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How Will Medicare-for-all Proposals Affect Medicaid?

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Summary

As the debate over the future direction of our health care system heats up leading into the 2020 Presidential election, several Democratic proposals to create a single, federal, universal health insurance program known as Medicare-for-all have garnered significant attention. These proposals would replace most current public and private health insurance with a new federal program that would guarantee health coverage for all or nearly all U.S. residents. However, many details about how a new public program would be implemented and financed are not yet known. While much attention has focused on the implications of ending private insurance and Medicare, the debate has largely ignored the effects on the low-income and vulnerable populations covered by Medicaid and the broader implications for states of eliminating the Medicaid program. Key changes related to Medicaid under current proposals include:

- Medicare-for-all proposals would generally eliminate current variation in eligibility, enrollment and renewal processes, benefits, and payment and delivery systems that are part of the current structure of Medicaid where states have considerable flexibility to design programs within broad federal rules.
- Proposals would extend coverage for certain Medicaid services important to vulnerable populations (such as comprehensive benefits for children and non-emergency medical transportation) to other populations. The proposals would continue Medicaid protections against high out-of-pocket costs.
- One of the most fundamental changes under Medicare-for-all would be uniform coverage of community-based long-term care services for all Americans. Medicaid is the primary payer for these services today, with substantial state variation in eligibility and coverage. Under current Medicare-for-all proposals, these services would be required and explicitly prioritized over institutional services. Medicare-for-all proposals vary as to whether they would include institutional long-term care, such as nursing homes, or instead continue the current Medicaid coverage of these services, locking in state spending, variation in benefits across states, and limited access to populations beyond Medicaid.
- Some proposals would have the federal government assume all or a significant share of the nearly $222 billion in state spending on Medicaid, leading to significant state savings, while other proposals call for a maintenance of effort for all or some current state Medicaid spending.
- The proposals would shift responsibility for designing and implementing much of health policy from states to the federal government, in contrast to states' role under Medicaid today.

Introduction

As the debate over the future direction of our health care system heats up leading into the 2020 Presidential election, several Democratic proposals to create a single, federal, universal health insurance program known as Medicare-for-all have garnered significant attention. These proposals would replace most current public and private health insurance with a new federal program that would guarantee health coverage for all or nearly all U.S. residents, though many details about how a new public program would be implemented and financed are not yet known. While much attention has focused on the implications of ending private insurance and Medicare, the debate has largely ignored the effects on the low-income and vulnerable populations covered by Medicaid and the broader implications for states of eliminating the Medicaid program.

Multiple Medicare-for-all proposals have been introduced in Congress and advanced by Presidential candidates. Currently, the proposals are characterized by two main approaches: proposals that create a single-payer system and eliminate other forms of coverage, including employer-sponsored insurance, Medicare and Medicaid; and proposals that eliminate the Medicare and Medicaid programs but maintain a role for private insurance. Medicare-for-all bills proposed by Rep. Pramila Jayapal (HR 1384) and Sen. Bernie Sanders (S. 1129) and endorsed by Presidential candidates Sen. Elizabeth Warren, Sen. Cory Booker, and Andrew Yang adopt the former approach. A Medicare-for-all proposal offered by Sen. Kamala Harris takes the latter approach. Each of these proposals differs in some way from the others. However, for purposes of this brief, we refer to these proposals collectively as Medicare-for-all, though we note where important differences in the proposals may have different implications for Medicaid.

Medicaid is administered by the states, and each state's program is unique, reflecting states' use of existing program flexibility and waiver authority to design their programs. Because of this variation, the specific implications of a shift from Medicaid to a Medicare-for-all program would vary across states. However, in all states, Medicaid plays a key role by providing affordable health coverage for vulnerable populations that includes a wide range of medical, behavioral health, and long-term care benefits. It also is the largest source of federal funds to states. This issue brief explores key ways in which a shift to Medicare-for-all could affect current Medicaid enrollees, future enrollees (such as those who may need long-term care coverage at a later time), and states, which jointly finance the Medicaid program along with the federal government. Table 1 summarizes key similarities and differences regarding eligibility, benefits, affordability, provider payment and delivery systems, and state financing in the main Medicare-for-all proposals and Medicaid.

