REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-11)
Medicaid Waivers and Maintenance of Effort Requirements
(Resolution 202-A-11)
(Reference Committee J)

EXECUTIVE SUMMARY

At the American Medical Association's (AMA) 2011 Annual Meeting, the House of Delegates referred Resolution 202 to the Board of Trustees. Introduced by the American Academy of Pediatrics, Resolution 202-A-11 asked that the AMA "strongly oppose conversion of Medicaid to a block grant program." The Board referred Resolution 202-A-11 to the Council on Medical Service for study. This report addresses Medicaid waivers regarding block grants as well as the exemption of maintenance of effort requirements. The report also seeks input from the House and the Federation regarding Medicaid in the context of entitlement reform.

Deficit reduction efforts in 2011 may include some Medicaid reforms, and broader entitlement reform is anticipated in 2013 with a newly seated Congress. The Council believes that a comprehensive review of our Medicaid policy now will enable the AMA to be a proactive participant in shaping the future of the program, particularly with the estimated expansion of Medicaid to 16 million new enrollees in 2014 due to the Patient Protection and Affordable Care Act (ACA, PL 111-148).

At the 2011 Annual Meeting, testimony on Resolution 202 supported state flexibility to tailor Medicaid programs to meet their needs and to be able to test alternative models for improving care, consistent with long-standing policy supporting the ability of states to develop and test different models for improving coverage for patients with low incomes. The Council considered a series of mechanisms to safeguard Medicaid beneficiaries and state budgets under any block grant scenario.

The Council also considered challenges to the ACA's maintenance of effort (MOE) requirements, which prohibit states from cutting eligibility levels for beneficiaries under the current federal matching rates in hopes of re-enrolling dropped beneficiaries under the ACA's higher matching rates for newly enrolled beneficiaries. The repeal of the MOE requirements would jeopardize health care coverage for Medicaid and Children's Health Insurance Program beneficiaries. As such, the Council recommends that the AMA oppose efforts to repeal the MOE requirements.

The Council is seeking the advice and suggestions of members of the House, state medical associations, and national medical specialty societies in developing recommendations on the overall financing of Medicaid. In particular, the Council is interested in hearing perspectives on AMA policy H-165.855 (see Appendix) regarding federal tax credits for the medical care portion of Medicaid for acute medical care patients to purchase individually owned health insurance. As an alternative to transitioning acute medical care Medicaid patients to tax credits and individually owned health insurance, the Council is also interested in whether the model of the current program can and should be strengthened. Accordingly, the Council is seeking input on changing the Federal Medical Assistance Percentages (FMAP) formula and whether the Medicaid program should be divided into two separate programs, one for patients who are eligible solely on the basis of having low incomes, focusing mostly on acute care needs and the other for the elderly and disabled population, focusing mostly on long term care.

The Council will prepare a report for consideration by the House at the 2012 Annual Meeting regarding Medicaid financing options.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-11

Subject: Medicaid Waivers and Maintenance of Effort Requirements (Resolution 202-A-11)

Presented by: Thomas E. Sullivan, MD, Chair

Referred to: Reference Committee J (Barbara J. Arnold, MD, Chair)

At the American Medical Association's (AMA) 2011 Annual Meeting, the House referred Resolution 202 to the Board of Trustees. Introduced by the American Academy of Pediatrics, Resolution 202-A-11 asked that the AMA "strongly oppose conversion of Medicaid to a block grant program." The Board referred Resolution 202-A-11 to the Council on Medical Service for study. This report addresses Medicaid waivers regarding block grants as well as the exemption of maintenance of effort requirements. The report also seeks input from the House of Delegates and the Federation regarding Medicaid in the context of entitlement reform.

MEDICAID COVERAGE

In 2010, Medicaid covered 68 million beneficiaries, including 33 million children, 11 million individuals with disabilities, 17 million non-disabled adults (including pregnant women and some parents of Medicaid covered children), 6 million seniors, and 1 million individuals in the US territories, as calculated by the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS). An estimated 70.4 million individuals are expected to rely on Medicaid in 2011, according to CMS.

