2023 Medicaid Update:
The State of The States

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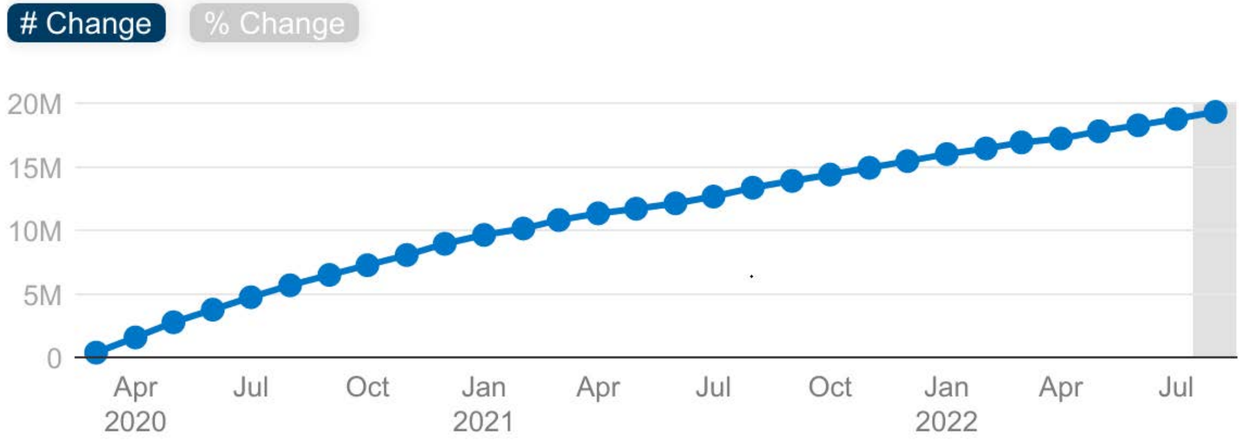
Medicaid Basics

- Medicaid: the U.S. health insurance program for low-income people
- Covers 1 in 4 Americans
  - 91 Million people
    - 84 million Medicaid + 7 million CHIP
    - 19 million increase enrollment from February 2020
- Medicare 64 million
- Medicaid population
  - 45% children (41 million) & 25% elderly and disabled
- Limits enrollees' out-of-pocket costs
- Total cost $734 billion

Pandemic Medicaid Growth

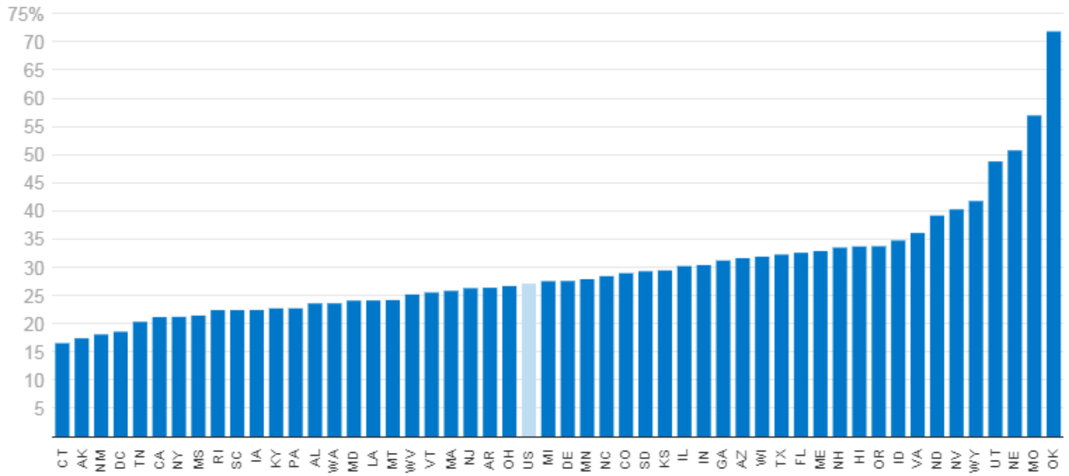
Medicaid/CHIP Enrollment Has Increased Since The Start Of The Pandemic.

Cumulative Change In Medicaid/CHIP Enrollment Since February 2020

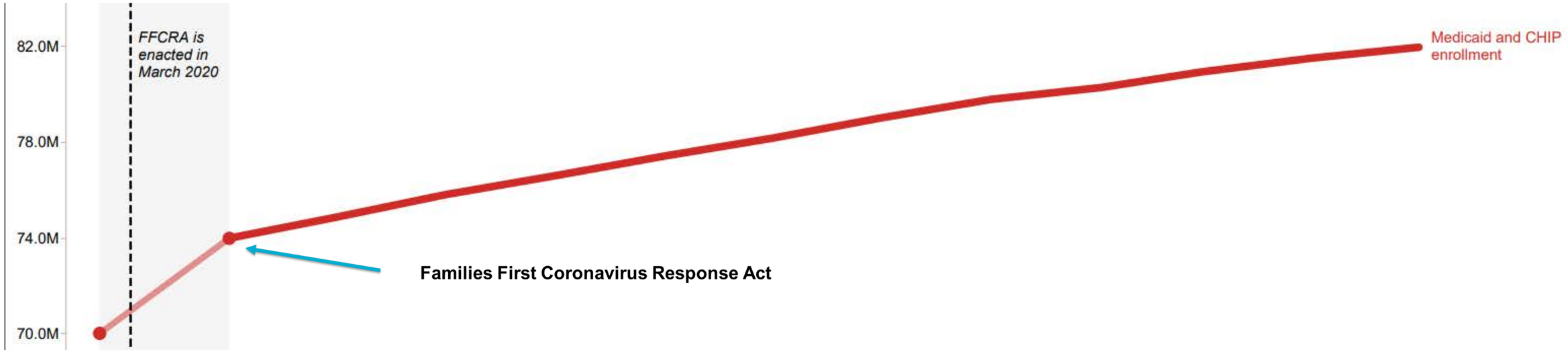


Enrollment From February 2020 To August 2022 Has Increased In Every State.

Cumulative Percent Change In Medicaid/CHIP Enrollment From February 2020 Through August 2022 By State



Federal Government Levers: Increasing Medicaid Enrollment

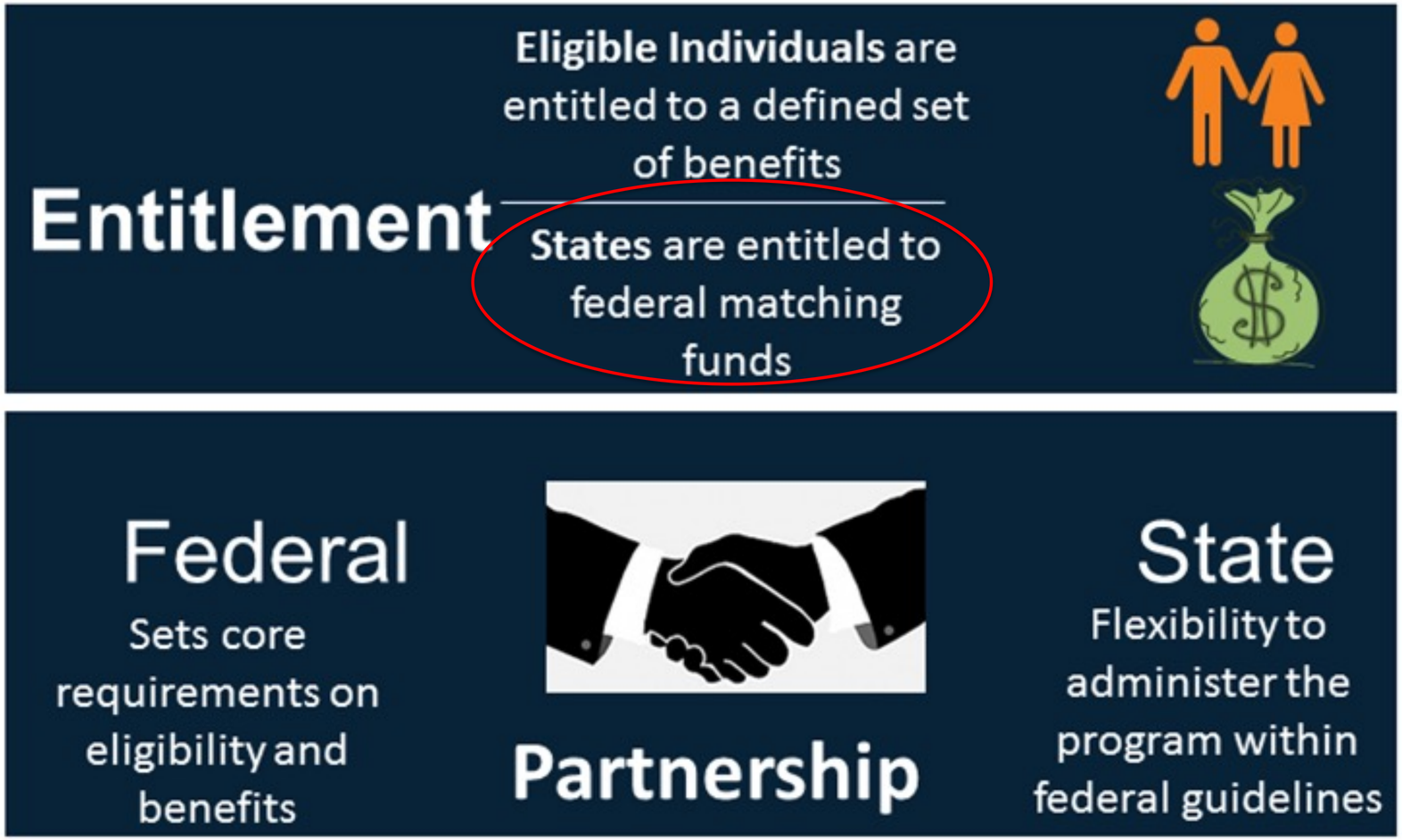


Families First Coronavirus Response Act
Increased federal funds going to states
Created an incentive for states to expand Medicaid
8 million Medicaid enrollees added from FFCRA alone

