

Medicaid Primer

American College of Radiology

2024

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Disclaimer

- To develop the Medicaid Primer ACR staff conducted an environmental scan of State and National Medicaid activities between 2018-2024. Content will require updates annually to reflect changes in Medicaid activities. Reference material can be accessed using the notes tab.

Content should be used for informational purposes only

ACR Medicaid Primer 2024

- Medicaid Overview
- History of Medicaid
- Medicaid Expansion and the Affordable Care Act
- Medicaid Waivers
- Medicaid Managed Care
- COVID-19 and Medicaid
- Medicaid National Landscape
- Importance of Medicaid in Radiology
- ACR Engagement with Medicaid
- Medicaid Network priorities, goals, and activities
- Medicaid Resources

Medicaid Overview

- Medicaid and the Children’s Health Insurance Program (CHIP) provide health coverage to millions of Americans
 - Including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities
- Medicaid and CHIP are funded jointly by states and the federal government
 - The programs are administered by states according to federal requirements.
- Medicaid is an “*entitlement*” program, which means that anyone who meets eligibility rules has a *right* to enroll in Medicaid coverage
 - Medicaid and CHIP provide comprehensive benefits to people who are determined eligible by states.

For information on benefits offered in your state, where to access services and how to apply for coverage in your state, see Medicaid.gov.

<https://www.medicaid.gov/about-us/contact-us/contact-state-page.html>

1

Medicaid facilitates **access** to care



2

Medicaid is not static, and has **evolved**



3

Medicaid is **financed** by states & federal government



4

Medicaid is health **insurance** for people with low income



5

Most Medicaid is administered through private **managed** plans



The 10 Essentials of Medicaid

6

Medicaid is a federal and state **partnership**



7

Public **perception** of Medicaid is positive



8

Medicaid serves diverse **populations**



9

Medicaid covers a broad **range** of health & long-term services



10

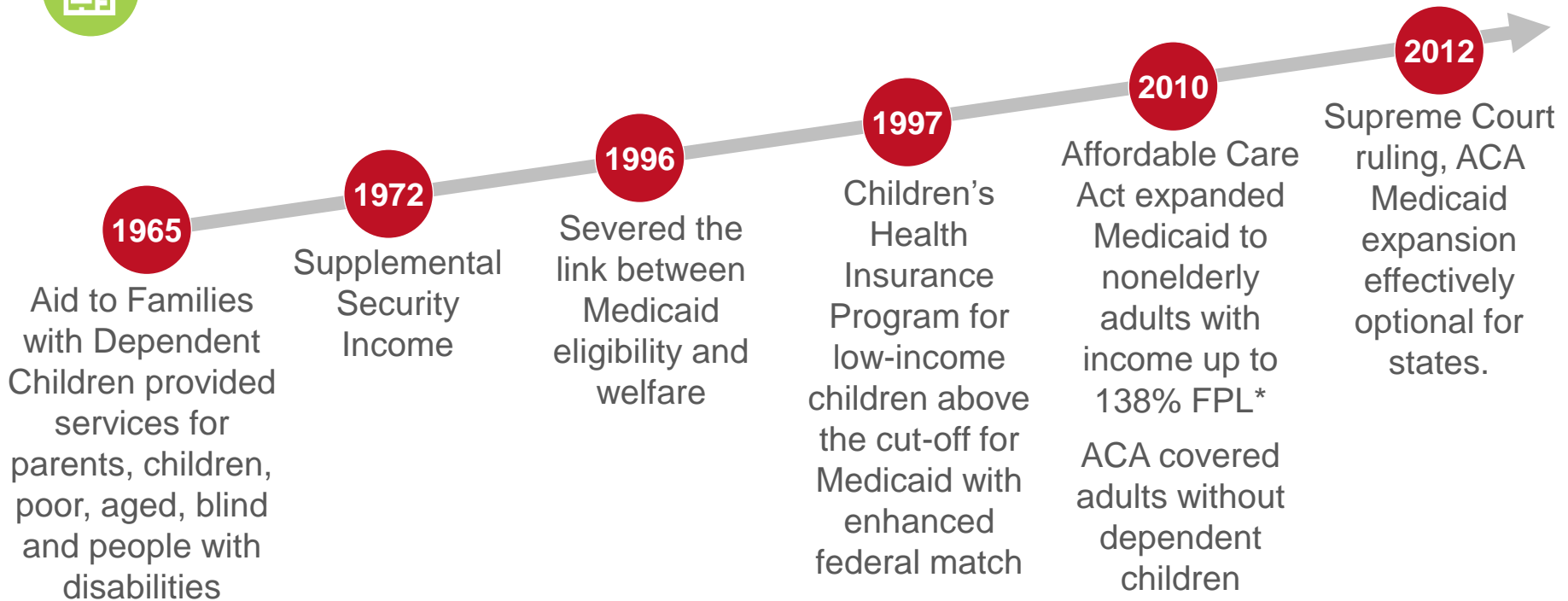
Spending is largely on the elderly and disabled



History of Medicaid

- Medicaid was authorized in 1965 by Title XIX of the Social Security Act.
 - States had the *option* to participate in Medicaid
 - Arizona was the last state to enact Medicaid in 1982
- Patient Protection and Affordable Care Act (ACA) allowed for states to “expand” Medicaid to new eligibility groups:
 - Adults under age 65 without dependent children and parents who are not eligible under Section 1931, and who are not pregnant, and not eligible for Medicare with incomes up to 138 percent FPL.
 - Although this group appears as a mandatory population in the statute, the Supreme Court ruling in NFIB v. Sebelius effectively made coverage of this group optional for states.