The Kaiser Family Foundation (KFF) provides annual updates on Medicaid enrollment and expenditures, with the most recent data being from 2009. According to KFF, Medicaid expenditures were distributed as follows: 61.9 percent for acute care, 33.3 percent for long-term care, and 4.8 percent for disproportionate share hospital payments. In 2009, while 28 percent of Medicaid enrollees were categorized as elderly or disabled, they accounted for 66 percent of all Medicaid costs. During the same year, children and adults accounted for 72 percent of enrollees, but only 34 percent of the costs.

MEDICAID FINANCING

A March 2011 report issued to Congress by the Medicaid and CHIP Payment and Access Commission (MACPAC) calculated that in 2010 Medicaid spending totaled $406 billion, with a federal share of $274 billion and a state share of $132 billion. Over the next 10 years, Medicaid expenditures are estimated to increase at an average annual rate of 8.3 percent and to reach $840.4 billion by FY 2019 according to CMS. This projected growth takes into account Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, Public Law 111-148). The financial sustainability of the Medicaid program has been in question for many years. Mechanisms to control Medicaid's costs have been proposed in the program's most recent years

reflecting the state of the US economy. However, current factors have created a new sense of urgency to examine Medicaid's growth. The US is experiencing the worst economic downturn since the Great Depression with a high unemployment rate, which in turn increases enrollment in Medicaid. As the safety net for the poor for more than 40 years, escalating responsibilities threaten the program's sustainability. Given states' budget deficits, the end of the temporarily enhanced Federal Medical Assistance Percentages (FMAP) funding in June 2011, the countercyclical nature of Medicaid with increased enrollment during challenging economic times, and the estimated addition of 16 million new enrollees expected in 2014 due to the ACA, many states are looking for ways to cut costs in their growing Medicaid programs.

The AMA has long advocated for tax credits over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[14], AMA Policy Database). Specifically, policy supports transitioning the medical care portion of the Medicaid program from joint federal and state financing to federally issued tax credits to allow acute care patients to purchase individual coverage (Policy H-165.855[1]). The policy also supports a seamless mechanism to quickly reassess program and tax credit eligibility with any changes in income and family dynamics (Policy H-165.855[3]). The ACA's creation of health insurance exchanges makes individually owned health insurance viable. As described in Council on Medical Service Report 6-I-11, before the House at this meeting, one problem with exchanges is the issue of "churn" between Medicaid eligibility and exchange eligibility, due to low-income patient income variations. Providing patients with the lowest incomes with tax credits would allow them to remain in the exchanges regardless of income changes, thus addressing churn.

Accordingly, the Council is reviewing AMA policy on federal tax credits for patients with the lowest incomes as an option to help stabilize the Medicaid program (Policy H-165.855, see Appendix) and is seeking input from the House of Delegates and the Federation. The Council is undertaking a comprehensive examination of the financial viability of the Medicaid program and options for financing the care of program beneficiaries. With state and federal solutions focused on cuts to Medicaid benefits and provider payment, the Council is exploring alternative approaches to the financing of Medicaid in order to stabilize the program without negatively impacting patients and physicians. The Council is considering this issue in two steps, as follows:

1. This report reviews the financial status of the Medicaid program and highlights AMA policy on providing tax credits for the medical care portion of Medicaid for acute care patients to purchase health insurance. It also considers federal and state proposals to control Medicaid entitlement spending, specifically waivers for block grants and exemptions from the maintenance of effort (MOE) requirements. The information regarding the financial status of the Medicaid program is presented for discussion and comment before the Reference Committee at the 2011 Interim Meeting. The Council presents policy recommendations regarding the issues of block grants and MOE requirements in this report. The Council asks that members of the House, as well as state medical associations and national medical specialty societies, convey any additional views and comments regarding the overall financing of Medicaid to the Council by January 6, 2012.

