REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (A-12)
Medicaid Financing Reform
(Reference Committee A)

EXECUTIVE SUMMARY

At its 2011 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted as amended the recommendations in Council on Medical Service Report 5, which called for members of the House of Delegates and the Federation to provide comments to the Council regarding the financing of Medicaid. The Council specifically requested input on updating Policy H-165.855, "Medical Care for Patients with Low Incomes," updating the Federal Medical Assistance Percentages (FMAP) formula and bifurcating the Medicaid program.

The Medicaid program has expanded over the years with the most excessive growth anticipated in 2014 due to an additional 16 million beneficiaries becoming eligible for the program as legislated by the Patient Protection and Affordable Care Act (ACA, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152). The anticipated expansion of the Medicaid program in the context of a rational focus on deficit reduction and entitlement reform has prompted the Council to consider Medicaid financing reform.

This report reviews and recommends modifications to long-standing AMA Policy H-165.855, "Medical Care for Patients with Low Incomes," which advocates financing the "medical care portion" of Medicaid with federally issued tax credits so that Medicaid beneficiaries have the same coverage choices as those with private coverage. With the ACA's establishment of health insurance exchanges, the Council believes Policy H-165.855 is more relevant today than when it was established in 2003. Nevertheless, sections of the policy will become obsolete in 2014 when provisions in the ACA transform Medicaid eligibility from categorical to income-based. The Council has proposed modifications to update the policy as detailed in the Discussion and Recommendations sections of this report (see the Appendix for a detailed explanation of each proposed modification to the policy).

The Council recommends changing the policy to give states the option to transition nonelderly and nondisabled Medicaid beneficiaries to a system of tax credits for the purchase of coverage. This targeted Medicaid population is comprised of low-income patients with medical needs, as opposed to those with disabilities or long-term care requirements. For most Medicaid recipients, Policy H-165.855 recognizes that tax credits will need to be equivalent to the entire cost of coverage, with little or no beneficiary cost-sharing. The Council strongly believes that pilot programs or state demonstrations continue to be needed to determine if tax credits are a viable option for Medicaid beneficiaries. Under the Council's proposed recommendations, the current Medicaid program would continue to exist in those states not choosing to transition to the use of premium tax credits for this portion of their Medicaid beneficiaries.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-12

Subject: Medicaid Financing Reform

Presented by: Thomas Sullivan, MD, Chair

Referred to: Reference Committee A
(Thomas J. Madejski, MD, Chair)

At its 2011 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted as amended the recommendations in Council on Medical Service Report 5, which called for members of the House of Delegates and the Federation to provide comments to the Council regarding the financing of Medicaid and for the AMA to make these comments available to AMA members via the AMA website or other appropriate mechanism. The Council agreed to present a follow-up report to the House at the 2012 Annual Meeting that would incorporate these comments and provide recommendations to reform Medicaid financing.

The Council requested that members of the House and Federation provide feedback on three issues regarding the financing of Medicaid: updating Policy H-165.855, "Medical Care for Patients with Low Incomes," updating the Federal Medical Assistance Percentages (FMAP) formula and bifurcating the Medicaid program. In response, input was provided by the following state medical associations and national medical specialty societies: Illinois State Medical Society; Oregon Medical Association; South Carolina Medical Association; American Academy of Pediatrics and the America Psychiatric Association. The following individual physician members also provided comments: George Anstadt, MD; Randy Gould, MD; Barbara L. McAneny, MD and W. Jeff Terry, MD. The Council appreciates all comments that were submitted and took them into consideration when drafting this report. All input is posted online at http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-medical-service/feedback-medicaid.page.

THE SCOPE OF THE MEDICAID PROGRAM

Two general views about the scope of the Medicaid program coexist in AMA policy. One perspective supports sustaining and expanding Medicaid as a safety net program, including eligibility expansions to improve access to health care coverage to otherwise uninsured groups, as outlined in Policies H-290.974 and H-290.986 (AMA Policy Database). The other view advocates for alternatives to public sector expansion. The AMA has long advocated for individually owned tax credits over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[14]) and for the medical care portion of the Medicaid program to be financed with federal tax credits to allow acute care patients to purchase individual coverage of their choice (Policy H-165.855[1]). The Council believes that these policies are complementary rather than contradictory and that maintaining all of these policies allows the AMA flexibility according to financial realities and the political environment.