Medicaid is not static but has evolved

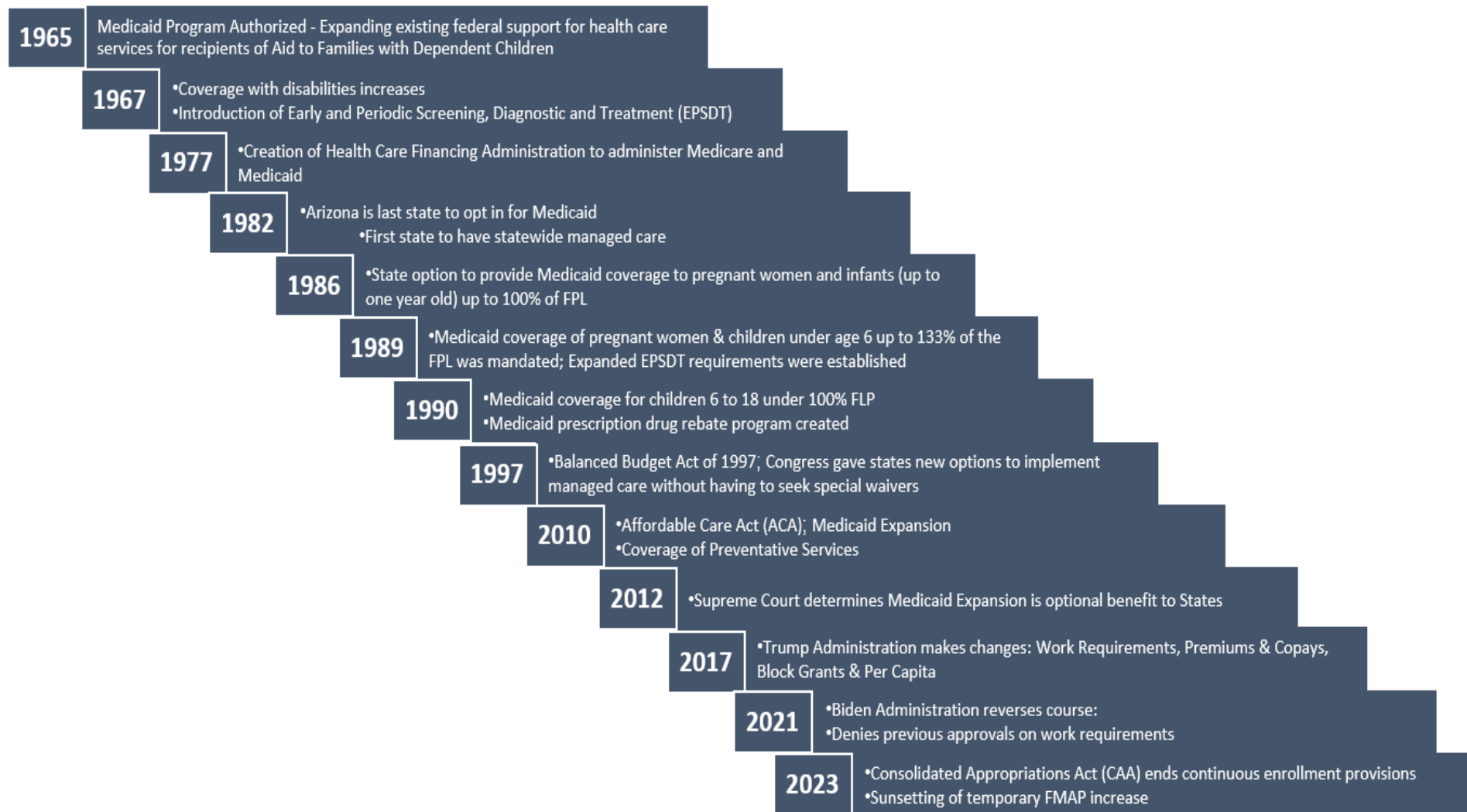


KEY POINT

Historic reductions in uncovered children and adults

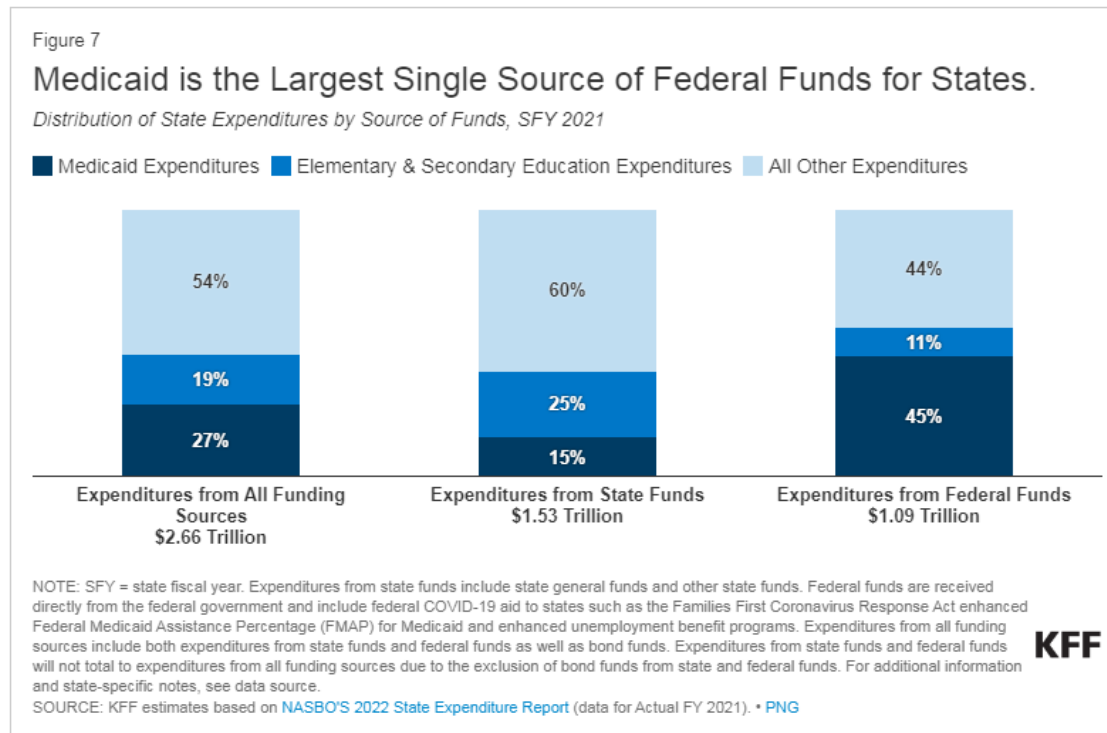
*\$20,120 for an individual in 2023

Federal Legislative Milestones in Medicaid and CHIP



A State and Federal Partnership

- Medicaid standards are set federally and administered by states
 - States have flexibility in coverage, services, and payments while following standards set by the federal government
- The cost of the Medicaid program is split between the federal government and states



Coverage and Reach of Medicaid

- Total coverage population of 88,414,773 individuals¹
 - Coverage either through fee-for-service and Medicaid Managed Care Organization (MCOs)
 - 74% (over 66 million) of beneficiaries receive coverage through an MCO²

¹Within 50 states and the District of Columbia – [As of September 2023](#)

²[As of December 2021](#)

Medicaid Covers 1 in 5 Americans

Traditional Medicaid covers:

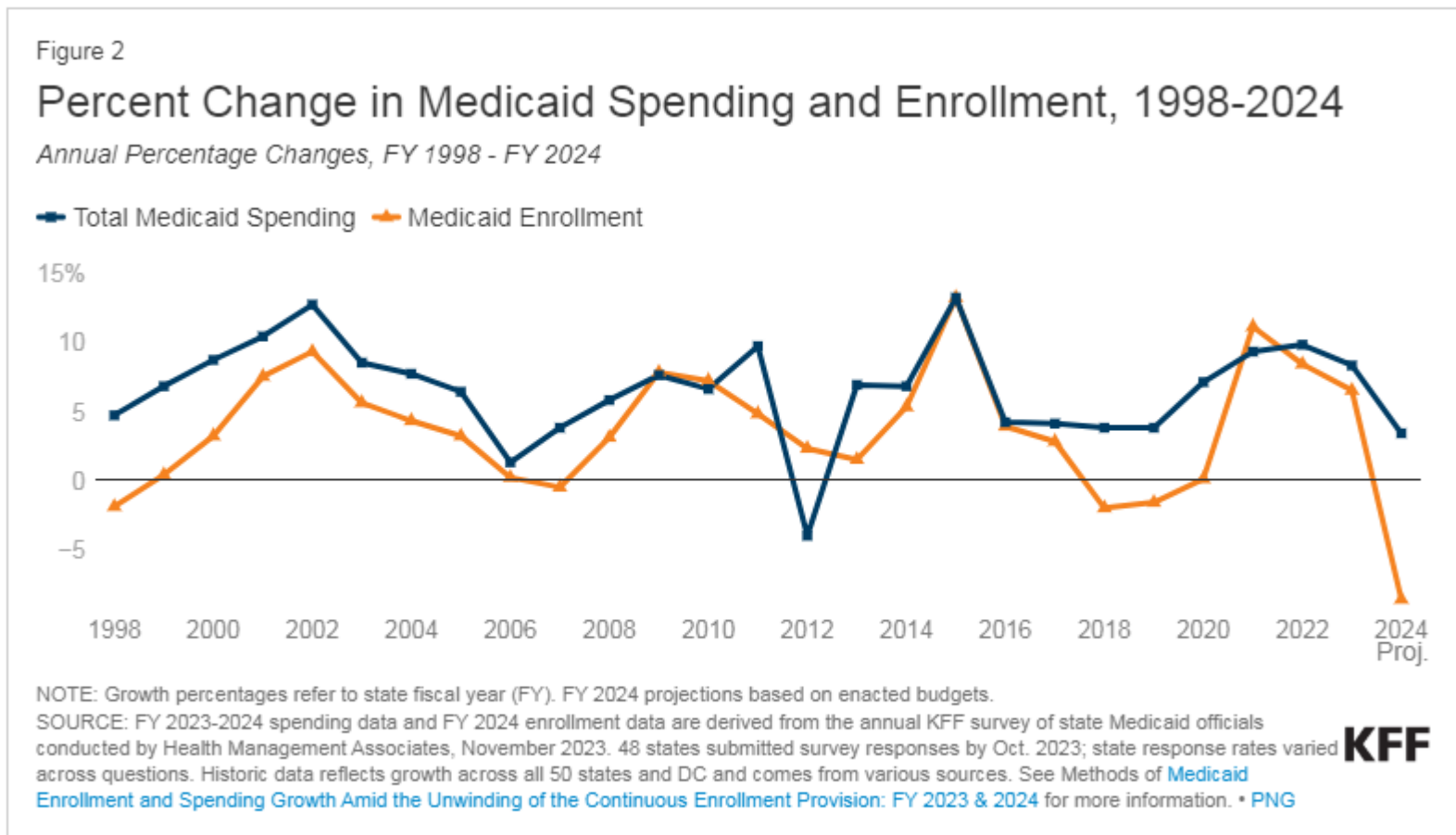
- Children through age 18 in families with income below 138 percent of the federal poverty line (\$20,120 for an individual in 2023)
- People who are pregnant and have income below 138 percent of the poverty line
- Certain parents or caretakers with very low income
- Most seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program
- In the states that have not implemented Medicaid expansion, adults over 21 are generally ineligible for Medicaid no matter how low their incomes are unless they are pregnant, caring for children, elderly, or have a disability

Access to Care

- Medicaid beneficiaries have better access to care than the uninsured and are less likely to postpone or go without needed care due to cost
- Rates of access to care and satisfaction with care among Medicaid enrollees are comparable to rates for people with private insurance
- Medicaid coverage of low-income pregnant women and children has contributed to dramatic declines in infant and child mortality
- ***Low Medicaid reimbursement rates have been associated with lower physician participation in Medicaid, especially among specialists***

Spending in Medicaid

- Medicaid is a counter-cyclical program: its enrollment expands to meet rising needs during an economic downturn



Federal Medical Assistance Percentage (FMAP)

- The federal share for most Medicaid service costs is determined by the **federal medical assistance percentage (FMAP)**, which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa).
- The formula is intended to reflect states' differing abilities to fund Medicaid from their own revenues.
- FMAPs have a statutory minimum of 50 percent and maximum of 83 percent.
 - Certain exceptions apply, however, for the territories and the District of Columbia (whose FMAPs are set in statute); special situations such as temporary state fiscal relief; and certain populations, providers, and services.
- The federal matching structure provides states with resources for coverage of their low-income residents and permits state Medicaid programs to respond to demographic and economic shifts, changing coverage needs, technological innovations, public health emergencies, and other events beyond states' control.
 - The guaranteed availability of federal Medicaid matching funds eases budgetary pressures on states during recessionary periods when enrollment rises.
- An increased FMAP was available to certain states that **expanded eligibility prior to the ACA**.
- **State-level information on FMAPs**

Benefits in Non-Medicaid Expansion

“Traditional” Medicaid

- Traditional Medicaid benefits include primary, acute care, and LTSS.
- States define the specific features of each covered benefit within four broad federal guidelines:
 - Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.
 - Within a state, services available to the various population groups must be equal in amount, duration, and scope. This requirement is the comparability rule.
 - The amount, duration, and scope of benefits must be the same statewide
 - With certain exceptions, enrollees must have freedom of choice among health care providers.