2. The Council will present a report at the 2012 Annual Meeting that contains a series of recommendations regarding Medicaid financing, based on input received.

The Council has previously used a two-report approach for other significant reports with potentially controversial recommendations. Most recently, the Council used this strategy when it developed policy recommendations for emerging physician payment and health care delivery reforms (Council on Medical Service Reports 4-I-08 and 6-A-09). The Council is also using a

two-report approach to address the issue of redesigning Medicare. The first of these reports, Council on Medical Service Report 4-I-11, is also before the House at this meeting.

MEDICAID EXPANSION UNDER THE ACA

Under the ACA, Medicaid will expand coverage eligibility for low-income Americans beginning on January 1, 2014. All individuals under age 65 with incomes up to 133 percent of the federal poverty level (FPL) ($14,484 for an individual or $29,726 for a family of four in 2011) will become eligible for Medicaid, expanding coverage to an additional 16 million individuals, many of whom will be low-income childless adults. The ACA's Medicaid expansion is a controversial element that will have a significant impact on how states provide coverage, physicians practice medicine and patients access care.

For the first time, the Federal Medical Assistance Percentages (FMAP), the Medicaid matching rate each state receives, will be tied to whether beneficiaries are newly eligible. For example, the ACA provides 100 percent federal financing to states for those newly eligible for Medicaid from 2014 to 2016. The federal contribution will then be phased down to 90 percent by 2020. On average, the federal government will finance about 95 percent of the costs of the new Medicaid coverage from 2014 to 2019. However, states will continue to receive their regular federal matching rates for individuals who qualify for Medicaid under their current eligibility rules, which range from 50 to 83 percent. As a condition of receiving federal payments, MOE requirements for Medicaid and Children's Health Insurance Program (CHIP) in the ACA and American Recovery and Reinvestment Act of 2009 (ARRA, PL 111-5) prohibit states from cutting eligibility levels for all existing adult Medicaid beneficiaries until 2014, and for all children in Medicaid and CHIP until 2019. MOE requirements counteract state incentives to drop Medicaid beneficiaries now in order to enroll and count them as newly eligible beneficiaries in 2014.

As a jointly financed partnership between the federal and state governments, the federal-state financing and administrative structure of Medicaid provides a framework of federal core requirements along with broad state options for program design and administration. States have traditionally had substantial flexibility with respect to deciding what services to cover, who to cover, how to deliver care, and how much to reimburse providers. However, much of the states' flexibility has been limited in recent years, first through ARRA, and more recently, through the ACA.

LEGISLATIVE SUMMARY

In response to the impending Medicaid expansion under the ACA, there has been increased activity on the federal and state levels. Facing the end of enhanced federal Medicaid funding in June 2011, which was provided under ARRA, and confronting large budget deficits, many states have advocated for a relaxation of the ACA MOE requirements to allow states to reduce eligibility for Medicaid beneficiaries whose incomes exceed 133 percent of the FPL. CMS provided guidance in February 2011, to state Medicaid directors on the MOE provisions, and reiterated that states experiencing or projecting a deficit may apply for a waiver from the MOE requirements for certain beneficiaries (e.g., non-pregnant, non-disabled adults whose incomes are above 133 of the FPL).

Legislation has been introduced in Congress to repeal both the ARRA MOE provisions and the ACA's Medicaid and CHIP MOE provisions (e.g., the "State Flexibility Act," H.R. 1683 [Gingrey, R-GA] and S. 868 [Hatch, R-UT]). On May 12, 2011, the House Energy and Commerce Subcommittee on Health voted along party lines to favorably report the Gingrey bill to the full Committee. There has been no action in the Senate on the legislation.

Legislation to convert Medicaid from an entitlement to a block grant program was included in the House-passed 2012 Budget Resolution. This approach, however, is opposed by many House and Senate Democrats, so the current prospects of converting Medicaid into a block grant program remain remote. However, the fate of the block grant proposal could change if Republicans take control of Congress and the White House in 2012.

