need, high-cost enrollees, state and federal policymakers continuously search for ways to increase care quality while saving Medicare and Medicaid dollars. For example, recent policy discussions have focused on how to enroll more dually eligible individuals into integrated plans, especially Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs).

The incidence of long COVID-19, considered a disabling condition under the Americans with Disabilities Act when it substantially limits major life activities, may increase the number of dually eligible enrollees—a group already disproportionately impacted by the pandemic—and highlight the need for improved health outcomes. Integrated care refers to delivery system and financing approaches that coordinate and integrate covered services and supports for dually eligible individuals. In theory, integrated plans should have a high potential for reducing costs and improving care; in reality, achieving integration has been difficult due in part to the complex and diverse needs among dually eligible people and the involvement of siloed government health programs that were not designed to work together. This report, initiated by the Council, provides an overview of existing integrated models, summarizes relevant AMA policy, and recommends new AMA policy outlining criteria essential to successful integrated care.

### BACKGROUND

The number of individuals dually eligible for Medicare and Medicaid has risen steadily in recent years to almost 12.3 million people.<sup>1</sup> In comparison to Medicare-only enrollees, dually eligible patients have more complex and chronic health needs and are more likely to experience inequities in social determinants of health that contribute to chronic disease.<sup>2</sup> Nearly half of dually eligible enrollees are people of color; dually eligible individuals are also more likely to be female, have functional and activities of daily living limitations, and report being in poorer health.<sup>3</sup>

According to preliminary Medicare COVID-19 data from the Centers for Medicare & Medicaid Services (CMS), dually eligible individuals were more than twice as likely to be infected with COVID-19, and more than three times as likely to be hospitalized by the virus, than Medicare-only patients.<sup>4</sup> Sixty-one percent of dually eligible individuals are age 65 and over, and 40 percent utilize Medicaid long-term services and supports (LTSS) ranging from nursing home care to home and community-based supports.<sup>5</sup> Over 40 percent have at least one mental health diagnosis, and just over half become dually eligible for Medicare-Medicaid because of disability.<sup>6</sup>

Although dually eligible individuals often face barriers to accessing primary and preventive care, this population utilizes more covered services,<sup>7</sup> including services in emergency departments.<sup>8</sup> Accordingly, dually eligible patients are disproportionately more costly to Medicare and Medicaid than traditional enrollees.<sup>9</sup> Although dually eligible individuals make up 20 percent of Medicare enrollees and 15 percent of Medicaid enrollees, they account for 34 percent of Medicare spending and 32 percent of Medicaid spending.<sup>10</sup>

Because Medicare and Medicaid are complex programs, each with distinct goals and coverage and payment rules, care for dually eligible individuals can be fragmented, poorly coordinated and difficult for patients to navigate. Cost-shifting persists across Medicare and Medicaid, and one program may be less likely to implement policy or program changes that result in savings to the other. Many stakeholders have noted that the disconnect between Medicare and Medicaid complicates care coordination and increases inefficiencies as well as administrative burdens among patients, physicians, and other providers.<sup>11</sup> Suboptimal care coordination may in turn compromise patient care and increase program spending.

Medicare benefits for this population include primary care, preventive care, inpatient and outpatient acute care, post-acute skilled nursing (SNF) care, and prescription drug coverage. Medicare is the primary payer while Medicaid may cover a range of services not covered by Medicare, including—depending on the state—LTSS, some behavioral health benefits, and transportation. Medicaid coverage varies by state and between partial-benefit and full-benefit dually eligible enrollees, with full-benefit enrollees—who make up over 70 percent of the dual eligible population—eligible for all services that are covered by Medicaid in their state. Partial-benefit enrollees receive Medicaid assistance with Medicare premiums and, in some cases, Medicare cost-sharing, but are not eligible for other Medicaid benefits. State and federal efforts to integrate benefits focus predominantly on full-benefit dual eligible enrollees.