States are required to cover a wide array of mandatory services:

- inpatient hospital care
- lab and x-ray services
- physician care
- nursing facility services (for individuals aged 21 and older)

States may provide optional services, some of which commonly are covered:

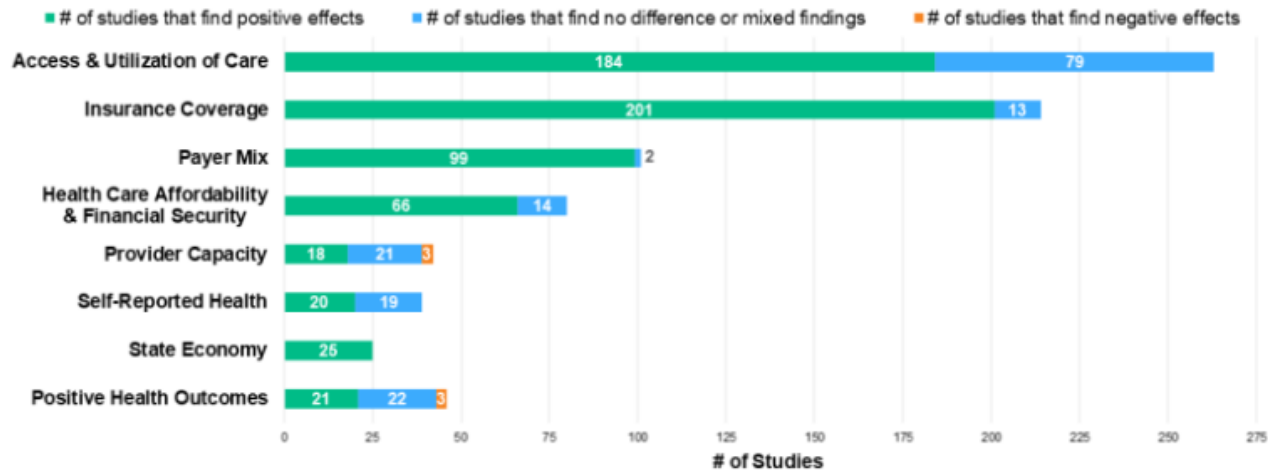
- personal care services
- prescription drugs
- clinic services
- physical therapy
- prosthetic devices

Medicaid and the Affordable Care Act

- Building on the Evidence Base: Studies on the Effects of Medicaid Expansion under the ACA (February 2020 to March 2021).
- Key Findings: Research was more focused on outcomes for specific populations, as well as specific outcomes such as mortality and social determinants of health.
- These studies build on existing research indicating that expansion is linked to gains in coverage; improvements in access, financial security, some measures of health status/outcomes; and economic benefits for states and providers.

Appendix Figure 1

Studies generally find positive effects of the ACA Medicaid expansion on different outcomes.



NOTES: Studies may have findings on multiple outcomes and be counted in multiple bars. "Insurance Coverage" includes coverage rates generally and for Medicaid.

SOURCE: KFF analysis of 601 studies of the impact of state Medicaid expansion published between January 2014 and March 2021.

Medicaid Expansion

- If all 10 remaining states expanded Medicaid, Medicaid enrollment would increase **by 5 million people**.
- States that have not implemented the expansion have uninsured rates that are nearly double the rate of expansion states (15.4% compared to 8.1%).
- Nationally, over six in ten (61%) people in the coverage gap are people of color, a share that is higher than for non-elderly adults generally in non-expansion states (47%) and for non-elderly adults nationwide (40%).
 - These differences in part explain persisting disparities in health insurance coverage by race/ethnicity.
 - The ongoing racial and ethnic disparities in coverage could further widen amid the unwinding of the Medicaid continuous enrollment provision.

Recent State Expansions

- **South Dakota:** Medicaid coverage under expansion began July 1, 2023.
- **North Carolina:** in March 2023, legislation adopting the Medicaid expansion was signed into law, although expansion was contingent on passage of a state budget. In September 2023, the state budget was passed.
 - Medicaid coverage under expansion began December 1, 2023.

Medicaid Waivers

Home- and community-based services (HCBS) 1915 waivers

1915 (c) HCBS waivers

- Through the 1915(c) waiver program, a state can help people who need LTSS and are Medicaid-eligible by designing its HCBS services based on their needs
- These waivers cannot be limited to a certain ethnic or racial group but can be limited in other ways:
 - May be statewide or geographically limited in coverage
 - May be limited to a certain medical diagnosis (e.g., mental health, developmental disability)

1915 (i) HCBS waivers

- Allows the state to provide certain HCBS to people who have incomes lower than 150% of the Federal Poverty Level and do not need to live in a facility to receive care.

1915(j) self-directed personal assistance services

- This program provides individuals with active roles in the services they receive. Participants can:
 - Direct types of care that they receive that they understand but cannot do (e.g., a person with a physical disability may wish to direct his or her own exercise program)
 - Choose who will be involved in providing their care
 - Include their own preferences, choices, and abilities in the service plan

1915 (k) Community First Choice

- This option expands Medicaid opportunities for the provision of home and community-based LTSS, facilitates community integration, and provides an enhanced federal match of six additional percentage points.

Medicaid Waivers: Section 1115 Waivers

Section 1115 of the Social Security Act gives

- the Secretary of HHS has the authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program
- The purpose of these demonstrations is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.
- Demonstrations must also be "budget neutral" to the Federal government

The Secretary Can Waive Requirements;

- There are certain provisions that cannot be waived:
 - State-wideness
 - Medical assistance cannot be less in amount, duration or scope
- Generally, section 1115 demonstrations are approved for an initial five-year period
- Frequently approved for an additional 3 to 5 years

Figure 1

Landscape of Approved and Pending Section 1115 Waivers

as of January 12, 2024

■ 64 Approved Across 47 States ■ 36 Pending Across 32 States

Eligibility



Benefits



SDOH & Other DSR



NOTE: For definitions and additional notes, see the [Waiver Tracker Definitions Tab](#).
SOURCE: [KFF Medicaid Waiver Tracker](#) • [Get the data](#) • [PNG](#)

Section 1115 waivers offer states an avenue to **test** new approaches in Medicaid. These waivers provide states considerable flexibility in how they operate their programs.

Section 1115 waivers generally reflect priorities identified by the states, CMS, and the **Administration**

Work Requirements Waiver

- CMS, under the Biden Administration, sent letters to all states with approved work requirements to begin the process of **withdrawing** waiver authorities in February 2021.
- Following the Biden Administration's withdrawals, in April 2022 the Supreme Court dismissed pending appeals in cases that had found work requirement approvals unlawful.
- The Supreme Court's dismissal does not preclude future presidential administrations from approving new Section 1115 work requirements.
- CMS determined that work requirements do not promote Medicaid program objectives. Though prior action from the Supreme Court does not preclude future presidential administrations from approving new Section 1115 work requirements, these would likely face legal challenges.
 - A 2023 HHS analysis showed that 21 million Americans' health coverage could be jeopardized if work requirements were implemented.

Medicaid State Plan Amendments

A Medicaid and CHIP state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It assures that a state will abide by Federal rules and may claim Federal matching funds for its program activities.

- The state plan determines individuals to be covered, services to be provided, methodologies for providers to be reimbursed, etc.
- States send state plan amendments (SPAs) to CMS for review and approval when planning to make a change to its program policies or operational approach.
- SPAs are also used to request permissible program changes, make corrections, or update the Medicaid or CHIP state plan with new information.

Medicaid State Plan Amendments

A Medicaid and CHIP state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.

When a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to the Centers for Medicare & Medicaid Services (CMS) for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.

Persons with disabilities having problems accessing the SPA PDF files may call 410-786-0429 for assistance.

Search Medicaid State Plan Amendments

Showing 1 to 10 of 13481 results

SHARE RESULTS

Transmittal Number: TX-23-0043

State: Texas

Summary: The proposed amendment updates the physicians' and other practitioners' fee schedules.