A proposal to significantly change federal Medicaid reimbursement for states by establishing a federal Medicaid "blended rate" is also being considered. Under this proposal, which was announced by the Administration, the following three reimbursement rates would be combined: the federal share of state Medicaid expenditures, federal reimbursement rates under CHIP, and the federal match rate for the newly expanded Medicaid population under the ACA. This proposal would shift a greater share of Medicaid spending to the states and is expected to cut $100 billion from federal Medicaid spending over the next decade.

Negotiations between Congress and the Administration to raise the national debt ceiling resulted in the Budget Control Act of 2011 (Pubic Law 112-25). While Medicaid was excluded from any immediate cuts, the legislation creates a Congressional Joint Select Committee on Deficit Reduction. This committee is charged with proposing further deficit reduction, with a stated goal of achieving at least $1.5 trillion in budgetary savings over 10 years. In order to reach this goal, entitlement reforms could be included in future cuts.

MEDICAID WAIVERS

Since the enactment of Medicaid in 1965, "Section 1115" waivers have been available to states to provide them with alternative options under Medicaid. According to CMS, Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

HHS has recently announced that once the Section 1115 Medicaid waivers expire that have expanded coverage to optional populations, states do not have to maintain the expanded coverage. For example, Arizona's Medicaid program covers 245,000 childless adults through a Section 1115 Medicaid waiver. Arizona's waiver expires on September 30, 2011, at which time Arizona can drop this coverage without violating the MOE requirements. According to CMS' information on waivers, the following eight states and the District of Columbia have Section 1115 Medicaid waivers that expand coverage to optional groups which will expire before 2014: Arizona, Hawaii, Indiana, Massachusetts, Minnesota, Oklahoma, Rhode Island and Wisconsin.

The ACA provides various opportunities to apply for waivers. A waiver program established through Section 1331 of the ACA will allow states to receive block grants to develop a "basic health program" offering standard plans to individuals who are not eligible for Medicaid but whose family income is less than 200 percent of the FPL. Section 1332 provides waivers for state innovation, which exempt states from some of the central requirements of the ACA, including the individual mandate and the creation by the state of an insurance exchange. Under a state innovation waiver, the state must demonstrate that it will provide coverage that meets the following criteria as compared to coverage through the ACA: is at least as comprehensive; is at least as

affordable; offers at least as great of protection against excessive out-of-pocket spending; covers at least as many residents; and will not increase the federal deficit.

MAINTENANCE OF EFFORT

As stated previously, as a condition of receiving federal payments, MOE requirements for Medicaid and CHIP in the ACA and ARRA prohibit states from cutting eligibility levels for all existing adult Medicaid beneficiaries until 2014, and for all children in Medicaid and CHIP until 2019. These provisions were designed to ensure that families and children with incomes slightly over the FPL do not lose eligibility for Medicaid and CHIP during the transition period between the ACA's date of enactment and January 1, 2014, when low-income individuals with incomes that exceed Medicaid eligibility levels will have access to subsidized coverage through state health insurance exchanges.

The MOE requirements have not been viewed favorably by all states due to widespread budgetary deficits coupled with the impending expansion of Medicaid coverage in 2014. As a result, state Medicaid directors have requested flexibility from CMS and some state governors have asked Congress to repeal the requirements altogether. A repeal of the MOE requirements would allow states to reduce coverage to the mandatory federal minimum levels by eliminating Medicaid coverage for individuals enrolled under the "state options" mechanism. State options provide federal matching funds to states for the extension of eligibility above federal minimum levels to pregnant women, children, parents, seniors, and individuals with disabilities. As a result of these options, all states have expanded coverage for children well above the mandatory minimum levels, and most have expanded coverage for some of the other groups.