## INTEGRATED CARE MODELS

Many stakeholders have maintained that managed care plans offering both Medicare and Medicaid services would improve quality and reduce spending for dually eligible individuals, and several integrated models were developed over the last decade. Early integrated care plans in Massachusetts, Minnesota, and Wisconsin were identified as promising in that they reduced enrollee use of hospital services and, importantly, redirected some LTSS use from nursing facilities to home and community-based care.<sup>12</sup> The most prominent integrated care plans include models tested through CMS demonstrations, D-SNPs, and the Program of All-Inclusive Care for the Elderly (PACE).

*Financial Alignment Initiative:* CMS has long cited financial misalignment between Medicare and Medicaid as a barrier to coordinating care for dually eligible enrollees, and it tests models with states using waivers. Financial Alignment Initiative (FAI) demonstrations are designed to better align financing and integrate primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees. FAI, which began in 2013, offers options to states for integrating care, including a capitated model that establishes Medicare-Medicaid Plans (MMP), a managed fee-for-service model, and a state option to create an alternative model. Nine of the 11 states that currently participate have chosen the capitated MMP model, in which CMS, a state, and a health plan enter a contract under which CMS and the state pay each health plan a prospective capitated monthly payment. States are permitted under the FAI to increase participation in MMPs using passive enrollment, which automatically enrolls dually eligible individuals in an MMP with the ability to opt out. Enrollment in MMPs has been lower than expected, although participation rates vary across participating states. Notably, a significant number of dually eligible people who have been passively enrolled in an MMP have subsequently opted out. Although evaluations have shown this model to be associated with decreased emergency department use and hospitalizations, other impacts—for example, on Medicare spending and savings—have been mixed and varied across participating states.<sup>13</sup>

Under FAI's managed fee-for-service (FFS) model, care is provided through FFS with assigned care coordinators to help enrollees obtain needed care. The state of Washington is implementing the FFS model and has experienced good enrollment numbers. Washington uses Medicaid health homes with a care coordinator and multidisciplinary team

servicing dually eligible enrollees. Evaluations of this model have shown decreased inpatient and SNF admissions and long-stay nursing facility use as well as major reductions in Medicare spending (which the state was able to share).

*Dual-Eligible Special Needs Plans:* D-SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and made permanent under the Bipartisan Budget Act of 2018. D-SNPs are available in 44 states and are required to contract with the Medicaid agency in each state in which they operate. “MIPPA” contracts, named for the Medicare Improvements for Patients and Providers Act under which they are authorized, are used by states to increase the level of integration. For example, states can use MIPPA contracts to require D-SNPs to align with managed LTSS (where such managed programs are available) so that dually eligible individuals are able to access Medicare and Medicaid services (including LTSS) through the same entity. States can similarly require D-SNP contractors to ensure coordination of behavioral health and/or other Medicaid services, and to share Medicare data with the state.

Predominant D-SNP integrated models fall into two categories: those that require aligned Medicaid managed LTSS; and fully integrated D-SNPs, which provide Medicare and Medicaid benefits, consistent with state policy. Research has found D-SNPs to be associated with reduced hospitalizations and readmissions; however, results have been mixed with regard to emergency department use and LTSS services.<sup>14</sup> There has been some evidence of decreased Medicare spending among D-SNPs, and many stakeholders find D-SNPs promising because they are widely available and have enrolled over three million dually eligible people.<sup>15</sup>

*PACE:* PACE provides comprehensive, interdisciplinary medical and social services to certain frail people over age 55, enabling them to remain at home instead of in a nursing home. PACE is the most integrated model but only serves about one percent of dually eligible individuals across 31 states. The program has been associated with reduced inpatient hospital use but the impact on nursing facility use and Medicaid spending has been mixed.