ED Medicaid and Medicare Managed Care Evolution

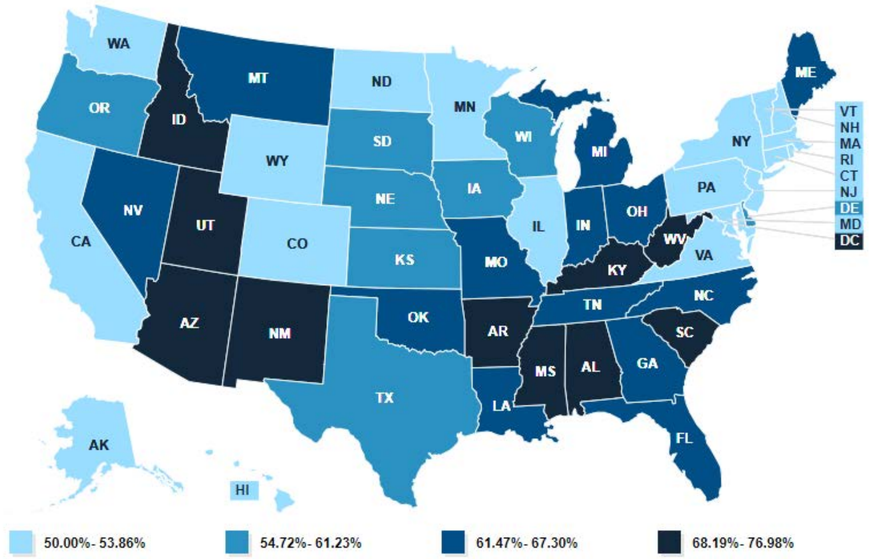
ED Payer Mix Major Components	2019	2022	Variance
Blue Cross	14.95	15.09%	+ 0.96%
Commercial	12.44%	12.79%	+0.35
Medicaid	9.80%	6.56%	**-3.24%**
Managed Medicaid	14.30	17.69	**+3.39**
Medicare	20.69%	15.97%	**-4.72**
Medicare Advantage (Managed)	8.32%	13.19%	**+5.58%**
Self Pay	10.18%	8.56%	-1.62%

COVID and Medicaid Financial Architecture



Pre COVID: Medicaid Federal Government Support Federal Medical Assistance Percentage (FMAP)

- Share of Medicaid spending born by the federal government
- Computed from a formula that takes into account the average per capita income for each state relative to the national average
- Statutory maximum = 83%
- Statutory minimum = 50%
- State examples:
  - MS = 76.39% (highest)
  - MA = 50%
  - DC = 70% (statutorily set)



COVID FMAP Increases

- Families First Coronavirus Response Act
- 6.2% increase to (FMAP)
  - January 1, 2020 through the last day of the calendar quarter in which the public health emergency terminates
- To Qualify for increased FMAP states must maintain Medicaid rolls:
  - Not make eligibility requirements more restrictive
  - Not terminate individuals (Post PHE Impact)
  - No increase in premiums or cost share
  - Cover COVID related “testing, services, treatment” with no cost share

Medicaid Post PHE- The “Unwinding”

Medicaid COVID Unwinding

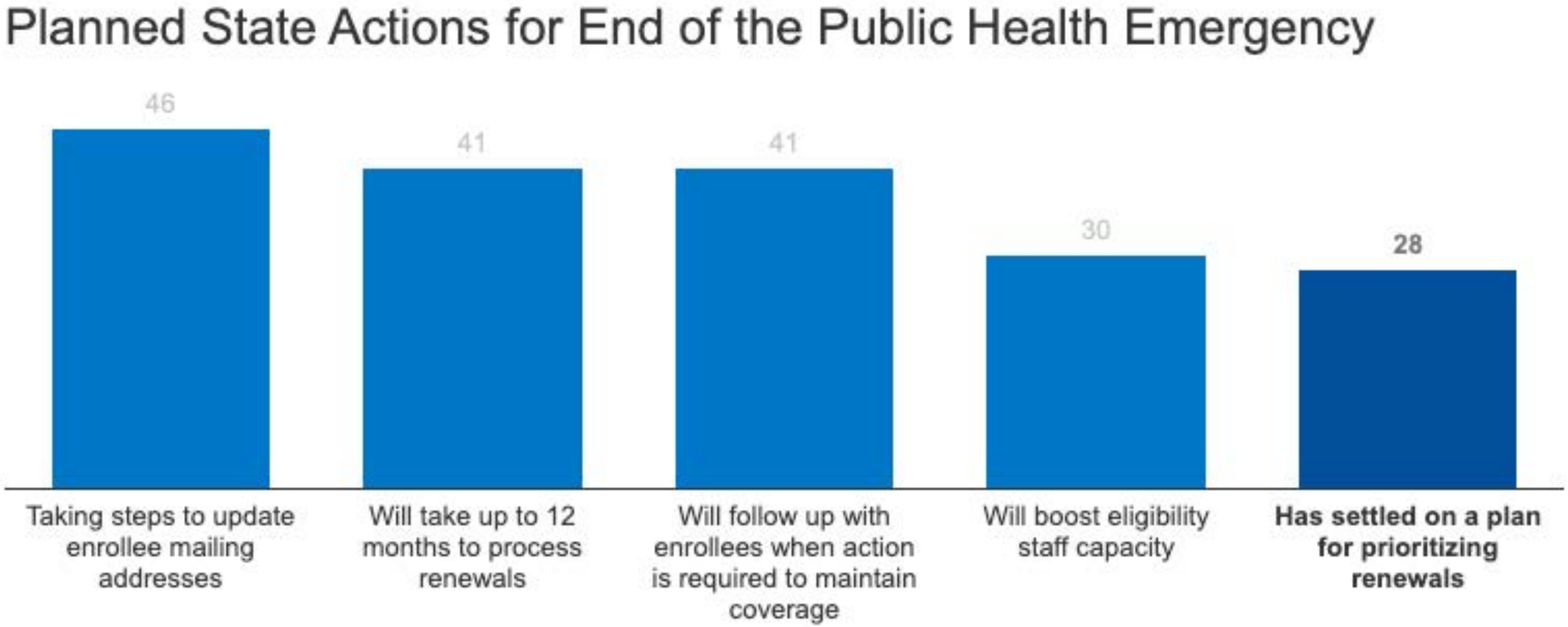
- The Consolidated Appropriations Act (CAA), 2023 includes a provision that unwinds the extensive increase in Medicaid enrollment and benefits that was part of the PHE
- States will resume normal operations including typical eligibility checks, detailed renewal requirements, and ending coverage for some now ineligible enrollees
- Federal Funding decreases will further spur the unwinding
  - The Family First Corona Virus Act increased FMAP (+6.2%) phases out from April - December 2023 ultimately to (0%)

Unwinding Medicaid Continuous Enrollment

- With the reinstatement of Medicaid renewal requirements millions of Medicaid beneficiaries are expected to lose coverage.
- Prior to enactment of the CAA, 2023, HHS estimated:
  - 7 million will lose Medicaid coverage despite still being eligible
  - 3 million will qualify for Marketplace premium tax credits
  - 5 million expected to obtain other coverage (e.g. employer sponsored insurance)
- Many would end up with a subsidized Exchange product (HDHP)
- Half a million would fall in a coverage gap (income too high for Medicaid, too low for Exchange tax credits)

Planned State Reach Out Actions End of The PHE

Figure 4



SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University for Children and Families, 2022 • PNG

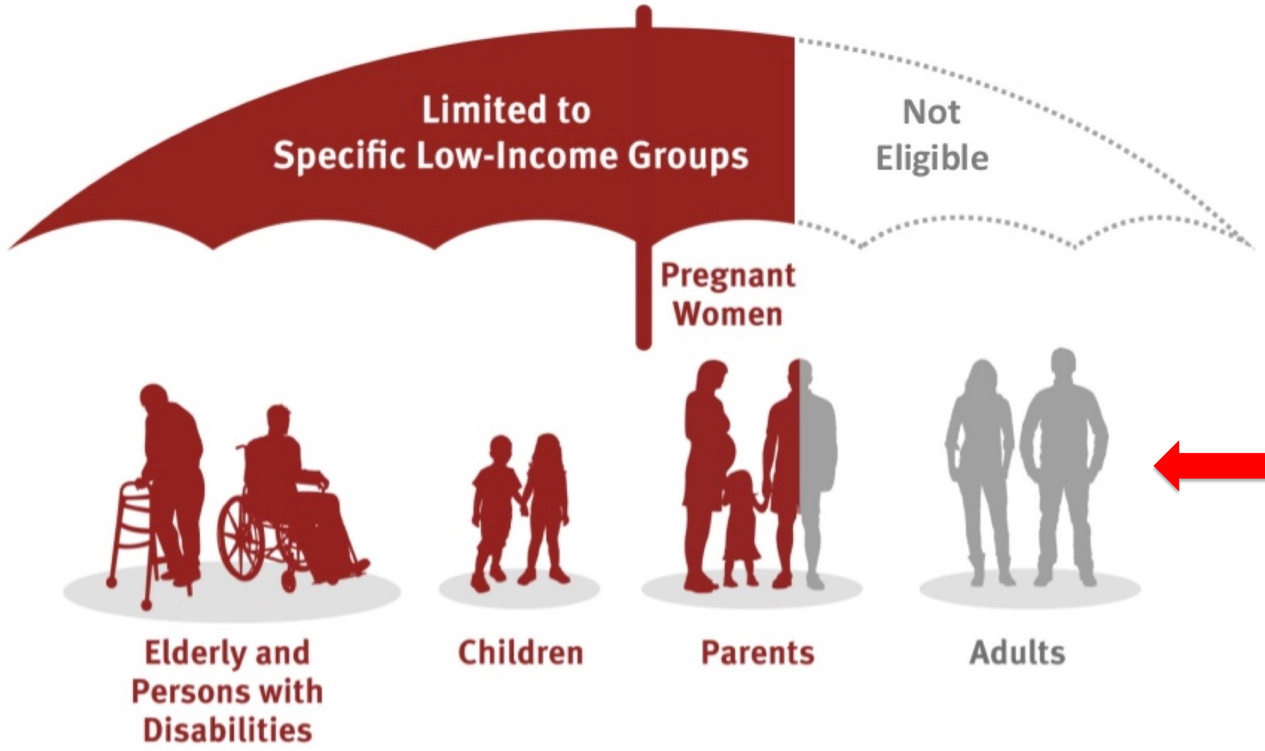
KFF

Medicaid Program Structure

Who Qualifies?
Medicaid Categorical Eligibility Prior to the ACA

Prior to the ACA, Medicaid eligibility was limited to specific low-income groups.