According to an analysis by the Georgetown University Health Policy Institute Center for Children and Families, if the MOE requirements were repealed, approximately 20.6 million individuals who are covered through the Medicaid state options mechanism would lose their coverage, including 7.5 million children, 8 million adults, 2.8 million seniors, and 2.3 million individuals with disabilities. The analysis points out additional consequences of repealing the MOE requirements, such as a discontinuation of streamlined Medicaid application and renewal procedures, a reversal of the success in decreasing the number of uninsured children down to a record low and a weakening of the overall economic recovery since cuts to Medicaid would result in cuts to state business activity and jobs.

BLOCK GRANTS

Block grants have been considered as a potential solution to reign in Medicaid's costs several times in the program's history. Deliberations on Medicaid block grants occurred in 1995 during the Clinton Administration and again in 2003 during the Bush Administration. Medicaid was not converted into a block grant program during these past debates due to strong opposition from stakeholder groups. As previously mentioned, the House Fiscal Year 2012 Budget Resolution proposes to convert Medicaid from an entitlement to a block grant program.

The House of Delegates discussion of Resolution 202-A-11, which opposes Medicaid block grants, was extensive and passionate. The most common concern focused on maintaining access to Medicaid for children, pregnant women, low income elderly individuals and the disabled, which could be jeopardized if the program was converted to block grants with limited funding. Maintaining sufficient physician payment under block grants was also a concern. Some state delegations supported the option of pursuing a block grant in order to have more control over their Medicaid programs and allow for state experimentation.

Several state delegations informed the House that block grants are being used successfully in their states to ensure Medicaid funding for specific populations, such as children and pregnant women. These states were referring to various types of block grants, such as Community Services Block Grants, Preventive Health and Health Services Block Grants and Maternal and Child Health Services Block Grants. These states brought up the concern that by opposing "block grants," they would no longer have access to the types of block grants that provide additional funding for their Medicaid programs. The specific block grants that these states rely on are different than the overarching federal block grant proposal referred to and opposed by Resolution 202-A-11.

Resolution 202-A-11 refers to legislation that would convert the Medicaid program from an entitlement to a block grant program, such as the House Fiscal Year 2012 Budget Resolution. Under this proposal, the federal matching rate would end, along with its mandate to cover particular groups and provide specific benefits. Federal spending would be capped annually and a designated amount of money would be distributed to states each year based on a formula rather than according to actual costs. In return, states would have independent discretion as to how to structure their Medicaid program and to determine eligibility and benefits. According to an analysis conducted by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, the House Fiscal Year 2012 Budget Resolution would result in $750 billion in federal savings from converting Medicaid to a block grant program between the years 2012 and 2021. During this time period, the cuts to the Medicaid program would range from a 26 percent to 44 percent decrease in funding, depending on the state.

Federal Medical Assistance Percentages (FMAP)

In the event that Medicaid is converted into a block grant program, the FMAP formula, which determines the Medicaid matching rate each state receives, would become obsolete. Under the current system, the FMAP formula is calculated using the average income per person in each state and for the nation as a whole, which is intended to give relatively poor states (as measured by per capita income) a higher share of federal dollars than wealthier states. However, this formula has long been criticized as it does not take into consideration factors such as each state's financial abilities, the concentration of low-income citizens, or service delivery costs.

In addition, critics argue that the FMAP encourages states to expand their Medicaid programs to cover optional populations and services, since the more money a state spends, the more federal matching dollars the state receives. As a result, there is a wide disparity in how much money each state provides per Medicaid beneficiary, which reflects how the state has chosen and been financially able to manage their Medicaid program. On the high end, Medicaid beneficiaries in New York received $9,442 on average per person in 2010, whereas on the low end, Medicaid beneficiaries in Utah averaged $4,731 per person according to the Bureau of Economic Analysis, Census Bureau.