Only about one in ten dually eligible individuals is enrolled in integrated care models despite considerable work over the years. Although D-SNPs have enrolled over three million people, PACE and FAI—both highly integrated—have enrolled 55,000 and 395,000 enrollees, respectively.<sup>16</sup> Most dually eligible enrollees (more than 70 percent) are in fee-for-service plans and, among those with Medicare Advantage plans, one quarter are in non-integrated plans.<sup>17</sup> Low enrollment numbers have been attributed to the lack of program availability in some areas and high rates of disenrollment from certain programs.<sup>18</sup> Resource constraints and competing priorities in states may also limit the availability of integrated programs.

## ELEMENTS OF SUCCESSFUL INTEGRATED CARE MODELS

At least 43 combinations of Medicare and Medicaid coverage are available nationwide, giving many dually eligible enrollees several plan options from which to choose.<sup>19</sup> D-SNP, MMP and PACE are targeted towards dually eligible individuals; additionally, some qualify for institutional special needs (I-SNP) plans, which are MA plans limited to patients with institutional-level care needs. While the literature has highlighted data challenges, including the lack of available Medicaid data, individuals enrolled in integrated programs have reported satisfaction with reduced cost-sharing and improved access to medical, behavioral health and other services.<sup>20</sup>

Each of the integrated models has different strengths and limitations in terms of level of integration, availability across states, enrollee experience, capacity to scale, and cost savings. A literature review of integrated models by Health Management Associates highlighted the following factors that contribute to improved programming for dually eligible individuals:

- Individual consumer engagement in program design, communications, implementation and ongoing program oversight;
- Provider engagement and robust networks;
- Care coordination and risk stratification;
- Strong state and federal government collaboration;
- Adequate state capacity; and
- Performance and outcome measures tailored to the population.<sup>21</sup>

Stakeholder interviews with patients, physicians, advocates, health plans, and state officials informed a second Health Management Associates brief that identified essential program elements needed for plans to successfully support dually eligible individuals. As stated in the report, the ten essential elements are:

1. Simplified Medicare and Medicaid eligibility processes and paperwork;
2. Comprehensive and expert consumer choice counseling and/or enrollment assistance;
3. Diverse consumer engagement to inform tailored delivery systems and integrated programs;
4. Robust data infrastructure to tailor and adapt program approaches and drive health equity;
5. Coordinated efforts to maximize capabilities to address unmet social needs;
6. Single process for assessments and plans of care, and one care team for each consumer;
7. Meaningful and transparent quality measurement to empower consumers and stakeholders;
8. Payment models to incentivize consumer quality of life improvements;
9. Adequate, engaged, and diverse workforce to support consumer needs; and
10. Access to needed services in rural areas.<sup>22</sup>

Of note, states are at various junctures of integrating care for dually eligible individuals. Some states, including Arizona, Idaho, and Tennessee, have made greater use of MIPPA authority and are providing fully integrated care. On the other hand, no integrated care options are available in North Dakota and Wyoming.<sup>23</sup> States may also employ multiple strategies to integrate care, as Ohio does by implementing both PACE and FAI.

Viable enhancements to integrated care plans are regularly discussed by the Medicaid and CHIP Payment and Access Commission and the Medicare Payment Advisory Commission. At least one proposal, from the Dual Eligible Coalition and Leavitt Partners, envisions consolidation of care under a new program—Title 22—that combines Medicare, Medicaid, and state funding into a fully integrated program specifically for dually eligible individuals.<sup>24</sup>

#### RELEVANT AMA POLICY

Policy H-290.967, established by Council Report 5-A-13, includes the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients: (1) various approaches to integrated delivery of care should be promoted under demonstrations; (2) customized benefits and services from health plans are necessary according to each beneficiary's specific medical needs; (3) care coordination demonstrations should not interfere with established patient-physician relationships; delivery and payment reform for dually eligible beneficiaries should involve practicing physicians and take into consideration the diverse patient population and local area resources; (4) states with approved financial alignment demonstration models should provide education and counseling to beneficiaries on options for receiving Medicare and Medicaid benefits; (5) conflicting payment rules between the Medicare and Medicaid programs should be eliminated; (6) Medicare and Medicaid benefit plans and the delivery of benefits should be coordinated; and (7) care plans for beneficiaries should be streamlined among all clinicians and social service agencies.