Medicaid's Role Today

Medicaid covers 75 million low-income adults, children, pregnant women, seniors, and people with disabilities. The Affordable Care Act (ACA) expanded Medicaid eligibility to serve as the basis of its larger set of coverage and affordability reforms. As of August 2019, 37 states including DC have adopted the ACA's Medicaid expansion. In 2017, the Medicaid expansion group included more than 12 million newly eligible low-income adults. However, 2.5 people remain in a coverage gap, with income too high to

qualify for Medicaid but too low to receive Marketplace subsidies in the 14 states that have not yet adopted the expansion. Medicaid also covers 45% of nonelderly adults with disabilities and millions more people with chronic conditions for whom private insurance, designed for a generally healthy population, is inadequate and/or unaffordable.

Medicaid covers a broad array of medical, behavioral health, and long-term care services. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children provides comprehensive coverage including preventive screenings, vision, dental, and hearing services, and any other medically necessary care. Federal standards outline minimum benefits for adults, such as hospital, physician, and nursing facility services. States also can cover a variety of optional benefits, such as prescription drugs and private duty nursing. Medicaid is the principal source of coverage for long-term services and supports (LTSS), including nursing home care as well as home and community-based services that enable seniors and people with disabilities to live independently. While all state Medicaid programs cover a comprehensive set of services, because states have flexibility to provide optional services for adults, there is significant variation across states.

Medicaid provides affordable coverage for its low-income enrollees. Federal standards prohibit states from charging premiums to those with incomes less than 150% of the federal poverty level (FPL), though some states impose premiums for certain adults through a Section 1115 waiver. Federal rules also limit cost-sharing to nominal amounts and entirely exempt certain groups and services from any cost sharing. Aggregate out-of-pocket costs for an individual may not exceed 5% of family income.

Medicaid provides access to a broad range of providers, including many with unique expertise in treating vulnerable and low-income populations. States set provider payment rates within broad federal guidelines, and as a result, there is significant variation across states in how provider rates are determined and in payment levels. Despite lower payment rates in Medicaid and gaps in access to some types of specialists, national data show that access to services for children and adults is comparable to private insurance and exceeds access for the uninsured. Medicaid programs contract with a broad range of providers, including many safety net clinics, hospitals, and other providers that have experience in meeting the needs of Medicaid's vulnerable enrollees. Managed care has become the dominant Medicaid delivery system, though states have substantial flexibility in designing their delivery and payment systems.

Medicaid is financed jointly by the federal government and the states, guaranteeing federal matching payments to states with no pre-set limit. The matching structure of the program provides states with resources that automatically adjust for demographic and economic shifts, rising health care costs, and changing state priorities. This structure also enables the program to respond to public health emergencies and natural and other disasters. Examples of this response include providing a coverage safety net to people affected by the HIV/AIDS epidemic and expanding eligibility and benefits for children and pregnant women exposed to high levels of lead during the Flint water crisis. Recessions, rising costs of prescription drugs, and increasing needs for long-term care and behavioral health services are factors that put upward pressure on Medicaid spending growth. However, over time, Medicaid growth per

enrollee has been lower than private health spending. Medicaid is a significant spending item in state budgets, but also the largest source of federal revenues due to the matching structure.

Implications of Medicare-for-all for Medicaid

Eligibility, Coverage, and Enrollment

Medicare-for-all programs would establish universal national health coverage for all or nearly all U.S. residents, eliminating the need for the specific eligibility pathways in the current Medicaid program. Medicare-for-all programs would establish uniform eligibility criteria across all states that are tied to U.S. residency and not based on income. Notably, Medicare-for-all would eliminate the current variability in eligibility for health coverage across states and fill in coverage gaps in states that have not adopted the ACA's Medicaid expansion. Under Medicaid, states must cover certain populations, such as very low-income parents and children, pregnant women, and poor people with disabilities who receive federal Supplemental Security Income (SSI) benefits. States then choose from a variety of optional coverage pathways and waiver authorities to expand coverage, especially for children with significant disabilities and seniors and adults with disabilities who need long-term care. While all states currently adopt at least one of these optional expansions, Medicaid eligibility criteria differ across states. Medicare-for-all programs would eliminate the need for specialized eligibility determinations based on disability or functional status. How current Medicaid enrollees, particularly those with complex health care needs, would be transitioned to a new coverage plan, is an important policy and implementation issue in the new proposals.