Rhode Island Global Consumer Choice Compact

Rhode Island is commonly highlighted as a successful example of a state with a Medicaid block grant program. However, the "Rhode Island Global Consumer Choice Compact" or "global waiver," is also not comparable to the block grant proposal issued by the House Fiscal Year 2012 Budget Resolution. The Rhode Island experience provides increased Medicaid funding to the state whereas the House Budget Resolution is designed to cut federal Medicaid funding to the states. Rhode Island operates its entire Medicaid program under a single 1115 demonstration waiver, which fundamentally differs from a traditional block grant. In Rhode Island's case, the spending cap is higher than the projected Medicaid spending costs for the state, federal spending has

increased relative to what it otherwise would have, and the state can give notice to CMS at any time if it wants to exit the waiver. In addition, some of the cost containment measures used by Rhode Island could have been carried out without the global waiver.

RELATED AMA POLICY

The AMA urges Medicaid reform to be undertaken in conjunction with broader health insurance reform in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients (Policy H-290.982). Provider taxes or fees to fund health care programs or to accomplish health system reform are strongly opposed by the AMA (Policy H-385.925[1,3,4]).

As previously stated, the AMA has long advocated for tax credits over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[14]) and states that the medical care portion of the Medicaid program should be financed with federally issued tax credits to allow acute care patients to purchase individual coverage (Policy H-165.855[1]). The AMA supports a seamless mechanism to quickly reassess program and tax credit eligibility with any changes in income and family dynamics (Policy H-165.855[3]). The AMA advocates that existing federal guidelines regarding types of health insurance coverage, such as the Federal Employees Health Benefits Program (FEHBP), should be used as a reference when considering if a given plan would provide meaningful coverage for adults (Policy H-165.846). In addition, the AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program should be used as the model for any essential health benefits package for children (Policy H-165.846[2]).

Regarding Medicaid waivers, the AMA advocates that proposed projects improve access to quality medical care, be preceded by a fair and open process for development, are properly funded, include sufficient provider payment levels to secure adequate access to providers, and do not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid (Policy H-290.987).

Physician participation in the Medicaid program is encouraged by the AMA in order to support access to care (Policy H-290.982[12]). The AMA has long advocated for sufficient provider payment. The AMA supports Medicaid payment for physician providers to be at minimum 100% of the RBRVS Medicare allowable (Policy H-385.921), and the AMA advocates allowing physicians to tax defer a specified percentage of their Medicaid income (Policy H-290.982[12]). The AMA opposes payment cuts in the Medicaid budget that may reduce patient access to care and undermine the quality of care provided to patients (Policy H-330.932[1]).

AMA policy does not specifically address converting Medicaid into a block grant program. However, the AMA strongly supports allowing states the flexibility to tailor their programs to their own unique needs and to test alternative models for improving coverage for low-income patients without incurring new and costly unfunded mandates or capping federal funds (Policy D-165.966).

While the AMA does not have policy addressing MOE requirements, in the absence of private sector reforms, the AMA supports maintaining Medicaid as a safety net program for the nation's most vulnerable populations. The AMA supports eligibility expansions of Medicaid with the goal of improving access to health care coverage to otherwise uninsured groups (Policies H-290.974 and H-290.986), specifically the elimination of categorical requirements and implementation of uniform eligibility for all persons below the poverty level (Policy H-290.997). The AMA encourages states to simplify their Medicaid enrollment process and to enroll all eligible individuals (Policies H-290.982[18], D-290.985[1,2] and H-165.877[13]).

DISCUSSION

The forthcoming recommendations of the Congressional Joint Select Committee on Deficit Reduction may include some Medicaid reforms. Escalating costs of the program and the dire finances of the country and the states make broader entitlement reform more likely in 2013 with a newly seated Congress. The Council believes that refining the AMA's position on Medicaid now will prepare our organization to be a proactive participant in shaping the future of the program.