Categorical Eligibility



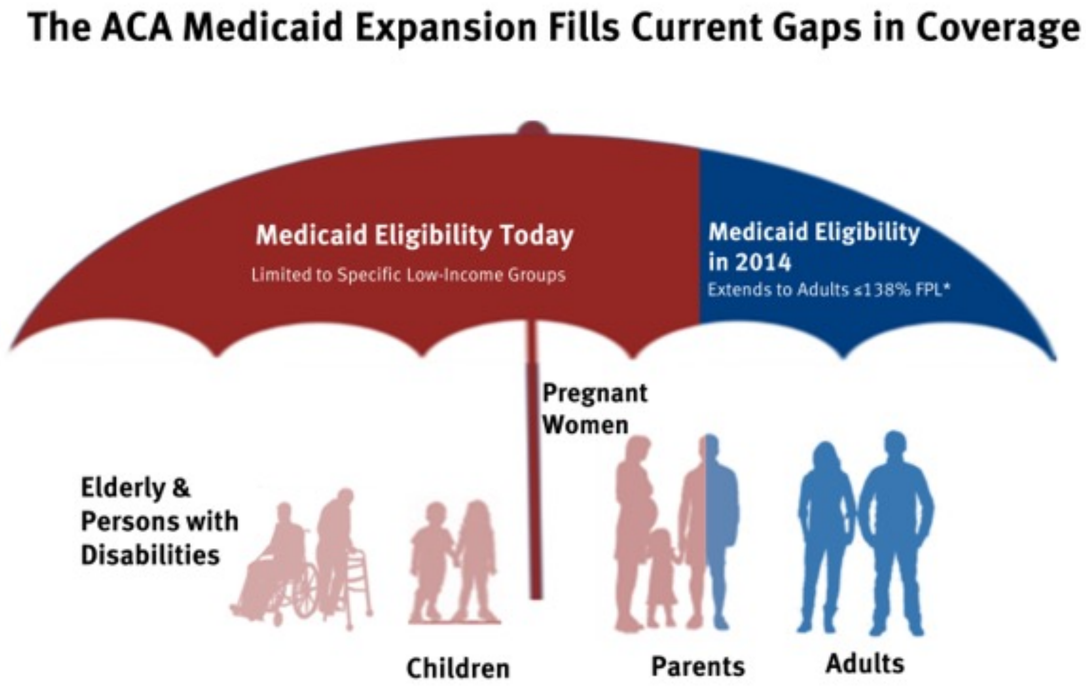
Excluded adults men/women without dependents

40 Million

THE HENRY J. KAISER FAMILY FOUNDATION

ACA and Medicaid Expansion: Eliminates Categorical Eligibility

- Goal of the Affordable Care Act
  -Reduce the # of uninsured
- Eliminated categorical eligibility: allowed coverage for adults without dependent children
- Expanded income eligibility
  $0 - 138% FPL (2022 ~$18K)
- Seamless coverage by ACA Exchange to 400% FPL (~$52K)



Include non disabled and w/o dependents

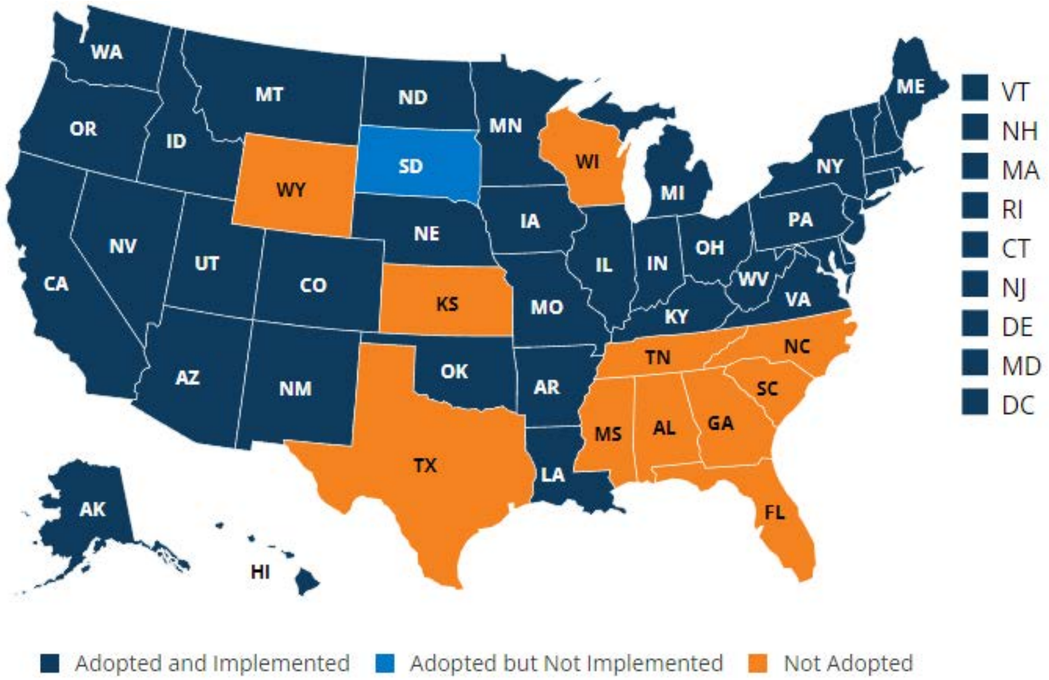
ACA led to Medicaid expansion of 15 million

2022-2023 Status of State Medicaid Expansion: Expansion States- Seamless Coverage

40 States have expanded Medicaid
0% – 138% FPL (Medicaid)
138% FPL– 400% FPL Exchange product

11 states no Medicaid expansion

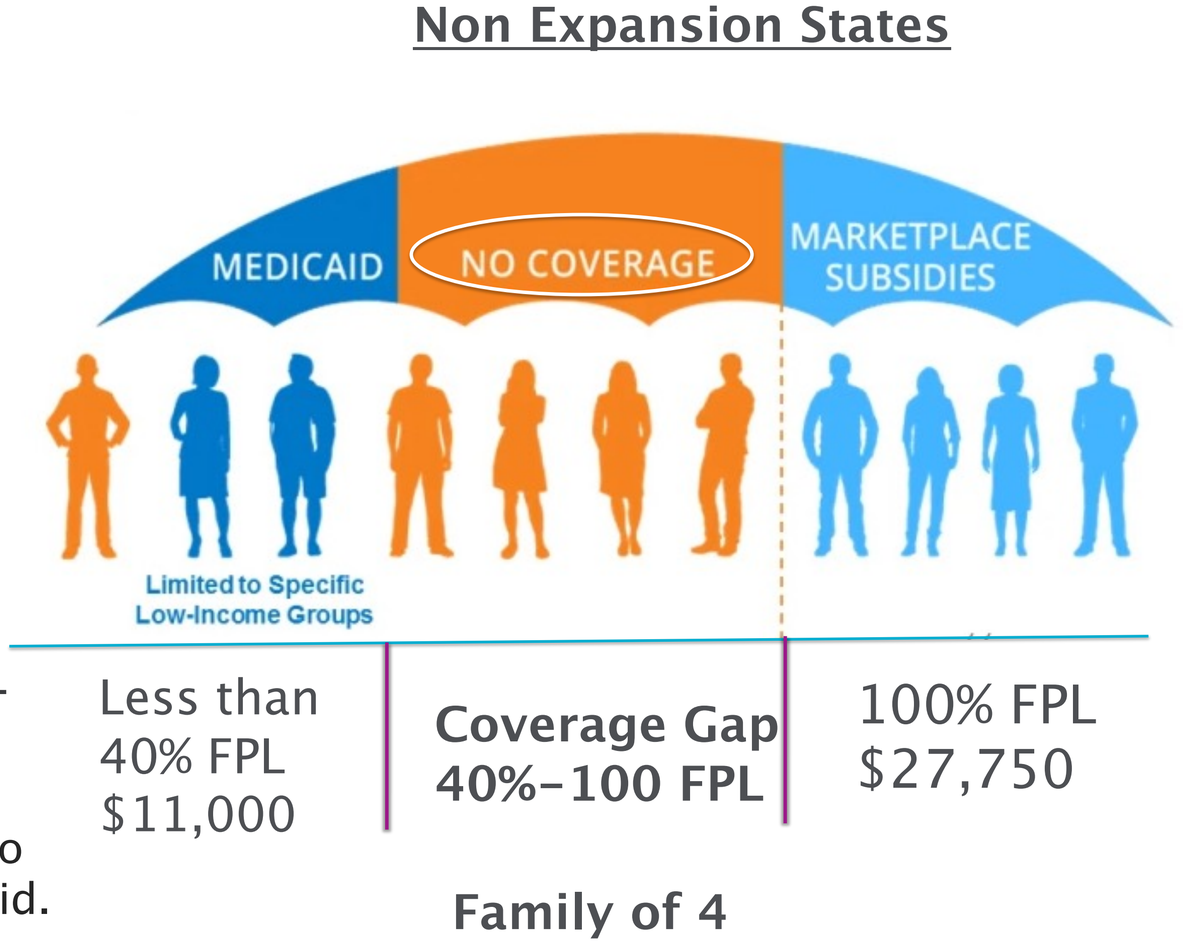
100% FPL– 400% FPL Exchange product
<100% FPL many not covered at all– coverage gap