Approval Date: 01/18/2024 Effective Date: 10/01/2023

Topics:

- Reimbursement

Links:

- [Approval Document](#)

SHARE THIS MEDICAID STATE PLAN AMENDMENT

Refine Your Search

Sort by Date

Date: Newest First

Filter by Approval Date

06/01/2001

01/19/2024

Filter by Effective Date

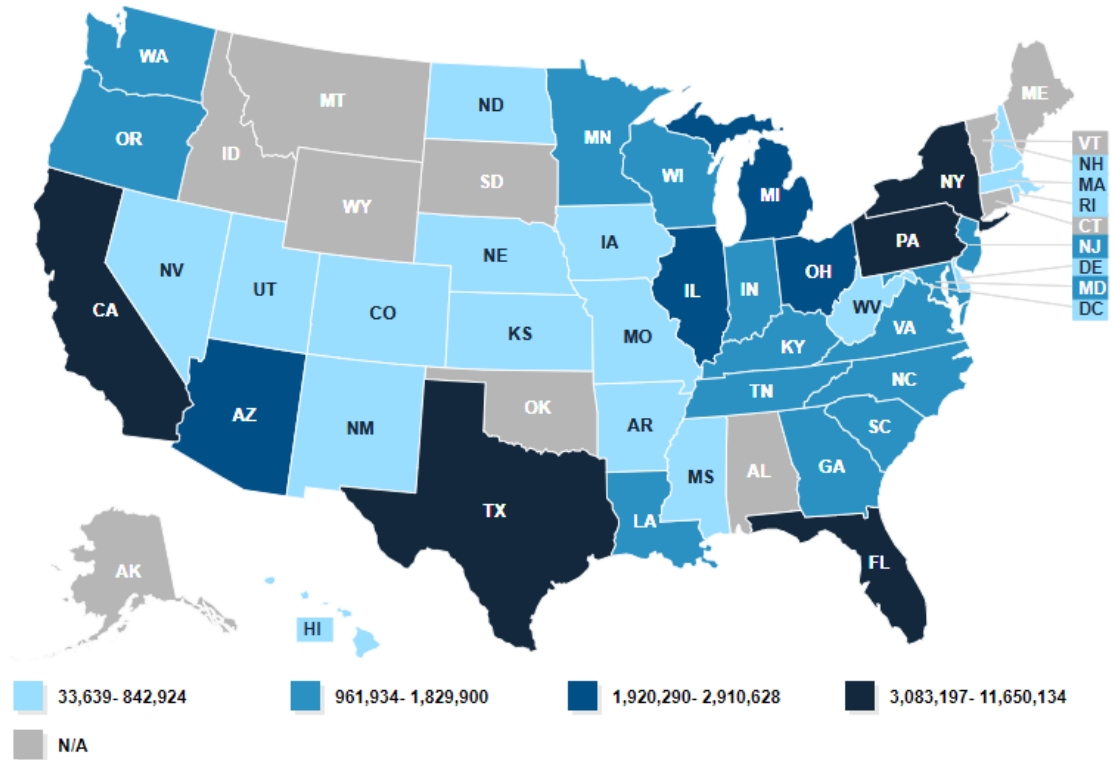
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<https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html>

Medicaid Managed Care

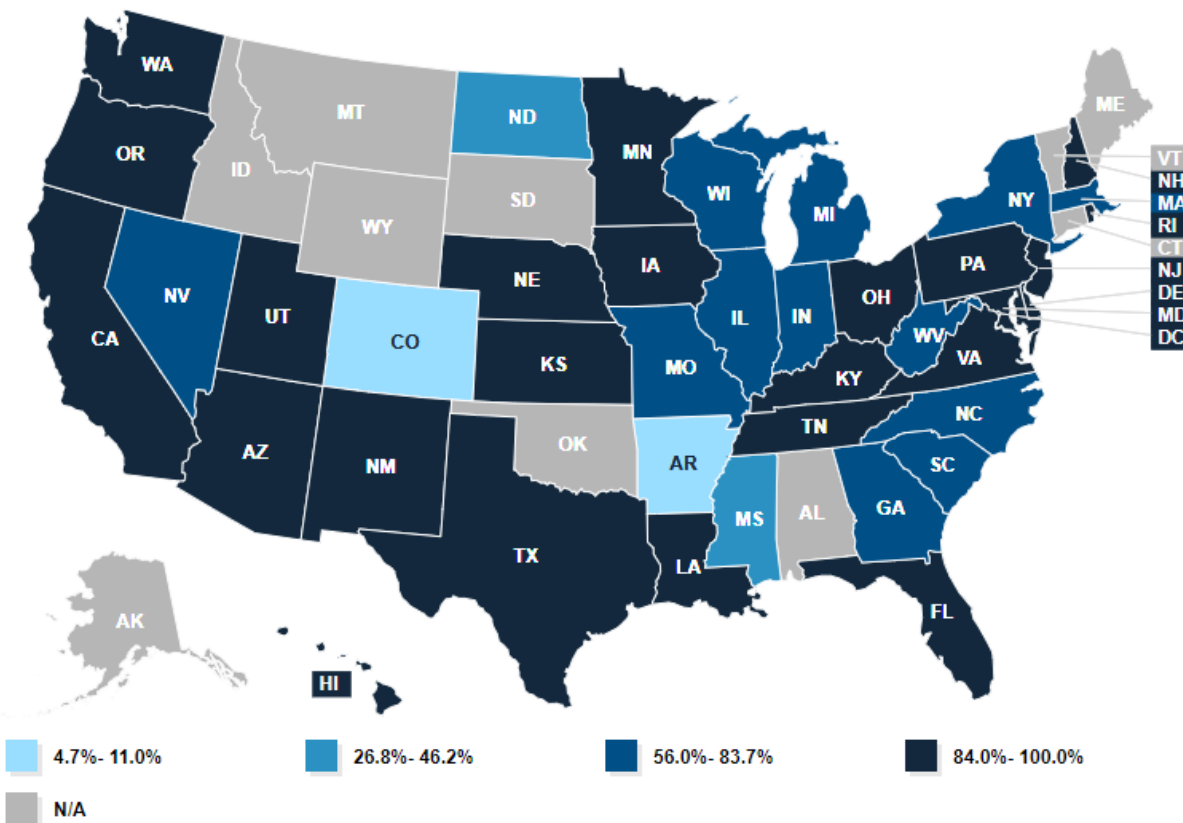
- States pay Medicaid managed care organizations (MCOs) a set per member per month payment for the Medicaid services specified in their contracts.
- Medicaid Managed Care Organization (MCO) covers 66 million beneficiaries, with 74% of Medicaid beneficiaries enrolled in comprehensive MCOs nationally.
- Today, capitated managed care is the dominant way in which states deliver services to Medicaid enrollees.

Number of MCO enrollees per state



Medicaid Managed Care

Percentage of Medicaid Population in an MCO



As of July 1, 2022 (most recent data available)

- Payments to comprehensive MCOs account for more than half of total national Medicaid spending (50.9% in FY2022).
- Thirty-five MCO states covered more than 75% of Medicaid beneficiaries in MCOs.
- In recent years, many states have moved to carve in behavioral health services, pharmacy benefits, and long-term services and supports to MCO contracts.

Medicaid Managed Care – AHEAD Model

- In September 2023, CMS announced a new model under the CMMI: **the Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.**
- The AHEAD model is an 11-year program (2024-2034) offering states the opportunity to leverage federal funding to make broad changes in the way healthcare is provided and paid for.
- State demonstration programs will involve multiple programs and strategies, but the key feature of the model is prospective lump sum payments to participating hospitals that cover the costs of providing all inpatient and outpatient care to a pre-defined patient population.
 - The lump sum payments would cover Medicaid enrollees, certain Medicare beneficiaries, and people who are covered by one or more private payers.
 - Up to eight participating states would also be eligible for a planning grant of up to \$12 million each to design and implement the model. This issue brief answers some key questions about the new model and explores considerations for potential state and private participants.