At the 2011 Annual Meeting, testimony on Resolution 202 emphasized that states should be allowed the flexibility to tailor their Medicaid programs to meet their unique needs and to be able to test alternative models for improving care for low-income patients. The AMA's long-standing position demonstrates a commitment to supporting the ability of states to develop and test different models for improving coverage for patients with low incomes (Policy D-165.966). As such, the Council recommends that Policy D-165.966 be reaffirmed.

In the context of the House Fiscal Year 2012 Budget Resolution proposing to convert Medicaid from an entitlement to a block grant program, the Council is concerned about the loss of coverage or benefits, especially if the provision of block grants leads to insufficient funds to cover low-income individuals. While Policy D-165.966 strongly supports allowing states the flexibility to tailor their programs to their unique needs and to test alternative models for improving coverage for low-income patients, it cautions against incurring new and costly unfunded mandates or capping federal funds. Under the House Budget Resolution, federal spending would be capped annually and a designated amount of money would be distributed to states each year based on a formula rather than according to actual costs, which is inconsistent with the AMA's position in opposition to capping federal funds, per Policy D-165.966.

At the 2011 Annual Meeting, testimony considered giving states the option to convert their Medicaid programs from entitlement to block grant programs in order to have more control and to allow for state experimentation. A main concern under a Medicaid block grant scenario is how much money states would receive from the federal government in the future, particularly in the event of an unexpected sharp rise in Medicaid costs. The Council took into consideration testimony in support of state experimentation as well as maintaining beneficiary access to Medicaid under a Medicaid block grant program. In response, the Council recommends that the AMA support giving states the option to convert their specific Medicaid program from an entitlement to a block grant program only if safeguards are in place to ensure this funding mechanism supports innovative delivery of care models that better serve this population and only if block grant funding is determined fairly according to each state's needs.

The Council is not supporting an abrupt national transition to block grant funding for Medicaid, but rather supporting states with pioneering methods to better serve the needs of their Medicaid population to be given the option to convert their Medicaid program into a federal block grant program. The Council believes that the safeguards outlined under a block grant scenario will protect the Medicaid program as a safety net for our nation's most vulnerable populations, while allowing states the ability to create unique Medicaid programs.

Given state deficits and the estimated addition of 16 million new Medicaid enrollees expected in 2014 due to the ACA, it is understandable that many states are seeking to cut costs to their growing Medicaid programs. The ACA's MOE requirements prohibiting states from cutting eligibility levels for all existing adult Medicaid beneficiaries until 2014, and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019, is a serious source of strain for many states. The ACA's enhanced match for newly eligible beneficiaries gives states an incentive to

drop beneficiaries now and then enroll them as new beneficiaries in 2014. However, long standing AMA policies support maintaining Medicaid as a safety net program for the nation's most vulnerable populations and eligibility expansions of Medicaid with the goal of improving access to health care coverage to otherwise uninsured groups (Policies H-290.974 and H-290.986). The repeal of the MOE requirements would seriously jeopardize health care coverage for this population. As such, the Council recommends that the AMA oppose any efforts to repeal the Medicaid MOE requirements.

The Council is seeking the advice and suggestions of members of the House, state medical associations, and national medical specialty societies in developing recommendations on the overall financing of Medicaid. The Council is interested in hearing perspectives on AMA Policy H-165.855 (see Appendix) regarding federal tax credits for the medical care portion of Medicaid for acute care patients to purchase individually owned health insurance. Doing so would place the full burden of financing this group of Medicaid enrollees on the federal government, thus freeing states of a historically burdensome expense. The Council is interested in feedback on whether such an approach is a viable position in the context of the ACA's health insurance exchanges, which create a marketplace for individually owned insurance.