November 2022

2023 ACA Coverage Gap For Non Expansion States

- The ACA has a meaningful coverage gap
  - Ineligible for that state's Medicaid
  - Income > 43% of FPL ($6,000 indiv.)
    - Don't qualify for Medicaid
  - Don't qualify for a subsidy to buy an Exchange plan
  - States not expanding Medicaid Exchange subsidies start at 100% of FPL



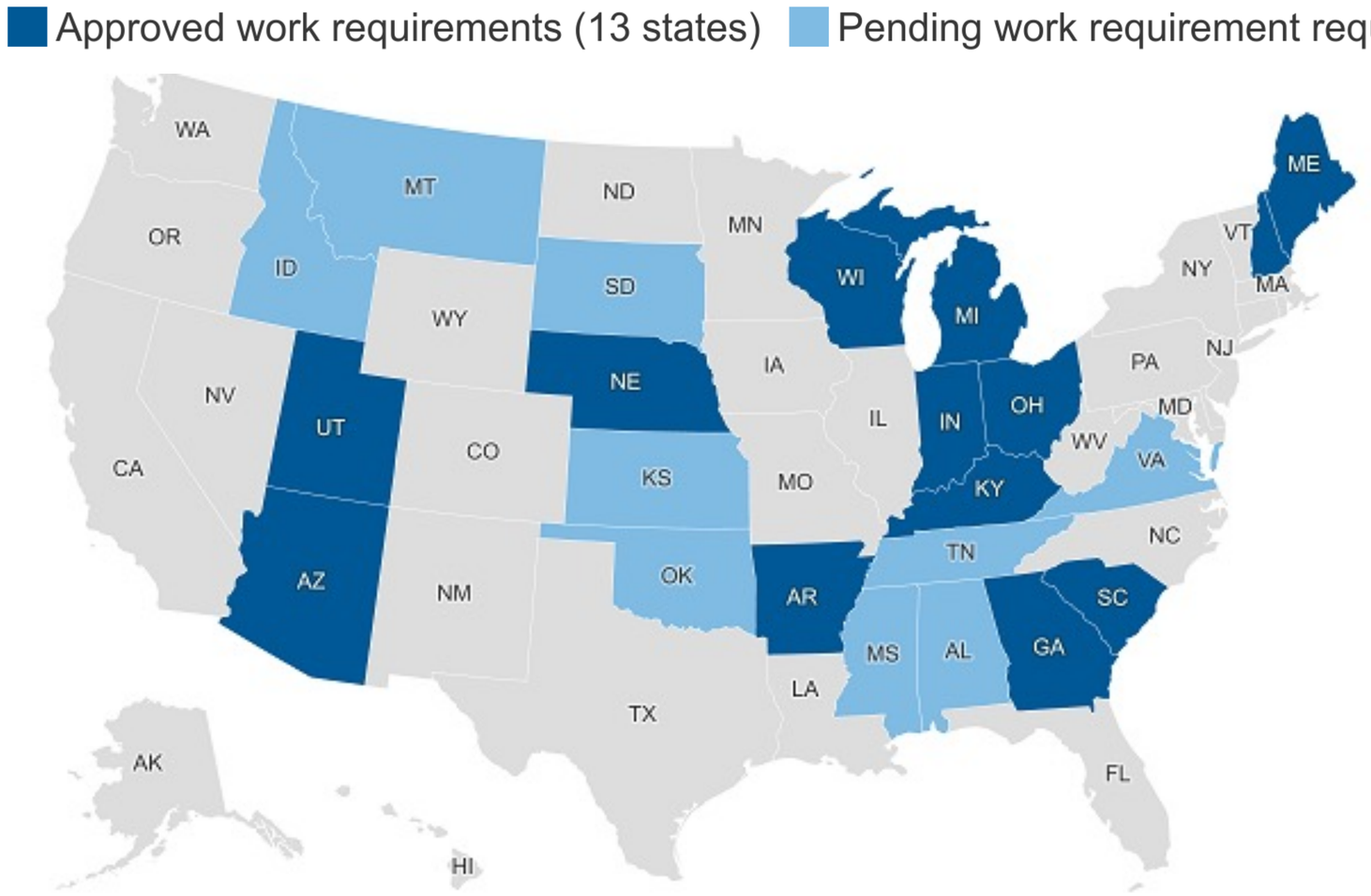
Coverage Gap closed by making the Exchange available to uninsured below 138% that don't qualify for state Medicaid. Exchange available at 100% FPL

Pendulum Swinging: 1115 Medicaid Waivers

1115 Waivers and Work Requirements

- Allow states to test Medicaid approaches that differ from federal program rules
- Waiver previously approved by CMS include:
  - Work requirements: able bodied working, in college, in SUD program, full time care taker
  - Ability to charge premiums up to 4% of family income
  - Eligibility and benefit restrictions
- Latest 1115 waivers pendulum swing expand Medicaid coverage
  - Work requirements sun setting
  - Premium requirements sun setting

Current Status of Medicaid Work Requirements: COVID Impact

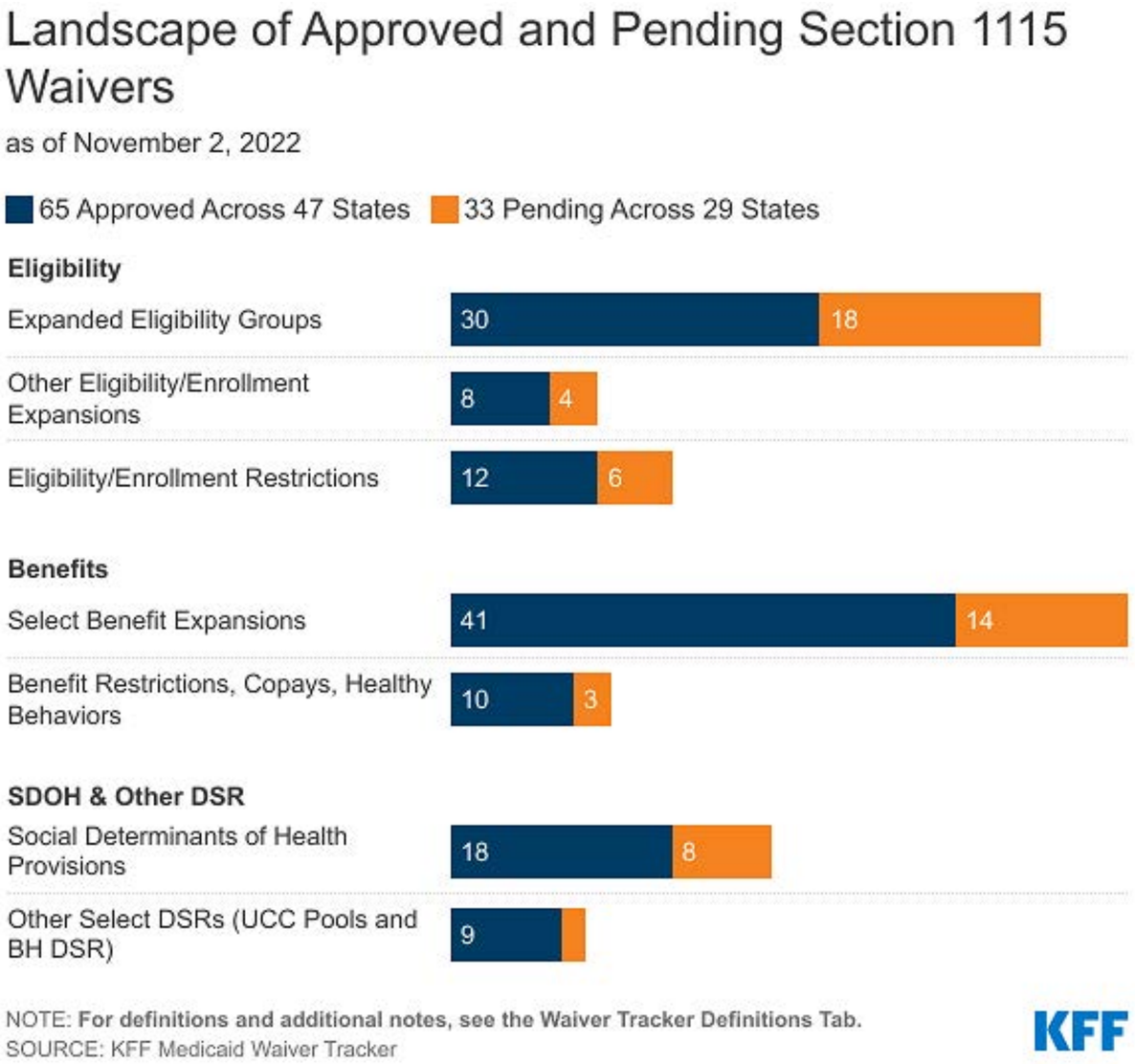


CMS withdrew work requirement waiver authorities in multiple states

Nebraska withdrew its work requirement waiver.

Georgia delayed implementation of its waiver.

2022-2023 1115 Waiver Authority Now Used to Expand Medicaid



Federal Regs Allow States to Impose Medicaid Cost Sharing

Medicaid.gov
Keeping America Healthy

Cost Sharing

States have the option to charge premiums and to establish out of pocket spending (cost sharing) requirements for Medicaid enrollees. Out of pocket costs may include copayments, coinsurance, deductibles.