THE NEED FOR REFORM

A March 2011 report of the Medicaid and CHIP Payment and Access Commission (MACPAC) calculated that Medicaid spending in 2010 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 the Centers for Medicare and Medicaid Services (CMS). While the overall fiscal situation in the states has improved, Medicaid continues to consume a growing portion of state budgets. According to the National Association of State Budget Officers, Medicaid accounted for 23.6 percent of total state spending in FY 2011, making it the single largest expenditure by states. As a result, nearly every state implemented at least one new policy to address Medicaid costs in FY 2011. The most common cost containment strategies being used by states include reducing provider payment and expanding managed care. Reductions in provider payment raise concerns about beneficiary access to health care.

UPDATING POLICY H-165.855, "MEDICAL CARE FOR PATIENTS WITH LOW INCOMES"

Long-standing AMA Policy H-165.920 advocates for individually selected and owned health insurance. Consistent with this coverage preference, Policy H-165.855 supports choice of health insurance coverage for the Medicaid population. In the context of the Patient Protection and Affordable Care Act (ACA, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152) and in response to comments received from members of the House of Delegates and the Federation, the Council suggests several modifications of Policy H-165.855.

Beginning in 2014, the ACA will provide refundable, advanceable and sliding-scale premium tax credits and cost-sharing subsidies to individuals with incomes between 133 and 400 percent of the federal poverty level (FPL) who are not eligible for other affordable coverage. Individuals who qualify for these premium tax credits will be able to purchase individually selected and owned health insurance through state health insurance exchanges, which will become operational in 2014. Also in 2014, individuals under age 65 with incomes up to 133 percent of the FPL ($11,170 for an individual or $23,050 for a family of four in 2012) will become eligible for Medicaid due to the ACA's Medicaid expansion.

Both the provision of premium tax credits and the creation of health insurance exchanges that offer more affordable choices are consistent with long-standing AMA policies on expanding health insurance coverage and choice. AMA policy advocates providing adequately funded tax credits to all individuals for the purchase of health insurance, including individuals currently qualifying for Medicaid (Policies H-165.855 and D-165.955). The AMA supports implementation of refundable, advanceable, individual tax credits for the exclusive purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, and the chronically ill (Policy H-165.851[1]). Designing tax credits to be refundable ensures that even individuals who do not owe taxes will receive the credit and making them advanceable helps those with low incomes, so individuals do not have to wait to be reimbursed when they file their income taxes. The AMA believes that funding for the expansion of health insurance coverage for uninsured children should preferably allow these children, through their parents or legal guardians, to select private insurance rather than being placed in the Medicaid program (Policy H-165.877[3]).

Policy H-165.855 was established nearly a decade ago with the adoption of the recommendations contained in Council on Medical Service Report 1-I-03. The policy supports federal tax credits for acute care Medicaid patients with varying cost-sharing obligations based on income and categorical

eligibility; supports a mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family composition; advocates choice in coverage, but also presumptive eligibility if an individual fails to make a coverage choice; and supports pilot projects incorporating these recommendations. While still relevant, sections of Policy H-165.855 will become obsolete in 2014 when provisions in the ACA transform Medicaid eligibility from categorical to income-based. The Council proposes modifications to the policy as detailed in the Discussion and Recommendations sections of this report. The recommended modifications to Policy H-165.855 better define the population that is being targeted by tax credits, replaces "federally issued" with "premium" tax credits to allow states to use a combination of federal and state financing for tax credits, updates the policy to be consistent with changes in the Medicaid program from categorical to income-based in 2014, and modernizes terminology.

With the ACA's establishment of health insurance exchanges that will include patient navigators, the Council believes Policy H-165.855 is more relevant today than when it was first established. Giving those with the lowest incomes the option of purchasing private coverage through state exchanges is consistent with Policy H-290.982[1], which urges that Medicaid reform not be undertaken in isolation, but rather 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.

The Medicaid beneficiaries being targeted with the tax credits are the nonelderly and nondisabled adults and children, who comprise approximately 74 percent of current Medicaid enrollees and 33 percent of Medicaid expenses. These are the low-income patients with medical needs, as opposed to those with disabilities or long-term care requirements. Consistent with Policy H-165.855[8], which encourages the development of pilot projects to test the feasibility of premium tax credits for the Medicaid population, including for children, the Council strongly believes that pilot programs or state demonstrations are needed to determine if tax credits are a viable option for this specific Medicaid population. Under the Council's proposed recommendations, the current Medicaid program would still exist in those states not choosing to use tax credits for this portion of their Medicaid beneficiaries.