Medicaid and CHIP in the Territories

- Medicaid and the State Children’s Health Insurance Program (CHIP) **operate in the five U.S. territories**—American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.
- These fact sheets summarize Medicaid and CHIP’s federal requirements and design features in the territories, including eligibility and enrollment, benefits, financing and spending, data and reporting, and quality and program integrity.
- See MACPAC’s territory-specific fact sheets.
 - [Medicaid and CHIP in American Samoa](#)
 - [Medicaid and CHIP in the Commonwealth of the Northern Mariana Islands](#)
 - [Medicaid and CHIP in Guam](#)
 - [Medicaid and CHIP in Puerto Rico](#)
 - [Medicaid and CHIP in the U.S. Virgin Islands](#)

COVID-19 and Medicaid

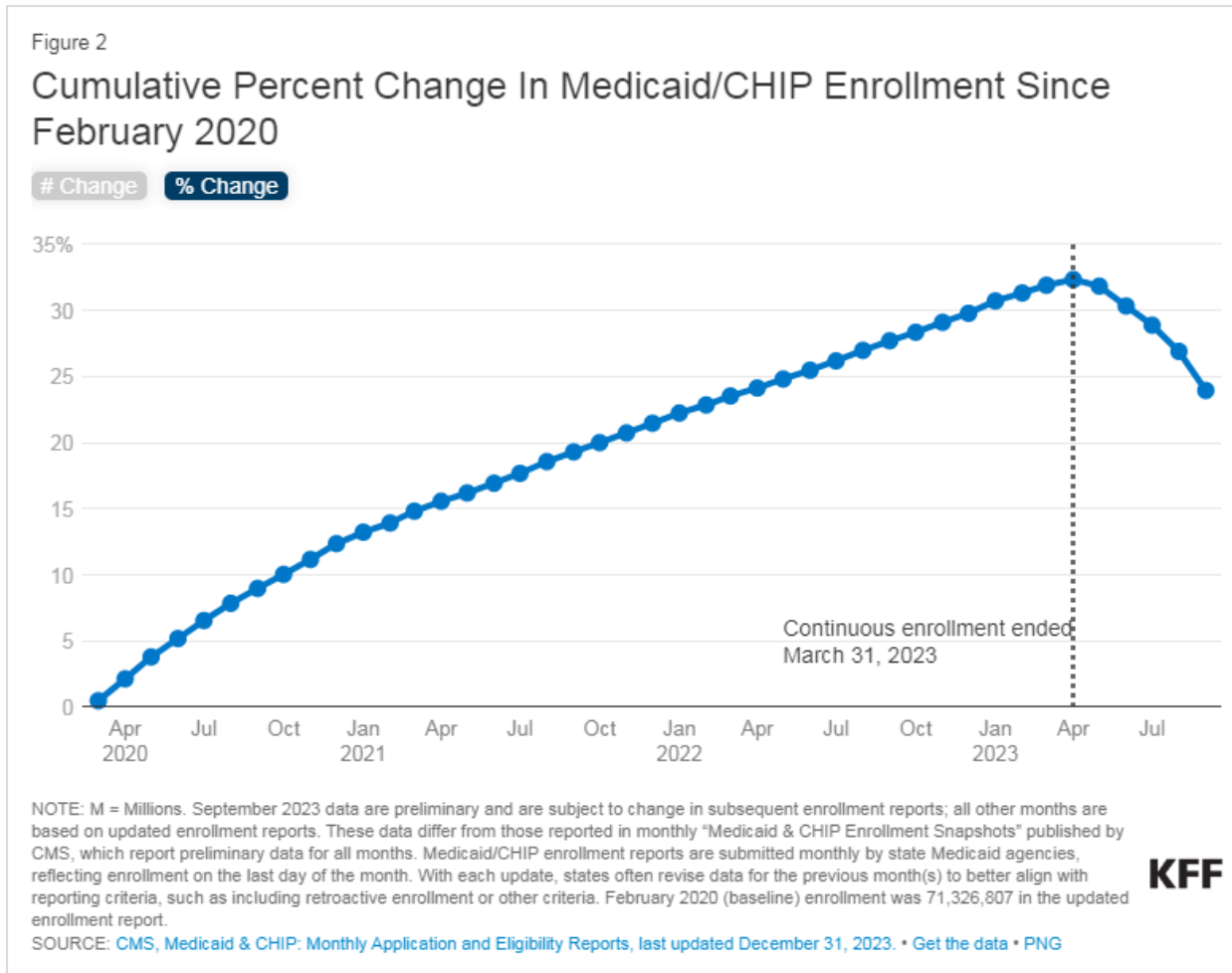
- The Medicaid program is the bedrock of the nation's health care system during times of difficulty. Medicaid is a countercyclical program, and during economic downturns more people turn to Medicaid for coverage.
- In March 2020, Congress created a provider relief fund intended to help cover expenses and lost revenue attributable to COVID-19 through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136). Congress later increased the size of the provider relief fund allocation to \$186.5 billion.
- CMS developed a [Medicaid & CHIP telehealth toolkit](#) to help states accelerate adoption of broader telehealth coverage policies in Medicaid and Children's Health Insurance Program (CHIP) during the 2019 Novel Coronavirus (COVID-19) public health emergency (PHE), and to provide additional support to state Medicaid and CHIP agencies in their adoption and implementation of telehealth as they begin to plan beyond PHE flexibilities.

Looking Ahead Post Pandemic

- The federal Public Health Emergency (PHE) for COVID-19 expired at the end of the day on **May 11, 2023**.
- The expiration of the continuous enrollment condition authorized by the Families First Coronavirus Response Act (FFCRA) presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act.
 - As a condition of receiving a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase under the FFCRA, states were required to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 Public Health Emergency.
- The Consolidated Appropriations Act, 2023, delinked the end of the FFCRA's Medicaid continuous enrollment condition from the end of the COVID-19 Public Health Emergency. As a result, the Medicaid continuous enrollment condition ended on March 31, 2023. **Beginning April 1, 2023**, states were able to terminate Medicaid enrollment for individuals no longer eligible. States will have up to 12 months to return to normal eligibility and enrollment operations.
- Enhanced FMAP funding was incrementally sunsetted throughout 2023 and expired on January 1, 2024.

Medicaid Beneficiaries Have Lost Coverage

- Total Medicaid/CHIP enrollment peaked to **94.5 million** in April 2023, an increase of 23.1 million or more than 32.4% from February 2020.



Medicaid Beneficiaries Have Lost Coverage

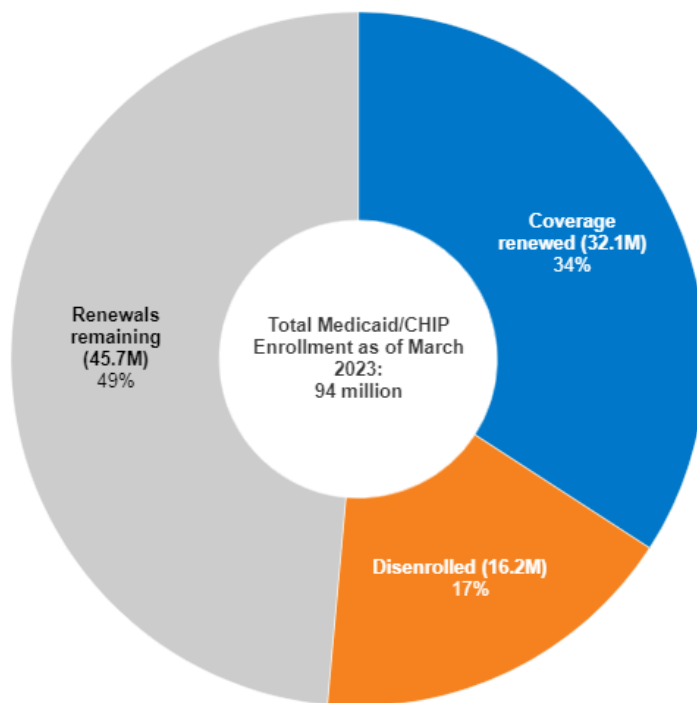
- At least 15,015,000 Medicaid enrollees have been disenrolled as of January 16, 2024, based on the most current state data.
- Across all states with available data, 71% of all people disenrolled had their coverage terminated for procedural reasons.
 - Procedural disenrollments are cases where people are disenrolled because they did not complete the renewal process and can occur when the state has outdated contact information or because the enrollee does not understand or otherwise does not complete renewal packets within a specific timeframe.
- Although the current data is limited, children accounted for roughly **four in ten (38%)** Medicaid disenrollments in the 23 states reporting age breakouts. The share of children disenrolled ranged from 65% in Texas to 19% in Massachusetts.

Medicaid Eligibility Redeterminations

- Ten months into the unwinding of the Medicaid continuous enrollment provision, states are continuing to reverify the eligibility of the roughly 94 million enrollees in the program.

To Date, States Have Reported Renewal Outcomes for Roughly Half of the People Who Were Enrolled in Medicaid/CHIP Prior to the Start of Unwinding.

Cumulative Medicaid Renewal Outcomes as a Share of March 2023 Medicaid/CHIP Enrollment:



- There is significant variation in the share of completed renewals across states, ranging from 87% in Oregon to 22% in Wyoming.
- Since the start of unwinding, Medicaid enrollment has declined in every state, ranging from 32% in Idaho to 1% in Maine.
- Disenrollment rates could moderate in the second half of the unwinding as states continue efforts to reduce procedural disenrollments and because some states have worked through “likely ineligible” populations.

NOTE: Based on the most recent state-reported unwinding data available from state websites and CMS reports. Time periods differ by state. Baseline enrollment based on March 2023 Medicaid/CHIP Performance Indicator Data from CMS and excludes enrollees with partial benefits, though states may include partial benefit enrollees in their unwinding data. Some states' baseline month for enrollment was in February or April, rather than March 2023. "Renewal remaining" includes enrollees with pending renewals or with renewals that are not yet due. The data source for one state (MA) does not include the number of people renewed or whose renewal was pending at time of reporting.