Premiums

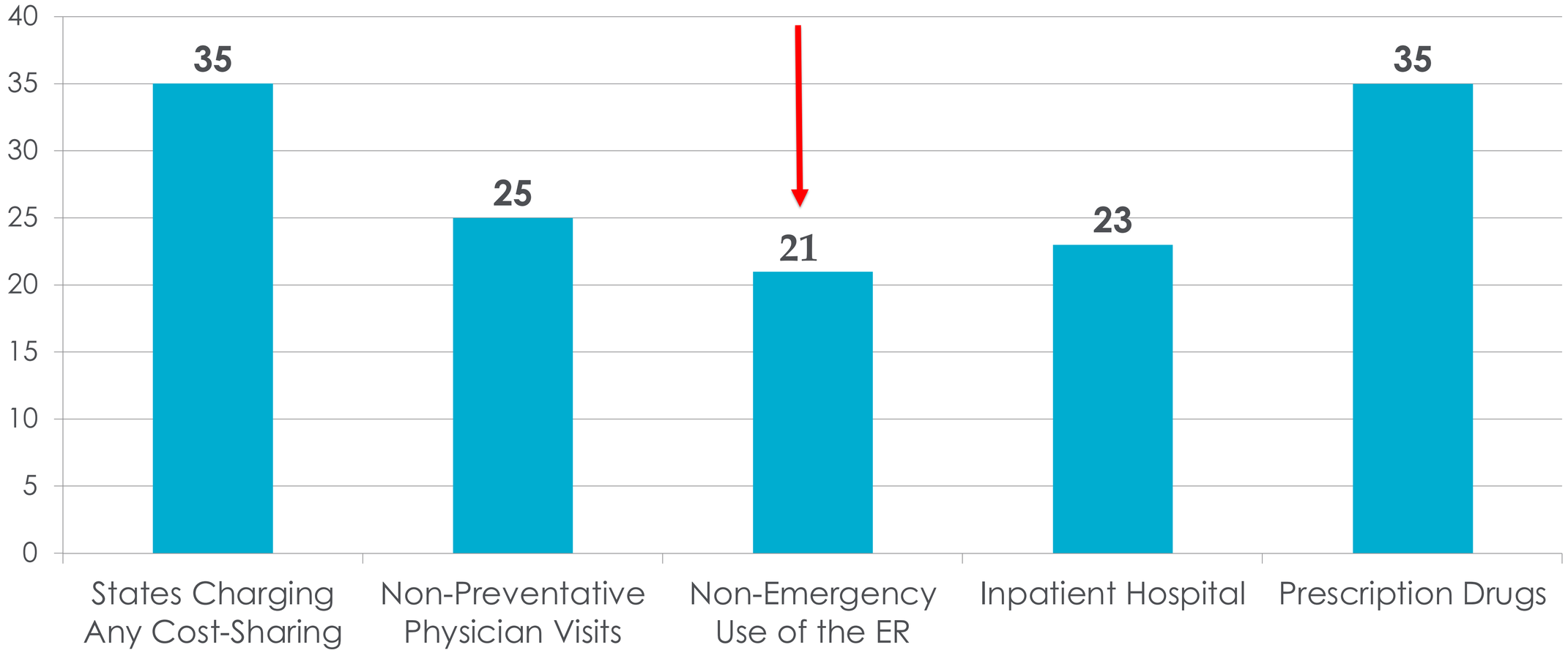
States can charge limited premiums and enrollment fees for groups of Medicaid enrollees with income at 150% FPL.

States have the option to impose higher, alternative premiums on other groups of enrollees, if their family incomes exceed 150% of the federal poverty level

Federal Allowable Cost Sharing Amounts for Adults in Medicaid Still In Play

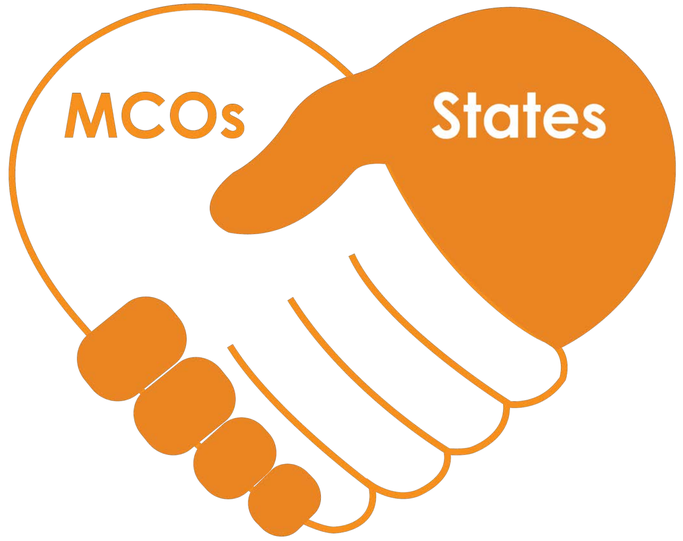
	<100% FPL	100-150% FPL	>150% FPL
Outpatient services	Up to $4	Up to 10% of state costs	Up to 20% of state costs
Non-urgent use of ER	**Up to $8**	**Up to $8**	**No limit**
Prescription Drugs	Preferred: Up to $4 Non-preferred: Up to $8	Preferred: Up to $4 Non-preferred: Up to $8	Preferred: Up to $4 Non-preferred: Up to 20% of State costs
Inpatient services	Up to $75/stay	Up to 10% of state costs	Up to 20% of state costs

Number of States with Cost Sharing for Selected Services for Adults



Medicaid Managed Care - A Dangerous Solution

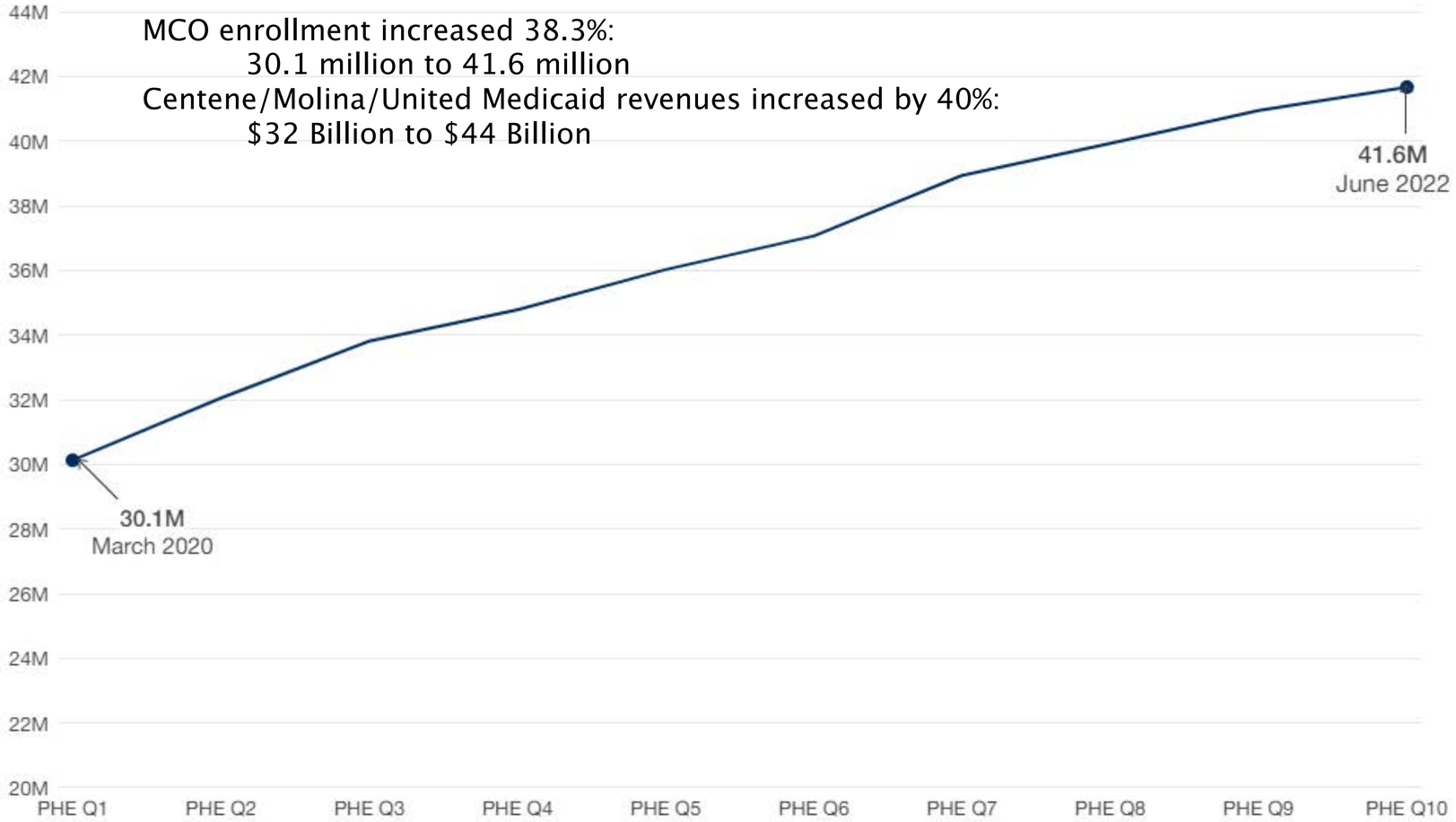
- States don't have the capacity for new enrollees
  - State budgets are strained
- Solution: Managed Care Organization (MCO) enters into a capitated arrangement with the state
  - Paid a per member per month fee
  - Profit driven by controlling health care costs
- 40 states have MCO agreements
- Nationwide 70% of all Medicaid beneficiaries now enrolled in risk based MCOs
- Market is now dominated by for-profit insurance companies