Federation Input

Feedback provided to the Council regarding Policy H-165.855 was mixed, although comments uniformly noted the need for the tax credits to be nearly equal or equal to the entire cost of coverage for the Medicaid population. The policy advocates the use of federal tax credits that are inversely related to income and large enough to incentivize recipients to purchase coverage.

A concern was issued regarding the ability of tax credits to enable the purchase of equivalent health care benefits for children as currently exist through Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Consistent with Policy H-165.846, which advocates that the EPSDT program be used as the model for any health benefits package for children, the Council agrees that these services are important, and as such, recommends amending Policy H-165.855 to model benefits purchased through premium tax credits after the EPSDT program.

In addition, concern was raised that even if a large enough subsidy was provided, this population would need assistance navigating the decision-making process to select an appropriate health plan suited to their individual needs. The ACA acknowledges that there will be a need for increased education and instruction in how to choose the appropriate health plan and requires each state health insurance exchange to establish a navigator program to help individuals make informed decisions about their choices. AMA policy on patient navigator programs recognizes this

educational function (Policy H-373.994). In the event that an individual does not choose a health plan, the Council recommends amending Policy H-165.855[4] to advocate that a mechanism be developed to assign a plan in the patient's geographic area through auto-enrollment until the next enrollment opportunity.

In terms of how these tax credits would be funded, feedback supported Policy H-165.920[12], which advocates that the employee federal income tax exclusion for employer-sponsored coverage be replaced with tax credits or vouchers to individuals and families for the purchase of health insurance. Two of the major rationales for replacing the tax exclusion with tax credits are that the tax exclusion is socially inequitable, and that removing the tax exclusion would generate tax revenue that could be used to finance federal tax credits. The tax exclusion is seen as inequitable because only those whose employers offer health insurance are eligible for it, and it provides a bigger tax break to employees in higher tax brackets (i.e., those with higher incomes).

FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP)

States receive federal matching funds of at least half their Medicaid program costs through the federal medical assistance percentage (FMAP). The formula used to calculate the FMAP seeks to narrow the gap between rich and poor states (measured as per capita income) by providing higher matching funds to poorer states. In 2012, the FMAP ranged from providing a low of 50 percent of a state's Medicaid program costs (Alaska, California, Colorado, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington and Wyoming) to a high of 74.18 percent (Mississippi), with an average of 59.62 percent.

The Council notes that in August, 2011, CMS issued a proposed rule on the Medicaid program and eligibility changes under the ACA. The proposed rule highlighted three alternative methodologies to use for purposes of applying the appropriate FMAP for expenditures for either currently eligible or newly eligible Medicaid beneficiaries in accordance with the ACA. The three proposed alternatives include: (1) using a threshold based on the 2009 eligibility regulations, (2) using a statistically valid sampling methodology, or (3) basing the FMAP methodology on reliable data sources. CMS has contracted with RAND and the State Health Access Data Assistance Center to test the feasibility of these proposed FMAP calculation methods. The following 10 states have been selected as pilot test states: Arizona, California, Indiana, Nebraska, New Hampshire, New York, Oregon, Tennessee, Virginia, and West Virginia. Using the 10 pilot states, RAND will assess how effectively states could use the alternative methodologies within the context of existing data. The study will also test the validity of the methods compared with a national data source, to ensure that the methodologies produce reliable and accurate results. A final rule and interim final rule on eligibility changes to the Medicaid program was issued by CMS in March 2012, which indicated that the methodologies for the FMAP policy will be finalized in future rulemaking.

Federation Input

Feedback provided to the Council expressed concern that some states are being negatively impacted by the FMAP formula since it is based on per capita income. A state's high per capita income may be largely due to a small group of extremely wealthy individuals in that state and not be representative of the citizens of the state as a whole. To address this potential skewing effect, feedback suggested that the FMAP calculation should incorporate the financial condition of each state and the concentration of low-income citizens. However, comments also acknowledged the complexity of the FMAP formula and strongly cautioned against recommending changes. While the Council does not view the FMAP as an ideal method of allocating resources, it agrees with

feedback to not recommend changes at this time since every scenario would negatively impact at least some states.

BIFURCATING MEDICAID

Bifurcating the Medicaid program refers to separating the program into two distinct programs: one for nonelderly and nondisabled patients and one for costly chronic care and long-term care patients who are dually eligible for both Medicaid and Medicare. The rationale for creating two distinct programs within Medicaid is to best account for the specific needs of each group. Medicaid beneficiaries who are nonelderly and nondisabled adults and children, as previously noted, account for approximately 74 percent of current enrollees and only 33 percent of Medicaid expenses. Alternatively, the disabled and elderly, or dually eligible population, account for approximately 25 percent of current Medicaid enrollees, and 68 percent of Medicaid expenses.