Immigrants' eligibility for coverage under Medicare-for-all is unclear, while their coverage under Medicaid today is subject to limitations. Medicare-for-all proposals grant authority to the Health and Human Services Secretary to define residency when determining eligibility for coverage, so it is not yet known how undocumented immigrants would be treated, though some proposals specifically cover legal immigrants and certain undocumented immigrants. Many Democratic candidates running for President say they support coverage for undocumented immigrants. Most legal immigrants are barred from Medicaid coverage for five years after entering the United States (except in the 35 states that have taken up the option to eliminate the five-year waiting period for Medicaid/CHIP coverage for lawfully-residing immigrant children and/or pregnant women). Undocumented immigrants are not eligible for Medicaid coverage, although state Medicaid programs reimburse providers for emergency care for individuals who are otherwise eligible for Medicaid except for their immigration status.

A process for auto-enrolling individuals into coverage under Medicare-for-all programs would replace existing application and renewal processes in Medicaid. Once established, all of the Medicare-for-all proposals call for automatically enrolling individuals in coverage at birth. Auto-enrollment would result in higher coverage rates compared to the current Medicaid program, since not everyone who is eligible for Medicaid presently is enrolled. Each state administers its own Medicaid eligibility determination system. The ACA included new policies and strategies to streamline the eligibility and enrollment process, such as greater reliance on electronic data sources instead of paper verification, in

an effort to keep eligible people enrolled in coverage. Nevertheless, the need to apply for and periodically renew Medicaid coverage can sometimes result in eligible individuals churning in and out of coverage.

Benefits

Medicare-for-all programs would cover a comprehensive set of health care services for adults that would eliminate the current variability in Medicaid benefit packages across states. For example, the Medicare-for-all proposals include some benefits that are optional in Medicaid for adults and consequently not available in all states, such as dental and vision care. The Medicare-for-all benefit package also would include mental health and substance use treatment services. While all state Medicaid programs cover mental health and substance use disorder services, the scope of coverage for adults can vary. Many states rely on Medicaid to cover specialized behavioral health services, and the Medicare-for-all proposals would include some of these benefits. For example, the Sanders and Jayapal proposals include day treatment and psychosocial rehabilitation for those with chronic mental illness. Also, although prescription drug coverage is not required by the Medicaid statute, all states cover this benefit. Medicaid must cover all drugs with a rebate agreement as medically necessary, but states may apply utilization controls such as prior authorization, a preferred drug formulary, or quantity limits on drug refills or pills per prescription, and those differ across states. While Medicare-for-all proposals would establish uniform coverage for prescription drugs across states, it is unclear if coverage would be as comprehensive. Under both Medicare-for-all and Medicaid, all covered services must be determined medically necessary.

Medicare-for-all would cover certain services important to vulnerable populations that currently are covered by Medicaid but not other payers. In current Medicare-for-all proposals, these include the EPSDT benefit that provides a comprehensive set of services for children as well as non-emergency medical transportation to access medical appointments, with the Sanders and Jayapal proposals limiting this benefit to those with low incomes and/or disabilities.

One of the most fundamental changes under Medicare-for-all would be uniform coverage of community-based long-term care services; Medicaid is the primary payer for these services today, with substantial state variation in eligibility and coverage. Medicare-for-all would cover many of the community-based long-term care services covered by Medicaid today. And, unlike Medicaid, where most community-based long-term care services are optional, these services would be required, and explicitly prioritized over institutional services, under Medicare-for-all. With community-based long-term care services included in the Medicare-for-all benefit package, everyone would be eligible to receive covered services without regard to income or assets, unlike in Medicaid today. The Jayapal proposal includes functional eligibility criteria (e.g. limitation in an activity of daily living) to qualify for LTSS; today, states set Medicaid LTSS functional eligibility criteria. Unlike other Medicaid services, states are allowed to cap enrollment for many community-based long-term care services, which means that some people who meet the eligibility criteria do not receive them. Including these services in Medicare-for-all could mean that individuals currently on state Medicaid waiver waiting lists as well as others who are not financially eligible for Medicaid could have access to these services. However, it could take time to develop adequate system capacity in terms of infrastructure and workforce to accommodate such an expansion in paid

LTSS. Additionally, the cost of providing a universal long-term care benefit package could result in some limitations or restrictions on these benefits as more details are known and Medicare-for-all is implemented.