SOURCE: KFF Medicaid Enrollment and Unwinding Tracker. Data as of January 30, 2024. CMS Performance Indicator Data (March 2023 Medicaid/CHIP Enrollment). • [Get the data](#) • [PNG](#)

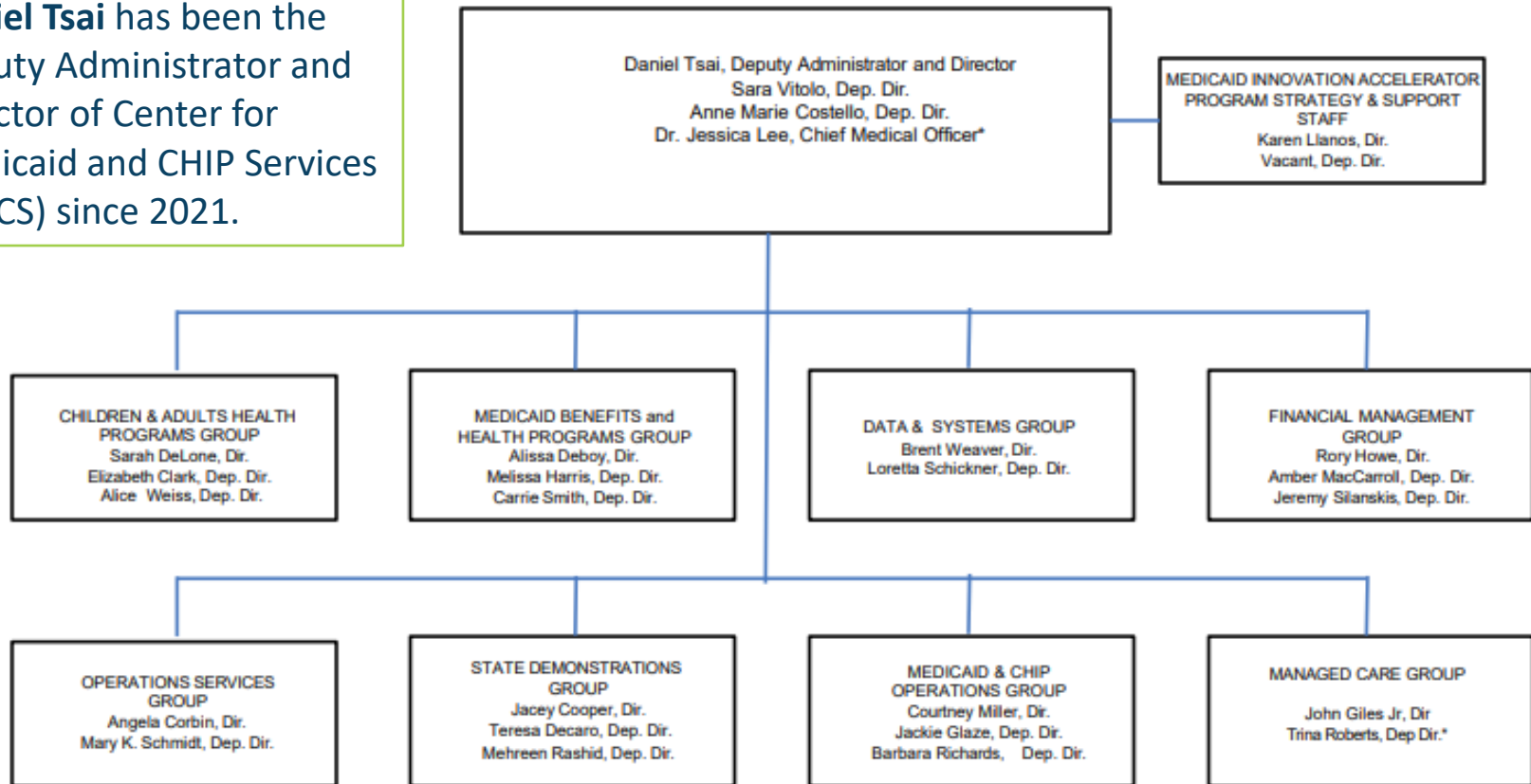
Medicaid National Landscape

- **The Medicaid and CHIP Payment and Access Commission (MACPAC)** is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The MACPAC releases its Reports to Congress twice annually, by March 15 and June 15 respectively.
- **The Medicaid Health Plans of America (MHPA)** represents the interests of the Medicaid managed care industry through advocacy and research to support innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA works on behalf of its 130+ member health plans, known as managed care organizations (MCOs), that serve approximately 43 million Medicaid enrollees in 40 states and the District of Columbia. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market.
- **The Center for Medicaid and CHIP Services (CMCS)** is organized into seven groups that are responsible for the various components of policy development and operations for Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). CMCS also has an Innovation Accelerator Program (IAP) team dedicated to supporting innovation and enhancing partnerships with states.

Medicaid Organizational Chart

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICAID AND CHIP SERVICES

Daniel Tsai has been the Deputy Administrator and Director of Center for Medicaid and CHIP Services (CMCS) since 2021.



Medicaid Regulations

- Medicaid Fiscal Accountability Rule ([MFAR](#))
- Medicaid Managed Care Rule ([Published in 2020](#))
- Coronavirus Aid, Relief, and Economic Security Act ([CARES Act](#), P.L. 116-136)
- [CMS-9912-IFC](#) Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency
- Reducing Provider and Patient Burden by Improving Prior Authorization Processes ([CMS-9123-P](#))
- Consolidated Appropriations Act ([CAA](#)), 2023
- CMS Interoperability and Prior Authorization Final Rule ([CMS-0057-F](#))

Importance of Medicaid in Radiology

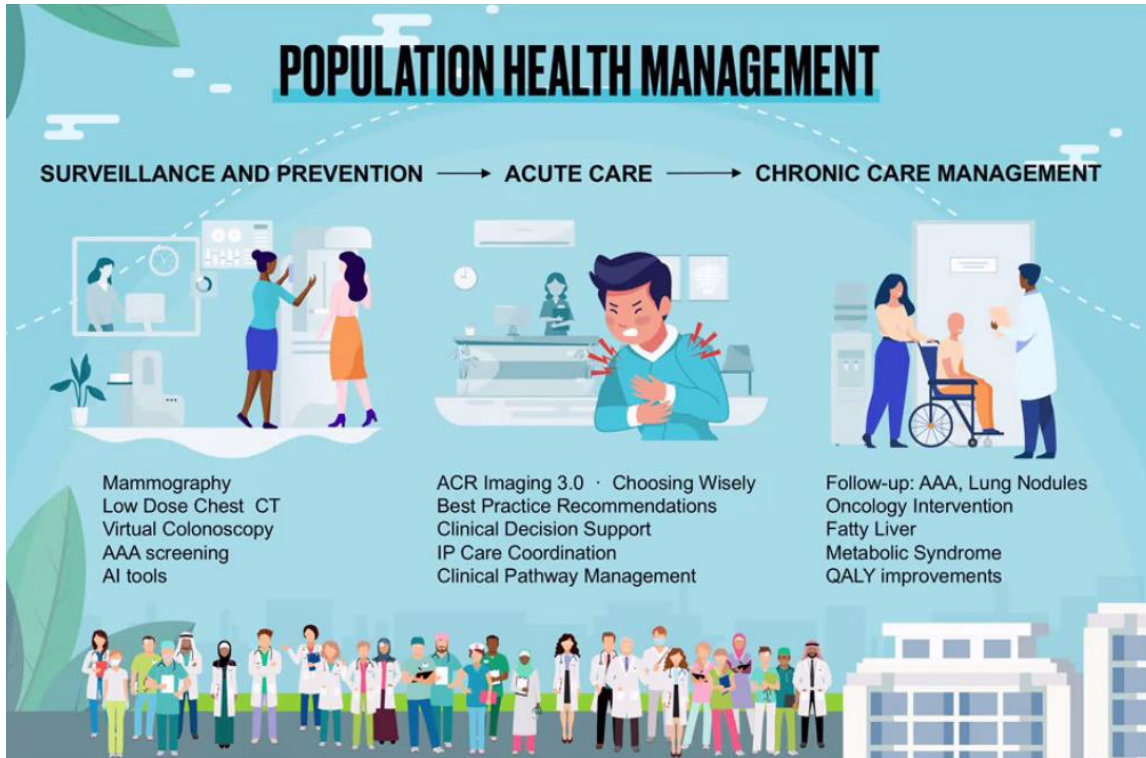
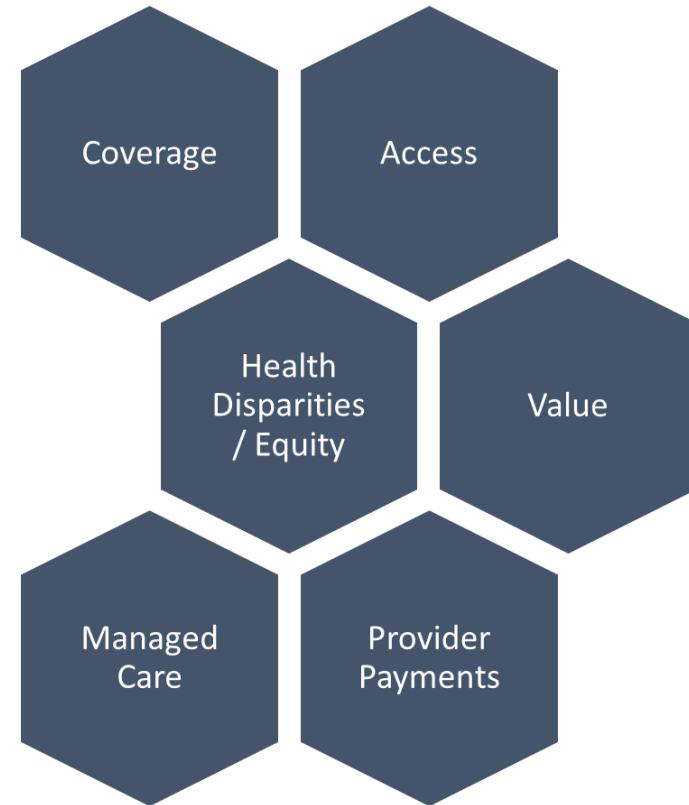