The dually eligible population totals approximately 9 million individuals, including 5.5 million low-income seniors and 3.4 million individuals with disabilities under the age of 65. This population has been attracting attention recently due to the tremendous cost it accounts for in the health care system. In 2011, the federal government spent $175.7 billion through the Medicare program and $80.9 billion through the Medicaid program on dually eligible beneficiaries; the states spent another $62.7 billion.

The ACA established the Federal Coordinated Health Care Office, or also known as the Medicare-Medicaid Coordination Office, to improve quality, reduce costs and improve the experience for dually eligible beneficiaries. Through the solicitation of proposals for the "State Demonstrations to Integrate Care for Medicare -Medicaid Enrollees" initiative, this office is working within the CMS Center for Medicaid and Medicare Innovation on state demonstrations to integrate care for dually eligible enrollees. In 2011, fifteen states were awarded up to $1 million each to develop preliminary service delivery and payment models that coordinate and integrate care for dually eligible beneficiaries. Implementation of selected proposals is planned for 2012. In addition, a total of 38 states and the District of Columbia have submitted letters of intent to participate in financial alignment demonstrations that support state efforts to coordinate and integrate care.

Federation Input

Feedback provided to the Council expressed mixed responses on the concept of bifurcating the Medicaid program. Several comments were in support of separating the Medicaid program into distinct programs based on specific populations so that delivery and payment system reforms could be implemented to address cost factors for each population. However, concerns also were expressed about the logistics of creating two separate programs, such as how the funding streams for the two programs would be segregated and how the proportion of funding would be determined. Given the creation of the Medicare-Medicaid Coordination Office and the state demonstrations initiative to integrate care for dually eligible enrollees, the Council believes monitoring the proposed studies is warranted at this time.

WORKFORCE

The ACA is expected to increase health insurance coverage to 32 million more Americans by 2019. There is mounting concern about the ability of the health care workforce to handle this expected surge in patient volume. The health care workforce has been experiencing a shortage of both physicians and nurses for the past decade and the future workforce is estimated to experience continued shortfalls. According to a 2010 analysis by the Association of American Medical

Colleges, the shortage of physicians is estimated to reach 130,600 by 2025. The shortage of registered nurses is expected to reach 260,000 by 2025 (Buerhaus, Auerbach and Staiger, 2009). The ACA attempts to address the workforce shortage by increasing Medicaid payments for primary care services provided by primary care physicians to 100 percent of the Medicare payment rates for 2013 and 2014. Of great concern is not only access to primary care physicians by the Medicaid population, but access to specialists, which is already extremely difficult in some areas of the country.

While various reports on the looming workforce shortage highlight nurses as the key to increasing access to care, the AMA advocates a physician-led team approach to care, with each member of the team playing the role they are educated and trained to play, as better suited to helping ensure that patients receive high-quality care and value for their health care spending (Policy D-35.985). The AMA Councils on Medical Education and Medical Service are exploring ways to foster health care teams that meet access challenges.

DISCUSSION

Given the Medicaid program's counter-cyclical impact on state budgets, states have always struggled to cover those most in need during economically challenging times. This counterintuitive financing structure has been in place for too long. With the ACA's establishment of health insurance exchanges that will include patient navigators, the Council believes that it is time to modernize AMA Policy H-165.855, which advocates "federal" tax credits with a change to "premium" tax credits. Advocating for premium tax credits will encourage states to use a combination of federal and state financing for tax credits exclusively designed for purchasing health insurance. Allowing states to have the option to provide premium tax credits to the Medicaid population will strengthen the health care safety net by empowering beneficiaries to purchase coverage of their own choosing. For most Medicaid recipients, the Council recognizes that premium tax credits will need to be equivalent to the entire cost of coverage, with little or no beneficiary cost-sharing. Importantly, education is needed for individuals navigating the purchase of their own health insurance for the first time.