Medicare-for-all proposals vary as to whether they would include institutional long-term care, such as nursing homes, or instead continue the current Medicaid coverage of these services. Under a scenario where Medicare-for-all includes institutional long-term care, all enrollees would receive these services as part of their basic benefit package as medically necessary, without regard to income or asset limits. The Jayapal proposal includes functional eligibility criteria for institutional long-term care, as it does for HCBS. The Jayapal benefit package includes a range of institutional services, which could also include institutions for mental disease (IMDs) and intermediate care facilities for those with intellectual or developmental disabilities (ICF/DD). Medicaid currently covers ICF/DD services but generally does not cover services in IMDs for individuals ages 21-64. If institutional services are carved out of Medicare-for-all and instead continue to be provided through state Medicaid programs, as under the Sanders bill, then individuals would need to continue to meet current eligibility criteria for these services, which vary across states. Under this approach, states would also be required to continue to pay their state share of costs for these services based on the current federal Medicaid matching rules. Those not eligible for Medicaid would continue to have to pay for institutional long-term care out of their own income and assets or through private long-term-care insurance, or spend-down to be eligible for Medicaid. The Sanders Medicare-for-all program would require states to maintain their existing Medicaid eligibility standards and spending on institutional long-term care services and would continue to provide states with federal matching payments for these services, locking in variation in eligibility standards across states.

Premiums and Cost Sharing

Medicare-for-all would continue the protections that Medicaid provides against high out-of-pocket costs. Medicare-for-all programs would eliminate or reduce premiums and cost sharing. The Sanders and Jayapal proposals would eliminate premiums and deductibles, and the Jayapal proposal would eliminate cost sharing, while the Sanders proposal would include minimal copayments on prescription drugs for those with incomes above 200% FPL. Under these proposals, today's Medicaid enrollees would continue to be protected from high out-of-pocket costs. While most Medicaid enrollees do not pay premiums and have limited out of pocket expenses, any who do would likely see these costs eliminated.

Payment and Delivery Systems

Similar to Medicaid, all licensed and certified providers would be eligible to participate in Medicare-for-all programs; however, given the scope of Medicare-for-all programs, it is likely a broader array of providers will participate, expanding the choice of providers for current Medicaid enrollees. State Medicaid programs are required to contract with federally qualified health centers, and most contract with other essential community providers, and consequently, these providers are an important source of care for Medicaid enrollees. While these contracting requirements are not part of current Medicare-for-all proposals, it is expected that health centers and other essential community providers would participate to the same extent they participate in Medicaid programs today.

Medicare-for-all programs would create a national fee schedule for paying providers, eliminating variation in payment rates across states and payers in Medicaid today. While few details are available, Medicare-for-all programs would establish payment rates for hospitals, physicians, and other providers, subject to a global budget process and negotiation under some proposals. In general, states have flexibility in setting Medicaid provider payment rates, leading for variation in payment rates across states. In general, Medicaid rates paid to physicians and some other providers are lower than Medicare rates, while other providers, such as safety net hospitals, may receive higher payments through Medicaid compared to Medicare due to supplemental payments. It is unclear whether payment rates under Medicare-for-all proposals would be based on Medicare rates or set using a different methodology. In addition, federal rules require special Medicaid payment rates for some providers, such as federally qualified health centers and rural health clinics that have contributed to their participation in the program. These providers are likely to see an increase in revenue from improved coverage under Medicare-for-all programs; however, given longstanding relationships Medicaid enrollees have with safety net providers, how they fare under a new program will matter.

The reliance on fee-for-service payments under current Medicare-for-all proposals may move away from current payment and delivery models adopted by state Medicaid programs. Medicare-for-all programs would pay physicians and other providers on a fee-for-service basis, while institutional providers would be paid through a global budget arrangement under some proposals or through fee-for-service under others. Medicaid initially relied on fee-for-service payments, but in recent years, states have experimented with innovative payment designs in their Medicaid programs that seek to improve quality of care, control costs, and address social determinants of health. In addition, through their contracts with managed care organizations as well as managed fee-for-service models, states have emphasized care management for people with complex health needs. Some proposals would allow for these types of payment and delivery models, including private managed care plans, while others would not. While moving to global budgets and a national fee schedule will likely lower costs, some of the benefits of care management strategies, particularly for people with multiple or complex conditions and other vulnerable patients, may be lost.