Photo credit: ACR graphic developed by Dr. Syed Zaidi, ACR Population Health Management Committee, Commission on Patient- and Family-Centered Care



USPSTF and Screening Recommendations

- Created in 1984, the U.S. Preventive Services Task Force an independent, volunteer panel of national experts in prevention and evidence-based medicine.
- The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.
 - All recommendations are published on the Task Force's Web site and/or in a peer-reviewed journal.
- The Task Force assigns each recommendation a letter grade (an A, B, C, or D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service.
- The Task Force does not consider the costs of a preventive service when determining a recommendation grade. The recommendations apply only to people who have no signs or symptoms of the specific disease or condition under evaluation, and the recommendations address only services offered in the primary care setting or services referred by a primary care clinician.

Current USPSTF Radiology Recommendations

- Breast Cancer Screening – **Draft Recommendation**

Population	Recommendation	Grade
Women ages 40 to 74 years	The USPSTF recommends biennial screening mammography for women ages 40 to 74 years.	B
Women age 75 years or older	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women age 75 years or older.	I
Women with dense breasts	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram. See the "Practice Considerations" section for more information on the patient population to whom this recommendation applies and on screening mammography modalities.	I

The Recommendation Development Process

The Task Force follows a multistep process when developing each of its recommendations. Use the graphic below to see where this recommendation is in the development process. [Learn about our full development process.](#)



Current USPSTF Radiology Recommendations

- Lung Cancer Screening**

Recommendation Summary

Population	Recommendation	Grade
Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B

- Colorectal Cancer Screening**

Recommendation Summary

Population	Recommendation	Grade
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B
Adults aged 76 to 85 years	The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	C

USPSTF Implications for Coverage

- The [ACA of 2010](#) requires insurers to cover preventive services with an “A” or “B” rating by the USPSTF at no cost to patients.
 - However, payers are given up to one year from the start of the next plan year to update their coverage policies when USPSTF guidelines are changed.



- ACR and national organizations consistently urge Medicare, Medicaid, and Private Payers to update coverage guidance.
- USPSTF final recommendations are published in [JAMA](#) and [increase the number of individuals eligible for screening](#) and has the potential to save more lives.

ALA State Lung Cancer Screening Coverage Toolkit

- The American Lung Association and The University of Texas MD Anderson Cancer Center have partnered to improve coverage for LDCT screenings for individuals at high risk for lung cancer in state Medicaid programs. Resources can be found [here](#).
- As of October 2023, **49 Medicaid fee-for-service programs cover lung cancer screening** and 1 program does not provide coverage.
- Medicaid fee-for-service programs that **cover lung cancer screening vary in eligibility criteria and barriers** to screening, including prior authorization and cost sharing.
- Medicaid enrollees are disproportionately at risk for lung cancer, as 22.7% of Medicaid beneficiaries are current smokers (compared to 9.2% of individuals with private insurance). Additionally, the five-year survival rate for lung cancer patients with Medicaid is 14.2%, compared to 21.9% for lung cancer patients with other insurance.

[LCS Coverage in State Medicaid FFS Programs](#)
[Access to Lung Cancer Screening in Medicaid Fact Sheet](#)
[Medicaid Expansion and Lung Cancer Factsheet](#)

ACR
Bulletin

Covering topics relevant to the practice of radiology

Career | Economics | **Patient Engagement** | Practice Management

<https://www.acr.org/Practice-Management-Quality-Informatics/ACR-Bulletin/Articles/September-2020/Providing-Healthcare-to-the-Most-Vulnerable>

Providing Healthcare to the Most Vulnerable

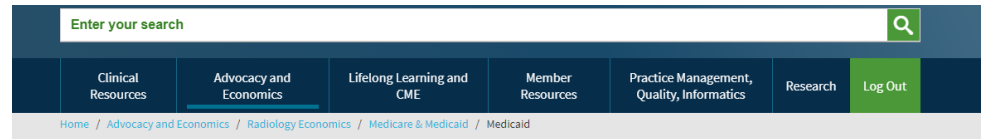
Medicaid, already the largest payer in the nation, is about to get larger as millions lose private health insurance as a result of COVID-19.



Overall, expansion appears to have significantly narrowed but not entirely closed the income and race-based gap in healthcare utilization.

ACR Engagement with Medicaid

The ACR monitors local Medicaid programs and reviews local coverage policies. In addition, our network's relationships with large, multistate Medicaid MCOs allows the ACR to have valued input in reviewing and commenting on medical coverage policies.



Medicaid

The ACR Medicaid Network representatives and economics and health policy staff monitor local Medicaid programs and review local coverage policies. In addition, the network's relationships with large, multistate Medicaid MCOs allow the ACR to have valued input in reviewing and commenting on medical coverage policies.

Medicaid and the Affordable Care Act

Under the Affordable Care Act (ACA), 36 states and the District of Columbia have taken advantage of federal subsidies and opted to expand Medicaid eligibility leading to a dramatic increase in Medicaid enrollment.

- Status of State Medicaid Expansion Decisions: [Interactive Map](#)
- The Effects of Medicaid Expansion under the ACA: [Updated Findings from a Literature Review](#)

Medicaid Waivers

Many states have taken advantage of 1115 demonstration waivers through CMS. Through these waivers, the Secretary of the Department of Health and Human Services may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.

- Medicaid Waiver Tracker: [Approved and Pending Section 1115 Waivers by State](#)
- State Waiver List: [CMS](#)

Medicaid Information and Resources

<https://www.acr.org/Advocacy-and-Economics/Radiology-Economics/Medicare-Medicaid/Medicaid>

Priorities and Goals of the Network

- Increase member awareness of Medicaid's role and its relevance to Radiology
- Continue to encourage members to engage with their state MCOs
- Continue to track, review and communicate state and national level changes in Medicaid programs

Areas of concern

- Long-term future of the Medicaid program
- Low Reimbursement rates for radiology

ACR Medicaid Network

Activities include:

- Weekly postings to Engage Platform (national & state specific news)
- Summaries of Medicaid regulations
- Publication of Medicaid content in ACR publications Bulletin, JACR, and Advocacy in Action News
- Tracking of state Medicaid activities

The screenshot shows the Engage forum interface for the ACR Medicaid Network. At the top, the Engage logo is displayed with the tagline "A discussion forum for ACR members". Below the logo is a navigation bar with links for Home, Communities, Directory, Browse, Participate, and FAQs, along with a search bar. The main heading is "ACR Medicaid Network" with a Settings icon. Below this, there are tabs for "Community Home", "Discussion 293", "Library 17", and "Members 114". A note indicates "last person joined: 5 months ago". A disclaimer is provided: "DISCLAIMER: By participating in this community, you agree to keep confidential all discussions and work products on College matters. Participants further acknowledge that they could be regarded as a potential source of information and that any comments made to third parties about such matters could improperly be construed as ACR's official position." There are links for "Back to discussions" and "Expand all | Collapse all". The main content area is titled "ACR Medicaid Updates" and includes a "Follow" button. A list of updates is shown, with the first entry titled "1. ACR Medicaid Updates" and a sub-entry "1. Medicaid Expansion/Demonstrations/State Updates" by Matcia Moore, posted 11 days ago. The sub-entry includes a link to "Medicaid Articles of Interest and Updates through March 23, 2023".

Medicaid Network Activities 2021-2024

Coverage

- Variations in LCS coverage in FFS; 49 **Medicaid fee-for-service** programs cover lung cancer screening.
- USPSTF final LCS recommendation extends screening **to age 50**.
- USPSTF final recommendation for CRC extends screening **to age 45**.
- In February 2022, CMS announced an update to the National Coverage Determination that expands coverage for screening lung cancer using LDCT in response to the USPSTF final recommendation.