The Council recommends amendments to update Policy H-165.855 in order to support giving premium tax credits to Medicaid beneficiaries (see Recommendation 1). Specifically, sections of Policy H-165.855 will become obsolete in 2014 when provisions in the ACA transform Medicaid eligibility from categorical to income-based. Accordingly, the Council recommends deleting the reference to eligibility based on categorical groups. The modifications also include deleting reference to "acute care" patients and defining this population as "nondisabled and nonelderly" to better reflect the identified population; replacing "federal" tax credits with "premium" tax credits to allow and encourage states to use a combination of financing for tax credits that are exclusively designated for purchasing health insurance; adding support for health plans modeled after the EPSDT program for children; supporting 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote continuity and coordination of patient care; and replacing "presumptive assessment of eligibility" with the contemporary term "auto-enrollment." In addition, the support of pilot programs was expanded to give states the option to participate in pilot programs or state demonstrations to provide premium tax credits to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children.

The Council strongly believes that state pilot programs or state demonstrations are needed to determine if premium tax credits are a viable option for Medicaid beneficiaries who are nonelderly and nondisabled adults and children. If pilot programs or state demonstrations exhibit successful

outcomes, the Council wants other states to be able to replicate or modify these programs to fit their needs.

By providing premium tax credits to the Medicaid population for the exclusive purchase of health insurance, states would be released from a historical obligation to provide financial support for health care services to this population. The fiscal constraints that state budgets face in economically challenging times cause some states to make decisions that are not in the best interest of beneficiaries and physicians. The federal government is already covering at least 50 percent of the cost of Medicaid beneficiaries through the FMAP formula, and in some states an even higher percentage. Providing the Medicaid population with premium tax credits would eliminate the issue of "churn," whereby fluctuating incomes may cause individuals to transition back and forth between eligibility for Medicaid and eligibility for premium tax credits and other subsidies through the state exchanges.

Premium tax credits would also provide fairness in the health care system by providing those with the lowest incomes the same health care options that are provided to those with higher incomes. States could use a variety of funding sources to finance the provision of premium tax credits to their residents. For example, Massachusetts used a combination of federal and state funds, including a Section 1115 Medicaid demonstration waiver, an annual private sector contribution through hospital and private payer assessments, and money from the state's general fund to finance nearly universal health care coverage in the state. The Council believes that allowing states the option to provide premium tax credits to Medicaid beneficiaries, rather than giving individual Medicaid beneficiaries the option to remain in the current Medicaid program or to receive tax credits, is administratively simpler and retains state autonomy and flexibility to tailor their Medicaid program to meet their needs.

The FMAP formula is not considered an ideal method of allocating resources to the states. However, the Council is encouraged with HHS plans to test alternatives to the current process. Similarly, the Council is optimistic about the Center for Medicare and Medicaid Innovation's state demonstrations to integrate care for dual eligible enrollees. Given that both programs are in flux, the Council believes monitoring the proposed studies is the most appropriate course of action at this time.

While the health care workforce shortage is not limited to impacting just Medicaid patients, it does and will continue to have a significant impact on this population. As more beneficiaries are added to the Medicaid program, the health care system is going to have to devise approaches to managing a much larger caseload. The AMA strongly advocates for the physician as the lead in the health care delivery team, and as such, the Council recommends reaffirming Policy D-35.985, which advocates for physician-led, team-based care. The AMA Councils on Medical Education and Medical Service are exploring ways to foster health care teams that meet access challenges.

The Council's suggested modifications to Policy H-165.855 mainly update this policy to better define the population that is being targeted by tax credits, replaces "federally issued" with "premium" tax credits to allow states to use a combination of federal and state financing for tax credits, updates the policy to be consistent with changes in the Medicaid program from categorical to income-based in 2014, and modernizes terminology.

Finally, the Council recommends rescinding Policy D-290.981, which called for the Federation and members of the House of Delegates to provide comments on Medicaid financing reform to the Council by January 6, 2012, for consideration in this follow-up report.

RECOMMENDATIONS

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

1. That our American Medical Association modify Policy H-165.855 by insertion and deletion to read as follows:

   It is the policy of our AMA that:

   (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or ~~the medical care portion of the Medicaid program should be financed~~ with ~~federally issued~~ premium tax-credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow ~~acute care~~ patients and their families to purchase coverage ~~individually and~~ through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with ~~varying~~ minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. ~~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 premium tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing~~.

   ~~(3)~~ (2) in order to limit patient churn and assure continuity and coordination 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.~~ adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.

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

   (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 through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.

~~(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)~~ (5) 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)~~ (6) as ~~individuals in the acute care~~ the nonelderly and nondisabled populations transition into needing chronic care ~~needs~~, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.

~~(8)~~ (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)

(8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.

2. That our AMA reaffirm Policy D-35.985, which advocates for physician-led, team-based care. (Reaffirm HOD Policy)

3. That our AMA rescind Policy D-290.981. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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