State Responsibilities

The state role in health care financing would change substantially under a Medicare-for-all program compared to Medicaid. The state share of spending for Medicaid was $222 billion in 2017. Medicare-for-all proposals vary in how much states could save and how much funding states would be required to contribute relative to current spending. For example, under the Jayapal proposal, states could see significant savings relative to current Medicaid spending because Medicaid would be eliminated, and there would be no state financing requirements. However, under other proposals, states would remain responsible through a maintenance of effort (MOE) requirement for all or part of current state spending on Medicaid. The Sanders Medicare-for-all program would require states to maintain their existing Medicaid eligibility standards and spending on institutional long-term care services and would continue to provide states with federal matching payments for these services, locking in variation in eligibility standards and financing across states. Long-term care accounts for more than one in five dollars of Medicaid spending

and in 2016, community based long-term care services accounted for 57% of all Medicaid spending on long-term care nationally, although this varies by state. The level of state savings under the Sanders proposal will vary based on current state spending on institutional long-term care services. Under the Harris proposal, states would be required to make MOE payments to the new program equal to the amounts they currently spend on Medicaid and CHIP, increased over time by inflation. Since Medicaid costs have typically increased at higher rates than inflation, states could see some savings over time, but significantly less relative to the Jayapal and Sanders proposals. It is not clear in the Harris and Sanders proposals how state spending from provider fees or taxes (a mechanism used by nearly every state to finance the state share of Medicaid) would be factored in the MOE calculation.

In addition to transferring fiscal responsibility, the proposals would shift the role of designing and implementing much of health policy from states to the federal government. Under current programs, states have significant flexibility to design and administer Medicaid and other related health programs. Medicare-for-all programs would create more uniformity in eligibility and benefits and could result in state savings, but the proposals would also limit states' ability to leverage Medicaid funding to implement innovative payment and delivery system reforms. Without a comprehensive Medicaid program – and the substantial financing of health care that comes along with it – state policymakers would have a much more diminished role in the health care system generally. Some role for states may remain. For example, the Sanders proposal calls for a regional administrative structure that would include state directors. While the proposals may open other avenues for innovation, the state role in administering all aspects of Medicaid and running insurance departments would diminish under Medicare-for-all programs as these functions shift to federal responsibility.

Looking Ahead

Many details about how a new Medicare-for-all program replacing all or most current public and private health insurance would be implemented and financed are not yet known. As proposals continue to emerge and develop, it is important to focus on the implications related to Medicaid, the program that currently covers 75 million low-income and vulnerable Americans. As with other parts of the health care system, there will be trade-offs. Medicare-for-all proposals would generally eliminate current variation in eligibility, enrollment and renewal processes, benefits, and payment and delivery systems that are part of the current structure of Medicaid, where states now have considerable flexibility to design programs within broad federal rules. However, the transition to a new program, even one with equally comprehensive benefits and cost sharing protections, could be particularly disruptive for current Medicaid enrollees who tend to be sicker with more complex health conditions, and for whom the ability to maintain relationships with current providers will be important. A smooth transition to any new system also will be critical for current Medicaid enrollees who rely on personal care and other services to meet daily self-care needs and maintain independent community living.

More broadly, Medicare-for-all programs would extend coverage for some Medicaid services to more Americans, most notably community-based long-term services and supports. For states, the role in health care financing would change substantially under a Medicare-for-all program. Some proposals would have

the federal government assume all or a significant share of the nearly $222 billion in state spending on Medicaid, leading to significant state savings. However, other proposals call for a state maintenance of effort around spending broadly or for specific services. The details about how the MOE would be implemented are not clear. In addition, the proposals would shift responsibility for much of health policy from states to the federal government. As the debate continues and additional details emerge, it will be important to continue to evaluate how Medicare-for-all proposals affect coverage, benefits, out of pocket costs and access to care for the low-income and vulnerable populations currently covered by Medicaid.