Access

- Dental Care for Head & Neck Cancer **is not covered** for patients requiring radiation therapy
 - States can cover dental care as an optional coverage. Not all states provide any coverage
- Radiation Treatment during admission to Rehab & Skilled Nursing facilities **is not covered** separately and results in treatment delays of post-operative patients and worse outcomes
- A Medicaid Alternative Payment Model Program In Oregon Led To Reduced Volume Of Imaging Services ([Abstract](#))

National

- MACPAC Recommendations to Congress ([March](#) and [June 2023 Reports](#))
- 2024 Medicaid [Adult Core Measure Set](#)
- Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for Unwinding of the Pandemic-Era Continuous Enrollment Provision ([April 2023](#))
- Results from Annual Medicaid Budget Survey for FY2023 and FY2024 ([November 2023](#))
- Medicaid and State Financing: What to Watch in Upcoming State Budget Debates ([January 2024](#))

Medicaid Resources

- **ACR Medicaid website** – <https://www.acr.org/Advocacy-and-Economics/Radiology-Economics/Medicare-Medicaid/Medicaid>
- **Medicaid 101** - <https://www.macpac.gov/medicaid-101/>
- **Congressional Research Service Medicaid: An Overview** - <https://fas.org/sgp/crs/misc/R43357.pdf>
- **Kaiser Family Foundation** - <https://www.kff.org/>
- **Medicaid and CHIP Eligibility and Enrollment Policies:** <https://www.kff.org/statedata/collection/medicaid-and-chip-eligibility-enrollment-and-renewal-policies/>
- **MACPAC** - <https://www.macpac.gov/about-macpac/>
- **MHPA** - <https://medicaidplans.org/>
- **AMA Medicaid Resources** - <https://www.ama-assn.org/practice-management/medicare-medicaid/strengthening-medicaid>

ACR State Medicaid and MCO Contact List

Medicaid State Contact Information								
Updated 05/10/2021								
State	Abbr.	Medicaid.gov (Link - State Overview)	State Medicaid Home Page	Provider Billing Manual (State Link)	Provider Billing Manual Date	State Plan Type (eg, Managed Care, Contract)	Director	Director Email
Alabama	AL	https://www.medicaid.gov/state-overviews/stateprofile.html?state=alabama	https://medicaid.alabama.gov/	https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.2G_Apr2021.aspx	April 2021	Managed Care	Jerri Jackson, Managed Care Division	jerri.jackson@medicaid.alabama.gov
Alaska	AK	https://www.medicaid.gov/state-overviews/stateprofile.html?state=alaska	http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	https://www.medicaidalaska.com/portals/wps/portal/enterprise/provider/billingmanuals/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os3hXX-cwF3cfQwMLA29LAyNjC0fvIFcDAzNvE6B8JE75QHdzYnQb4ACOBgR0h4Nci1uFIQF eebDrQPJ47PfyM9N1S_IDY0wyAxIBwBAIFS9/dl3/d3/L2dBISeVZ0FBIS9nQSEh/	Jan 2021	Coordinated Care	Renee Gayhart (HCS Dir.) Albert E. Wall (Deputy Commissioner, Medicaid & Health Care Policy)	renee.gayhart@alaska.gov Al.Wall@alaska.gov
American Samoa	AS	https://www.medicaid.gov/state-overviews/american-samoa.html	https://medicaid.as.gov/			Fee-for-service	Sandra King Young	
Arizona	AZ	https://www.medicaid.gov/state-overviews/stateprofile.html?state=arizona	https://www.azahcccs.gov/	https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/	Jan 2021	Managed Care	Jami Snyder	jami.snyder@azahcccs.gov
Arkansas	AR	https://www.medicaid.gov/state-overviews/stateprofile.html?state=arkansas	https://medicaid.mmis.arkansas.gov/	https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/medx-prov/	May 2021	Fee-for-service	Dawn Stehle	dawn.zekis@arkansas.gov
California	CA	https://www.medicaid.gov/state-overviews/stateprofile.html?state=california	https://www.medi-cal.ca.gov/	https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Medi-CalProviderManuals.aspx	Mar 2021	Managed Care	Will Lightbourne	
Colorado	CO	https://www.medicaid.gov/state-overviews/stateprofile.html	https://www.healthfirstcolorado.com/	https://hcpf.colorado.gov/gen-info-manual	Apr 2021	Managed Care	Tracy Johnson	tracy.johnson@state.co.us

ACR Medicaid Network

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ARCHIVE INFO

- The following slides were included in prior versions of this presentation but are no longer the most recent important topics for Medicaid. They are still included for reference.

COVID Relief Funding for Medicaid Providers

Key Sources of Federal Support:

- Provider Relief Fund (\$178 billion)
- American Rescue Plan (ARP) rural funds (\$8.5 billion)
- Waived 2% Medicare sequestration temporarily
- Delayed 4% reduction in Medicare payments (PAYGO) until 2023
- Increased physician payments by 3% for 2022-Medicare Physician Fee Schedule (MPFS)
- Paycheck Protection Program (PPP) loans
 - [MedPAC estimates \\$100 billion provided to healthcare providers](#)
- Increased Medicare payments for inpatient COVID-19 admissions
- Expanded coverage of Medicare telehealth services

American Rescue Plan Act of 2021 Medicaid Provisions

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). This action represents the largest expansion of health coverage for the American people since the Affordable Care Act in 2010 and has a significant and immediate impact on state Medicaid and CHIP programs and beneficiaries.

- Section 9811 and Section 9821 Mandatory Coverage of COVID-19 Vaccines, Vaccine Administration, Testing, and Treatment in Medicaid and CHIP
- Section 9814 Temporary Increase in FMAP for Medical Assistance under State Medicaid Plans which Begin to Expend Amounts for Certain Mandatory Individuals
- Sections 9812 and 9822 Modifications to Certain Coverage under Medicaid and CHIP for Pregnant and Postpartum Women

<https://www.medicaid.gov/sites/default/files/2021-06/ARP%20Overview%20CIB%20-%20cib060321.pdf>

FMAP Increases and COVID-19

While the FMAP increase is an effective tool, states may still face shortfalls resulting from increased costs from the public health and economic crises associated with COVID-19.

- To both support Medicaid and provide broad fiscal relief as state revenues declined, the Families First Coronavirus Response Act (FFCRA) authorized a **6.2 percentage point increase in the FMAP** for states that meet certain maintenance of eligibility requirements.
 - The additional funds are available retroactively to January 1, 2020 through the quarter in which the public health emergency period ends.
- The conditions attached to states' receipt of the FMAP increase, such as continuous eligibility, are designed to keep people connected to coverage and provide access to care during the public health emergency period.

Enhanced FMAP Funding has Sunsetted

- Enhanced federal funding is now set to wind down each quarter, beginning on April 1 and sunseting on January 1, 2024.
- States are eligible for this enhanced funding if they comply with certain rules:
 - States cannot restrict eligibility standards, methodologies, and procedures and cannot increase premiums as required in FFCRA.
 - States must also comply with federal rules about conducting renewals.
 - States are required to maintain up to date contact information and attempt to contact enrollees prior to disenrollment when mail is returned.

Time Frame	Enhanced FMAP Percentage
Through March 2023	6.2%
April 1, 2023	5%
July 1, 2023	2.5%
October 1, 2023	1.5%
January 1, 2024	Sunset – 0%

Medicaid Maintenance of Eligibility (MOE) Requirements

- To receive the additional 6.2 percentage point FMAP increase, states must meet certain MOE requirements.
 - Under a new Interim Final Rule (IFR), CMS has reinterpreted the MOE to allow states to decrease benefits, increase cost-sharing, and in some cases, terminate enrollment for people considered not "validly enrolled" or change eligibility groups while still receiving increased federal matching funds.
 - CMS will not require separate demonstration of compliance from states but will allow states to passively attest by drawing down the funds.
 - If CMS later determines that the state does not satisfy all of the conditions, the state must return the enhanced funds.
- If an enrollee is determined no longer eligible for Medicaid under any eligibility pathway, states must maintain the same coverage through the end of the month in which the PHE ends.

Oklahoma Expands Medicaid

- In June 2020, Oklahomans took to the polls and voted to expand Medicaid.
- Expansion of coverage to include low-income adults began on **July 1, 2021**
 - Nearly 250,000 Oklahomans have enrolled since expansion in July
 - As of October 2021, 1.1 million OK residents enrolled (net increase 29%)
- Medicaid benefits will include access to primary and preventive care, emergency, substance abuse, and prescription drug benefits.
- OK will gain additional federal support for their Medicaid program through the American Rescue Plan (ARP), estimated to be nearly \$500 million over two years

"Medicaid is a lifeline for millions of people in this country and a step in the long road to achieving health equity by providing access to essential health care," said CMS Administrator Chiquita Brooks-LaSure. "Oklahoma is now a model for other states looking to expand health coverage to those who need it most."

Missouri Expands Medicaid

- Expansion enrollment processing began October 1, 2021
 - Up to **275,000 Missourians** are expected to gain eligibility (but the pace of enrollment is slower than expected)
 - As of early 2022, **58,000 residents enrolled**
- GOP lawmakers continue to try to unravel Medicaid expansion during 2022 – more updates to come
- MO will gain additional federal support for their Medicaid program through the American Rescue Plan (ARP), estimated to be nearly \$968 million over two years