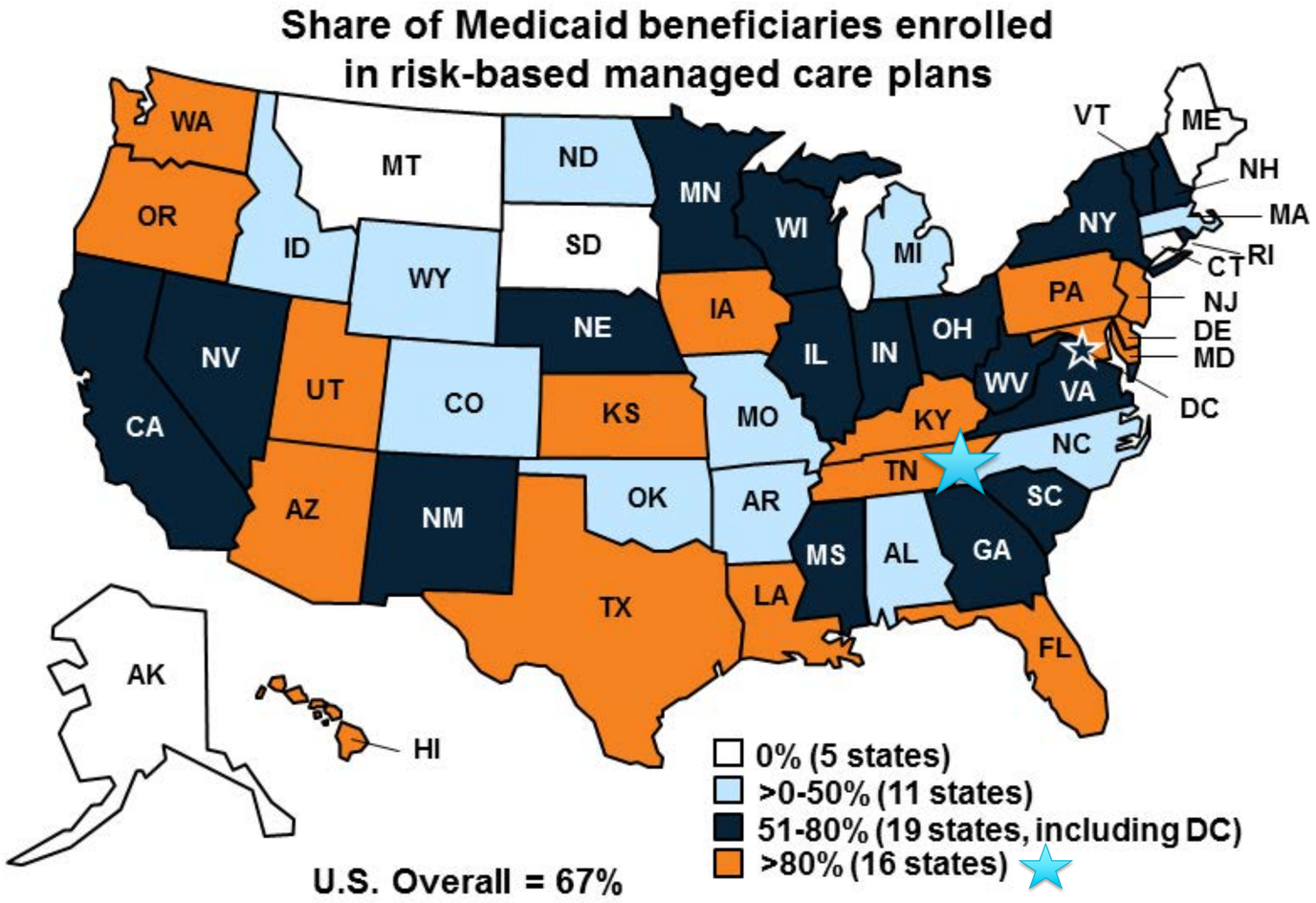
Managed Medicaid MCO Growth During The Pandemic

"Big Five" Growth in Medicaid Enrollment during COVID-19 Public Health Emergency (Aetna/Anthem/Centene/Molina/United)

MCO enrollment increased 38.3%:
30.1 million to 41.6 million
Centene/Molina/United Medicaid revenues increased by 40%:
$32 Billion to $44 Billion

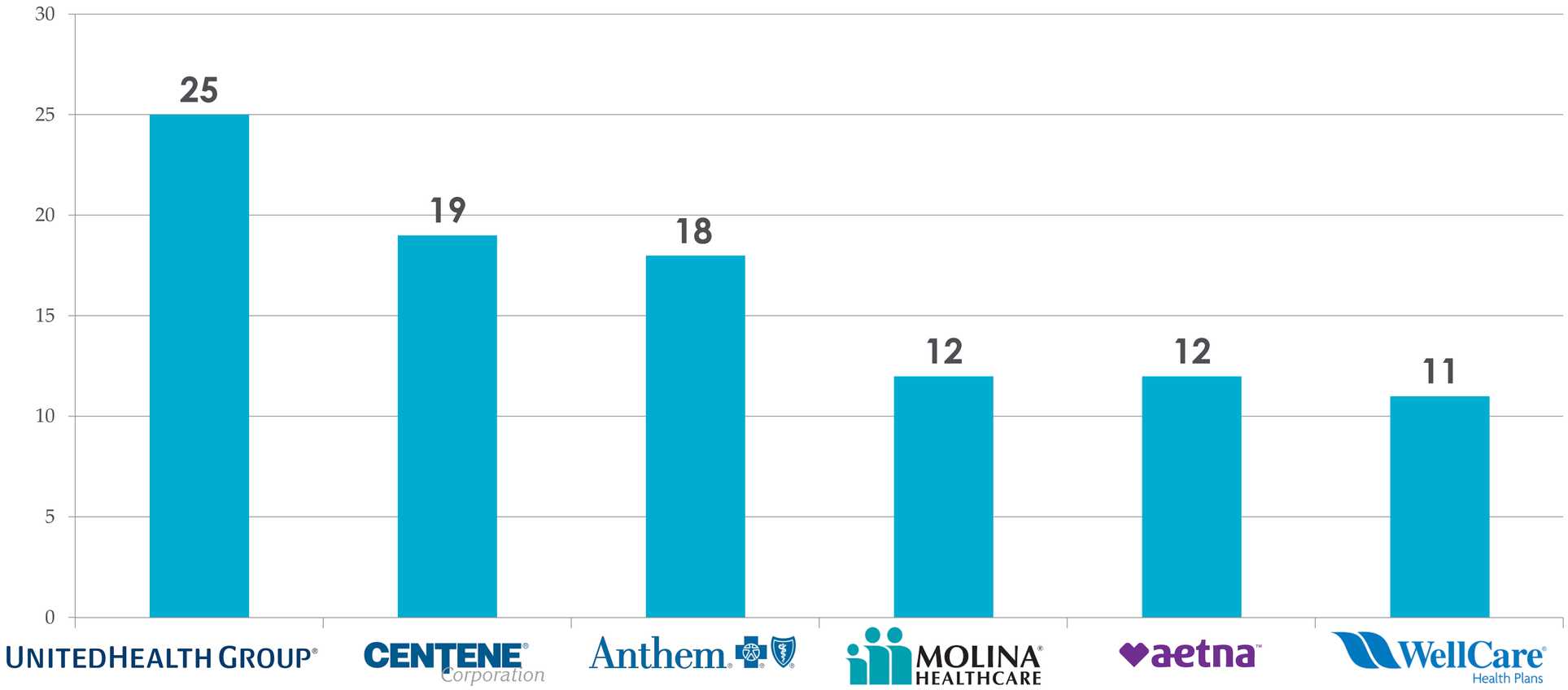


Specifics States: Essentially A Medicaid MCO Monopoly



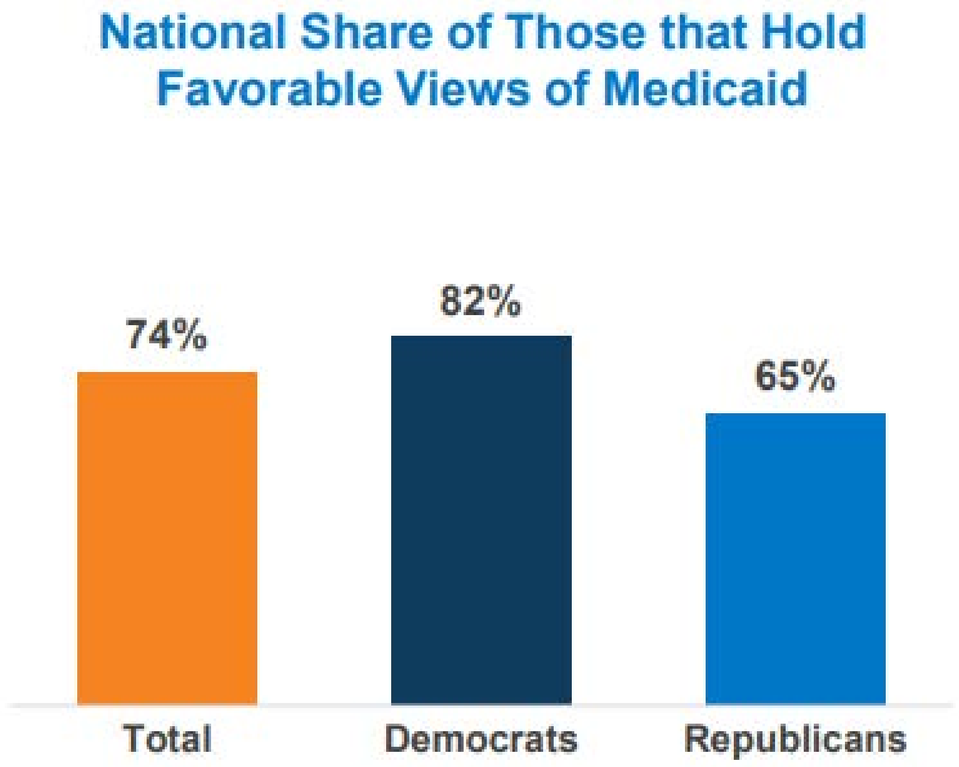
Who Are These Carriers?
6 Medicaid MCOs Dominate The Market