Addressing Medicare-Medicaid dual eligible demonstration programs, Policy D-290.980 advocates that established patient-provider relationships and current treatment plans will not be disrupted; dually eligible individuals should not be automatically enrolled without their approval or consent; any savings from coordination of care to dually eligible individuals should arise from better health outcomes and efficiencies gained; and demonstrations should not be employed as a policy lever to reduce provider payment rates. Policy H-290.984 strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. Similarly, Policy D-290.978 calls on CMS to require states to develop processes to facilitate opting out of managed care programs by dual-eligible individuals. Policies D-290.998 and H-290.978 advocate that states pay Medicare deductibles and cost-sharing for dual-eligible patients.

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 for public and private health plans are outlined in Policy H-285.908. Policy H-285.973 (1) advocates that all managed care plans be required to provide appropriate access, when geographically available, to representatives of all medical and surgical specialties and subspecialties; and (2) advocates that health plans not restrict appropriate referrals to medical and surgical subspecialists, including those specialties that are age group specific.

Policy H-280.945 supports (1) incentivizing states to expand the availability of and access to home and community-based services; and (2) better integration of health and social services and supports, including the PACE program. Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-180.944 states that “health equity,” defined as optimal health for all, 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.

## DISCUSSION

Because dually eligible individuals are typically medically complex and in need of a wide range of services and supports, they are among the highest need and highest cost enrollees within Medicare and Medicaid.<sup>25</sup> Integrated care plans are promising models for providing care that addresses the medical, behavioral, long-term care and social needs of this diverse patient population. In its review of the literature, the Council found that new models as well as enhancements to existing models have the potential to improve care quality and life quality for dually eligible people, but that success often depends on state capacity and resources available to implement integrated care. Managing the costs of care for dually eligible people is particularly challenging because nearly half of enrollees require LTSS, including those who receive institutional-level care. The Council highlights its recent work on LTSS, including Council on Medical Service Report 5-A-18, Financing LTSS, which established AMA policy (Policy H-280.945) supportive of incentivizing states to expand the availability of and access to home and community-based services. Council on Medical Service Report 4, presented at this meeting, recommends new AMA supporting streamlined funding for home and community-based services.

The Council supports ongoing study and refinement by CMS and states and hopes that increased collaboration and learning will help expand best practices. Accordingly, in lieu of supporting any specific model, the Council recommends support for integrated care that aligns with AMA policy and meets additional criteria that are critical to ensuring an integrated model’s success.

The Council further recommends reaffirmation of Policy H-290.967, which establishes principles on care delivery and financing reform for dually eligible patients; Policy D-290.978, which calls on CMS to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals; and Policy H-165.822 on health plan initiatives addressing social determinants of health. Finally, the Council recommends reaffirmation of Policy H-180.944, which defines health equity as optimal health for all and promotes equity in care. In comparison to Medicare enrollees, a greater share of dual eligible individuals are people of color, women, and people with disabilities. Advances in health equity and reducing disparities in health and health access must be considered by integrated care models if they are to improve care quality, life quality, and health outcomes over the long term.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:
  - a. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals’ needs and preferences.
  - b. Coverage of medical, behavioral health, and long-term services and supports is aligned.
  - c. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed.
  - d. Enrollee choice of plan and physician is honored, allowing existing patient-physician relationships to be maintained.
  - e. Services are easy to navigate and access, including in rural areas.
  - f. Care coordination is prioritized, with quality case management available as appropriate.

- g. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized.
  - h. Administrative burdens on patients, physicians and other providers are minimized.
  - i. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
  - j. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation.
2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients.
  3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals.
  4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health.
  5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity.

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