As an alternative to transitioning acute medical care Medicaid patients to tax credits and individually owned health insurance, the Council is also interested in whether the model of the current program can and should be strengthened. Accordingly, the Council is seeking input on the FMAP formula, particularly perspectives regarding whether the current formula is fair, and if not, suggestions on how to update the formula. In addition, the Council is seeking insights regarding the potential to divide the Medicaid program into two separate programs, one for patients who are eligible solely on the basis of having low incomes, focusing mostly on acute care needs and the other for the elderly and disabled population, focusing mostly on long-term care. Low-income medical care patients account for much less of the resources than do the elderly and disabled Medicaid beneficiaries receiving long-term care services, so distinguishing separate programs may provide for administrative simplification and more focused service provision. Any additional perspectives on the financing of Medicaid are also requested. Please see the Appendix of this report for specific questions to consider. At this time, it is critical that the AMA develop Medicaid policy with the best interests of patients and physicians in mind. Using the input received and other sources of information, the Council will prepare a follow-up report on Medicaid financing for the 2012 Annual Meeting.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 202-A-11, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy D-165.966, which advocates that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. (Reaffirm HOD Policy)

2. That our AMA oppose any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. (New HOD Policy)

3. That our AMA forward the testimony and comments from Reference Committee and House discussions regarding the financing of Medicaid to the Council on Medical Service for consideration in developing its recommendations for a follow-up report at the 2012 Annual Meeting. (Directive to Take Action)

4. That our AMA encourage members of the House, state medical associations, and national medical specialty societies to forward any additional comments on the financing of Medicaid to the Council on Medical Service by January 6, 2012. (Directive to Take Action)

5. That our AMA make the comments submitted to the Council on Medical Service for its 2012 Annual Meeting report on Medicaid financing available to AMA members via the AMA website or other appropriate mechanism. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.

APPENDIX

H-165.855 Medical Care for Patients with Low Incomes

It is the policy of our AMA that:

(1) the medical care portion of the Medicaid program should be financed with federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP), with varying cost-sharing obligations based on income and eligibility under the current Medicaid program as described below:

(a) Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive tax credits that are large enough to enable them to purchase coverage with no cost-sharing obligations.

(b) Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive tax credits that are large enough to enable them to purchase coverage with limited cost-sharing.

(2) individuals who do not qualify for Medicaid, and have resources that are insufficient to purchase health insurance, should receive federally issued tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing.

(3) in order to assure continuity of care, there should be a seamless mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family.

(4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area until the next enrollment opportunity.

(5) to support the development of a safety net mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.

(6) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available as either a mandatory or optional services under Medicaid, but are not medical benefits per se.

(7) as individuals in the acute care population transition into chronic care needs, they should be eligible for sufficient additional subsidization to allow them to maintain their current coverage.

(8) our AMA encourages the development of pilot projects, including children, incorporating the above recommendations. (CMS Rep. 1, I-03; Reaffirmed in lieu of Resolution 105-A-06; Reaffirmation I-07)

Considerations on Medicaid Financing

1. Updating Policy H-165.855, "Medical Care for Patients with Low Incomes," which would transition the acute medical care (as opposed to long-term care) patients to federal income-related tax credits for the purchase of private health insurance.

    - Are tax credits a viable option for the Medicaid population in the context of the ACA's health insurance exchanges, which create a marketplace for individually owned insurance?

    - How should eligibility for tax credits be determined?

    - Would the "churn" between Medicaid eligibility and tax credit eligibility be fully addressed (i.e., eliminated)?

    - How should cost-sharing levels be determined?

    - How should the need for costly chronic care be handled?

    - If states were freed of the cost of insuring patients with low incomes, should they have other obligations? For example, states could be expected to assist with patient cost-sharing or with social supports such as care coordination and transportation.

2. The Federal Medical Assistance Percentages (FMAP) formula

    - Is the current FMAP formula fair?

    - Do you have suggestions for updating the FMAP formula?

3. Separating Medicaid into two distinct programs

    - Should the Medicaid program continue to be a shared state and federal program, but divided into two distinct programs: one for those who qualify for Medicaid based solely on having low incomes, focusing on acute medical care, and the other for the elderly and disabled populations, focusing mostly on long-term care?

    - Would such a model protect the funding allocated for those needing medical care?

Please send comments to:

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