Appendix

Appendix Table 1: Key Features of Medicare-for-all Proposals Compared to Medicaid					
Feature		**Medicare for All** (Sanders, S. 1129)	**Medicare for All** (Jayapal, H.R. 1384)	**Medicare for All** (Harris)	**Medicaid**
Eligibility and Enrollment		All U.S. residents, to be defined by the HHS Secretary. Individuals to be auto-enrolled at birth.	All U.S. residents, to be defined by the HHS Secretary. Individuals to be auto-enrolled at birth.	All US residents Individuals to be auto-enrolled at birth.	States must cover low-income parents, children, pregnant women, seniors, and people with disabilities. State options to expand coverage to all adults up to 138% FPL and to cover seniors and people with disabilities at higher income levels. Legal immigrants generally ineligible for coverage for 5 years. Undocumented immigrants only eligible for emergency services. Individuals must apply and periodically renew eligibility.
Covered Benefits		Medically necessary services, including hospital services, ambulatory patient services, primary and preventive services, mental health and substance abuse services, laboratory and diagnostic services, comprehensive reproductive services, pediatrics, rehabilitative and habilitative services, emergency services are covered. States are required to continue covering any services covered through a Medicaid state plan amendment that are not included in the Medicare-for-all benefit package, and they may provide additional benefits at state expense	Medically necessary services, including hospital services, ambulatory patient services, primary and preventive services, mental health and substance abuse services, laboratory and diagnostic services, comprehensive reproductive services, pediatrics, rehabilitative and habilitative services, emergency services are covered. States may provide additional benefits at state expense	Covers all medically necessary services, including emergency room visits, doctor visits, mental health and substance use disorder treatment, and comprehensive reproductive health services	All medically necessary services covered for children. Core set of services covered for adults, with additional services covered at state option.
	Vision, dental, hearing	Covered	Covered	Covered	Covered for children; at state option for adults
	EPSDT	Covered	Covered	Covered	Covered

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Feature		**Medicare for All** (Sanders, S. 1129)	**Medicare for All** (Jayapal, H.R. 1384)	**Medicare for All** (Harris)	**Medicaid**
	Non-emergency transportation	Covered for people with low incomes and/or disabilities	Covered	Not addressed	Covered
	Institutional long-term care	Medicaid coverage for these services would continue.	Covered, subject to functional eligibility criteria	Covered	Covered with state option to expand financial eligibility up to 300% SSI and impose asset limit, subject to functional eligibility criteria.
	Community-based long-term care	Covered	Covered, subject to functional eligibility criteria	Covered	Covered primarily at state option for adults, with state option to expand financial eligibility up to 300% SSI and impose asset limit, subject to functional eligibility criteria.
	Prescription drugs	Secretary to establish a formulary that discourages use of ineffective, dangerous or excessively costly drugs when better alternatives are available and promotes use of generic drugs. Off-formulary drugs are covered subject to rules established by Secretary.	Covered	Covered	All drugs with rebate agreement covered as medically necessary. State option to apply utilization controls such as prior authorization, preferred drug formulary
Premiums and Cost Sharing		None. Limited authority for Secretary to require cost sharing for prescription drugs for those with income above 200% FPL.	None	No deductibles, and no co-payments for high quality care	State option to charge premiums to those above 150% FPL. Nominal cost-sharing, with certain services and populations exempt from all cost sharing. Cost sharing cannot exceed 5% household income.
Covered Providers		All state-licensed and certified providers who meet applicable provider standards and file a participation agreement.	All state-licensed and certified providers who meet applicable provider standards and file a participation agreement.	All Medicare providers, and possibly others eligible to participate	States establish provider licensing or other criteria. States must contract with federally qualified health centers.
Provider Payment		Secretary to establish a fee schedule in a manner consistent with the processes for determining Medicare payments and a new process for updating fees.	Payments established through global budget process and negotiations Hospitals/facilities paid quarterly lump	Doctors, nurses, and other providers will be paid appropriate rates	States set provider payment rates and methodology subject to general federal standards.

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		sum to cover operating expenses under a global budget; amount of payments determined by annual negotiation Physicians/clinicians in general paid fee-for-service based on a fee schedule determined by the Secretary, taking into account current Medicare fee schedule, expertise of providers, information from national data/tracking program and subject to annual review		
Delivery System	Fee-for-service; global budget for institutional providers; would allow current payment and delivery system reforms to continue	Fee-for-service; global budget for institutional providers	Private insurers permitted to offer managed care plans, but must meet strict consumer protections. Will accelerate delivery system reforms and value-based care that rewards meaningful outcomes	Fee-for-service, managed fee-for-service, or managed care at state option.
State Role in Financing	State maintenance of effort (MOE) on spending on institutional long-term care as well as any Medicaid benefit provided through a state plan amendment that is not covered in the Medicare-for-all benefit package.	No state financing requirement	State financing MOE required, equal to current payment amounts indexed for inflation.	Jointly financed by state and federal dollars.