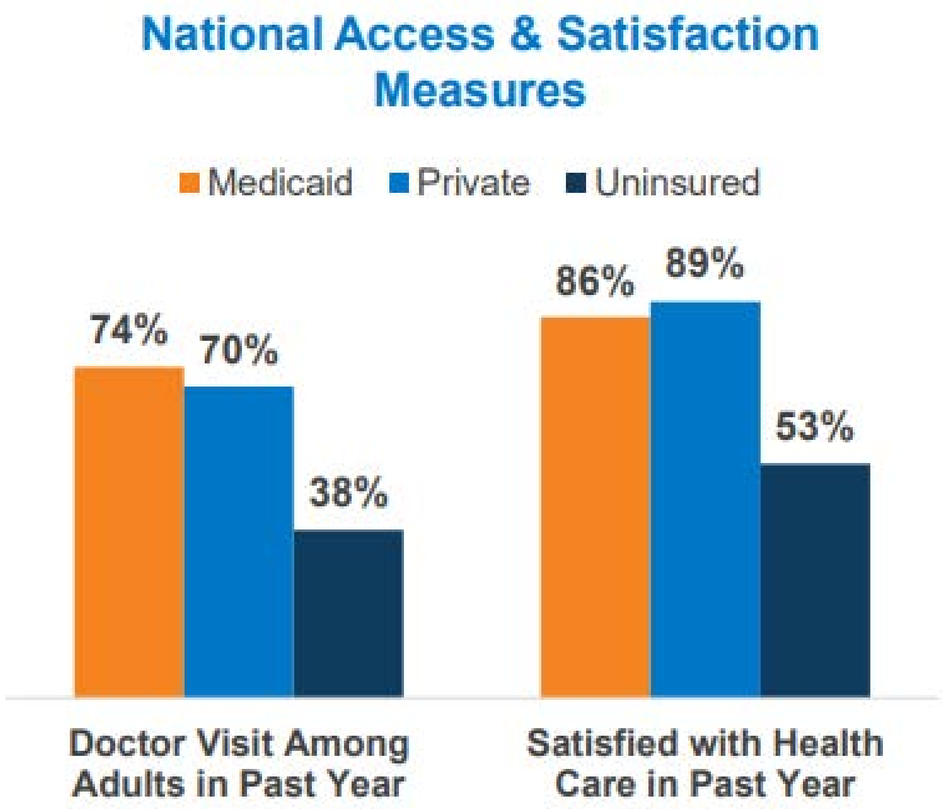
Number of States Insurance Companies Provide Medicaid MCO Services



States Get Tough and Managed Care Takes Over

Perception Is…Still Reality





Source: Kaiser Family Foundation 2020 U.S. Medicaid Fact Sheet

Improve Outcomes vs. Reduce Costs

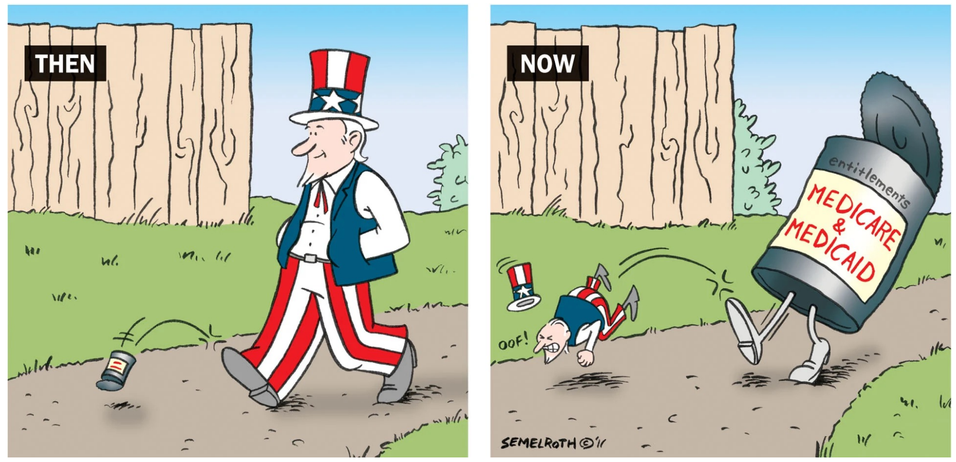
- Getting over the COVID-19 hump:
  - COVID-19 complicated insuring Medicaid populations
  - Utilization declined, but slowly recovering
  - Medicaid beneficiaries= higher rate of chronic conditions compared to Medicare and private insurance
  - Complex needs= higher usage, including the ED
- MCOs are responding to COVID:
  - Disease management
  - Care coordination
  - Mental health services
- 70% of Medicaid enrollees participate in this type of care model

Medicaid Managed Care – End of FFS?

- 40 states with at least 25% of Medicaid enrollees in an MCO
- 73% of Medicaid $$ now flow through an MCO
- 69% of Medicaid enrollees in a comprehensive plan
- Majority of MCOs formed by Section 1915(b) waivers give states wide array of options to enroll individuals in Medicaid
- Insurers accept contracts and risk, mixed bag of results for many
  - E.G. Michigan: Enrollment % increase, profits decline in 2016, both enrollment and profits increase exponentially in 2017
- Telehealth services rise during COVID-19 – but what happens after the PHE ends?

Managed Medicaid During COVID-19

- Enhanced capacity
  - Respond to both public health and economic crises
  - Disaster-Relief state plan amendments (SPAs), Section 1135 waivers and Section 1915(c) Appendix K waivers
- Expand Access
  - Record CHIP coverage availability
  - Expanded LTSS eligibility and services
  - Greater access to prescriptions
  - Emphasized telehealth



41 states increased provider payment rates for state plan services

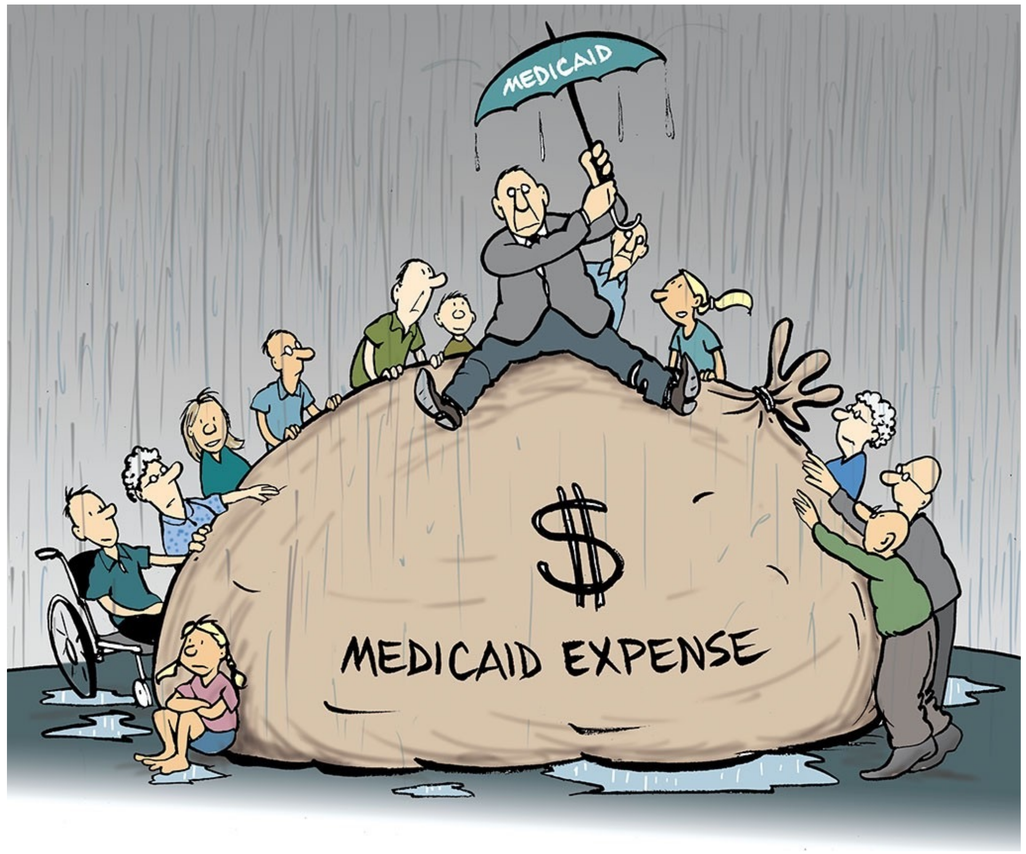
How Can Insurers "Insure" Profits?

- Medicaid and Medicare account for 60% of Anthem, Aetna, Cigna, Humana, and United revenues and 20% of their total plan membership
- Section 1915(b) waivers give insurers flexibility to operate Medicaid programs as they see fit with minimal interference
- Cost savings measures come into focus for physicians:
  - Extract performance-based fees based on existing quality measures
  - Create shared savings programs

Our opportunity: Physician-driven models (ACEP's AUCM)?

Is Medicaid Having a Renaissance?

- State budgets are NOT created equal:
  - Reduction in federal funds for every $1 cut in state funds
  - States flush with tax $$
  - The Families-First FMAP bump
  - Build Back Better bump
- State budget revenue forecasts for FY22-25 are positive
- Managed Medicaid is NOT a Medicaid renaissance



New Medicaid: Flexibility for States

- Section 1115 Waiver – U.S. Supreme Court
  - HHS attempted to create greater flexibility for Medicaid savings
  - Trump and Biden Administrations provided support via amicus briefs
- VA State Plan Amendments – Utilization and Readmission Penalties
  - Ongoing fight with EM since 2020!
  - Auto downcode for "potentially avoidable" services
  - 30-day readmission penalty for same or similar diagnosis – 50% reduction in payment

"Providers are not entitled to any reimbursement at all, let alone compensation of their "supplies and service" expended in an effort to secure such rates…" – VA Department of Medical Assistance Services

Prudent Layperson Standard (PLP)

- Requires insurers to cover visits based on the patient's symptoms, not the final diagnosis
- Eliminates the requirements for prior authorization before seeking emergency care

Erosion of PLP is the greatest threat in Managed Medicaid

What Are the Key Takeaways for PLP?

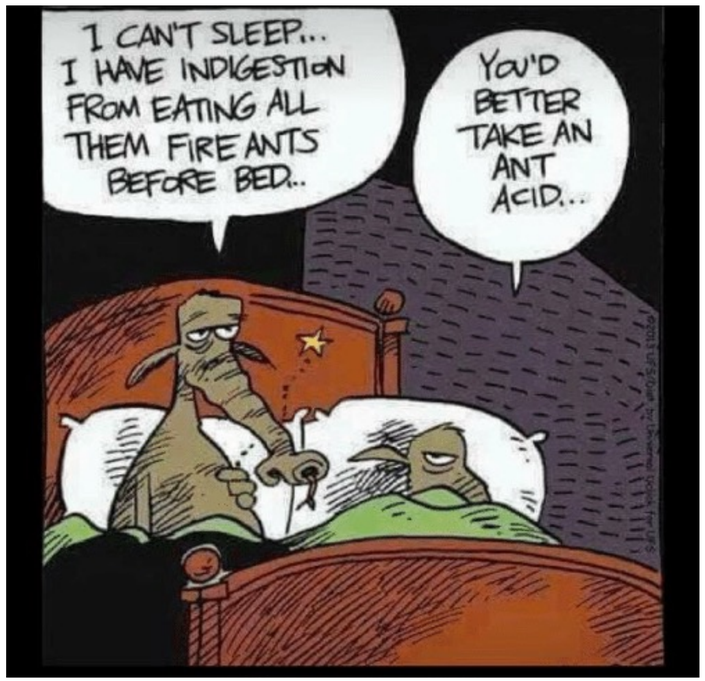
- First enacted in Maryland in 1993, later adopted by Congress in the Balanced Budget Act of 1997, bolstered by the ACA in 2010
- Forty-eight states have codified PLP laws (except for Mississippi and Wyoming)
- Insurers and employers are shifting health care costs onto patients and medical providers in direct violation of PLP
- ACEP.org Stopping Insurer Bad Behavior to track denials and provide resources to ACEP members

How is PLP Defined?

- 2010 ACA Patient Bill of Rights: SEC. 2719A ø42 U.S.C. 300gg–19a. PATIENT PROTECTIONS (B) EMERGENCY SERVICES
  1. Medical screening
  2. Examination
  3. Stabilization
- A Prudent layperson with average knowledge of health and medicine could reasonably expect:
  - Serious jeopardy to health
  - Impairment of bodily functions
  - Dysfunction of an organ or part
- Claims Processing – insurer shall consider the presenting symptoms rather than the final diagnosis as well as the health care services provided

Example of a PLP Situation in the ED

- A 60-year-old male presents to the ED complaining of chest pain, but after the EM Physician performs an MSE, it is determined that the final diagnosis is GERD



Think about the possibilities…

- ✓ Serious jeopardy to health
- ✓ Impairment of bodily functions
- ✓ Dysfunction of an organ or part

Patients who are afraid their ED visit will not be covered by insurance are 50% more likely to delay care

Why Do Patients Make Poor Physicians?

- Tools and Tests – patients lack knowledge, make bad decisions
  - Several insurers believe a blow to the head does not warrant an ED visit if the final diagnosis is a simple scalp contusion
  - JAMA found patients with a low-acuity condition often present with complaints similar to patients with more serious conditions
  - 6% of ED visits treatable in a primary care setting, chief complaint reported were same as 89% of ALL ED visits

Acute respiratory infection	Abdominal contusion
Acute pharyngitis	Alzheimer's Disease

Will Delayed Care Change Perspectives?

- Seeking care becomes a financial calculation when seconds matter
- Insurers believe changing patient attitudes will change behaviors and lower premiums for insurance products
- Hesitation results in greater costs to the healthcare system
  - Heavy burden on primary care
  - Permanent disability or death
  - Liability and legal ramifications

Bottom line: 1 in 4 Americans report their medical condition got worse after they elected to not seek care in an ED

Why Insurers Care About PLP – or Not

- Insurers say the majority of ED visits end with a diagnosis for something that is not an emergency
  - Insurers also say: “If you think you are having an emergency, you should seek emergency care”
- Increasing ED utilization is expensive and unnecessary
  - ED utilization has not exceeded the normal rate of inflation
- Plan members are better served in other acute care settings
  - Urgent and primary care are encouraged as alternatives to the ED

Playing the Game of Insurer Whac-A-Mole…

- Diagnosis List – CPT codes including life-threatening situations:
  - Candida SEPSIS & Meningitis, contusion of the head, foreign body of the throat, neck contusion, and sprains
- Leveling of Services – Direct lower acuity patients to the "correct care setting" for services with lower complexity and severity
  - Level 4-5 auto downcoded to Level 3 by algorithm
- Time Limits – Patients whose chief complaint has been present for greater than 72 hours is now considered non-emergent as the patient had ample time to schedule a visit at a lower acuity setting

Why Diagnosis Lists Violate PLP

- CMS prohibits the use of codes (either symptoms or final diagnosis) for denying Medicare and Medicaid managed care claims
  - No way to capture every scenario for an emergency medical condition
- Discouraging patients from seeking emergency care is a violation of the 2010 ACA Patient Bill of Rights
- Arbitrary, "black box" mechanisms to denying coverage under a policy is a deceptive business practice, not a legal justification

Despite the legal risks, insurers keep posting these policies

How to Play the Game

- **Step 1:** Insurer Posts Illegal and/or Deceptive Policy
  - Usually violates accepted AMA CPT guidelines
- **Step 2:** ACEP responds via Letter
  - "President" writes letter on behalf of emergency physicians
- **Step 3:** Insurer Retracts Policy
  - Unless part of a lawsuit, no admittance of guilt

Process begins again…

What Can Patients Do?

- Contact your state department of insurance and report violations of PLP by your insurer, escalate to state attorney general
- If you have a story to share about how your insurance coverage was denied for an emergency, let ACEP know
- Find out what your health insurance policy covers and advocate for fair and reasonable coverage for emergency care to your state and federal legislators

What Can Doctors Do?

- Contact your state Department of Insurance and report violations of PLP by your insurer
- Keep sending denied claims back to the insurer – it costs them money to deny claims
- Contact ACEP if you receive a letter from an insurer implementing a new non-emergent use of the ED policy, such as diagnosis lists
- Advocate for fair and reasonable coverage for emergency care to your state and federal legislators
- Encourage patients not to delay necessary care

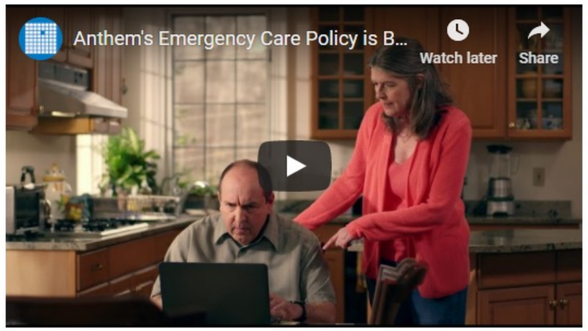
Note: No Surprises Act only addresses rate disputes

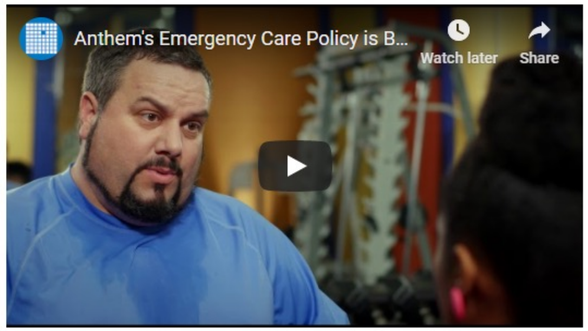
Future of PLP

- Less “diagnosis list” more “let’s pick apart your chart” policies
- States with weak PLP statutes are proposing strengthening language
- Federal lawmakers will need to step up pressure on insurers
- Patient education will continue to be of utmost importance

Support Fair Insurance Coverage

Get informed. Get involved.





Anthem Blue Cross Blue Shield has announced it will not pay for emergency visits in six states: Georgia, Kentucky, Indiana, Missouri, New Hampshire and Ohio, based on secret lists of diagnoses (nearly 2,000 in Missouri from a list that ACEP obtained). Unless stopped, this policy could be implemented in more states, with additional health insurance companies following with policies of their own.

This policy is unlawful, because it violates the prudent layperson standard, which is part of federal law, including the Affordable Care Act, and 47 state laws. Patients can’t be expected to self-diagnose their medical conditions. Two people may have identical symptoms but have different diagnoses — one life threatening, one non-urgent.

Modifier 25 Under Attack

- **Modifier 25:** A significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service
  - A patient sustained a severe laceration to the scalp. Before suturing the laceration, the physician performed and documented a comprehensive history and exam to determine if the patient sustained neurological damage
  - The physician then performed a 3.0 cm intermediate repair (12032) to the scalp
  - Based on the signs, symptoms, and conditions documented, the physician went above and beyond the normal preoperative work. The proper billing would be procedure code12032 and E/M code.

2022: The Year Modifier 25 Died?

- Horizon BCBS of NJ
  - May 2022 policy asked doctors to limit use of Modifier 25
  - ACEP responded in June 2022 challenging merits of policy
- Aetna (TX)
  - August 2022 ACEP becomes aware of Aetna no longer accepting any claims billed with Modifier 25
  - Fraud, Waste, and Abuse claims refuted by ACEP
- Cigna (Nationwide)
  - August 1, 2022 claims to be denied if Modifier 25 is used. ACEP and other medical specialty societies push back, policy rescinded

MCO Claims Appeals Process

- Appeals are made directly to the insurer, not the state
  - Providers in most cases cannot appeal to the state, only to the MCO directly
  - Some states have “reconsideration request” forms
  - Most states will not mediate disputes, as written in the waiver
- Solution is two-fold for providers:
  1. First appeal to the MCO, then to the state
  2. Go through arbitration/mediation - state still has fiduciary responsibility to hear complaints

"You didn't say, 'Mother, may I?'"

Is Medicaid Doomed?

- Satisfaction for enrollees is high but not for doctors
- 1135 Waivers erode ability to enroll able-bodied adults without kids
- MCOs pinching pennies on behalf of state treasuries

BUT…

- New 2023 CPT guidelines protect PLP
- Harmful 1135 Waiver apps abandoned
- Post-COVID unwinding process stalled

Conclusion

- ACEP advocated for protections for patients so they can access the ED without fear of having their claims denied by an insurer unnecessarily
- Insurers responded to federal and state laws by denying claims based on the FINAL diagnosis instead of the SYMPTOMS
- Shifting health care costs to patients for PLP issues is ILLEGAL and should be reported
- Reach out to ACEP with denials, contact federal and state legislators when insurers attempt to pull new shenanigans

Go to ACEP.org Stopping Insurer Bad Behavior

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