consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid News Curator: Volume 4

Reading and highlighting the Medicaid interwebs to save you time

December 28th, 2018

1. Medicaid will use federal tax data to determine eligibility
2. Audit Finds 8% Of Louisiana Medicaid Recipients Don't Actually Qualify For Benefits
3. Mississippi's Republican governor quietly considering Medicaid expansion
4. OHIO: Hearing on revealing CVS Medicaid-billing data is delayed for months
5. Why Pa.-based Amerihealth Caritas, Medicaid insurer, is offering to pay for members' GEDs
6. Ohio Medicaid plan that saves $21 million a year is mysteriously delayed
7. Medicaid Dollars Will Help Hawaii's Homeless Find Housing
8. Missouri could be next battleground over Medicaid work requirements
9. Nearly 200,000 Virginians have enrolled in expanded Medicaid. But 'we're still not getting to everybody,' state says
10. Work requirement back in forefront of Medicaid debate
11. Idaho preparing for Medicaid expansion
12. Changes coming for Spokane Medicaid clients in 2019

SourceURL: http://www.hannapub.com/ouachitacitizen/news/local_state_headlines/medicaid-will-use-federal-tax-data-to-determine-eligibility/article_e9cf5b90-0795-11e9-8d32-e7016e741498.html

Medicaid will use federal tax data to determine eligibility

Louisiana's new Medicaid eligibility and enrollment system will now give the health department access to federal income tax data of potential Medicaid enrollees to ensure they are eligible for Medicaid.

The capability is in addition to numerous other income and employment data sources that are now available to Medicaid to ensure that all recipients meet the strict financial eligibility standards.

The new system has replaced a 1990's-era computer system that used manual entry processes to determine eligibility. Where the old system required eligibility workers to manually access separate and individual data sources to verify income and employment, the new system automatically connects to 20 different data sources to verify eligibility.

Beginning next year, the system will automatically connect to the federal tax information system. This data source will be another tool that will assist Medicaid in verification of yearly reported income, tax filing status and household size. Since each of these information sources has a role in eligibility determinations, Medicaid staff have verification from another source of annual financial information.

Dr. Rebekah Gee, secretary of the Louisiana Department of Health, said replacing the aging eligibility system has been a priority for this administration.

"Whether in a response to an audit or to legislators, we have testified numerous times about the limitations of the computer system we inherited. Today, we now have the system and tools to make more accurate Medicaid eligibility decisions," Gee said.

An audit recently released by the Louisiana Legislative Auditor reviewed 60 Medicaid case files and concluded the old system – one that is no longer in use –

is inadequate.

"The problems uncovered by the auditor in this report should not surprise him or anyone else that follows our agency and Medicaid eligibility, as the findings are about a system that is no longer in use," Gee said.

The findings in the audit released today suggest that Medicaid eligibility determinations, made using the old system, would be more accurate if the agency reviewed federal income tax data before determining if someone meets financial eligibility requirements.

Although the old system did not access these important financial records, the new system connects to 20 different data sources to verify eligibility. In addition, the new system will connect to the federal income tax data system starting in May 2019.

"This new system is designed to address many of the shortcomings that both the Department and the auditor have identified over the past several years," said Gee. "We appreciate the auditor helping to identify areas for improvement, and we are pleased that we are already working to resolve what was identified."

Audit Finds 8% Of Louisiana Medicaid Recipients Don't Actually

Qualify For Benefits

by ABC 30 News

An audit of Louisiana's Medicaid program found that the state could save more than $100 million per year if it starts verifying that recipients are eligible through income tax records. A report by Louisiana's Legislative Auditor indicates that for every 60 people to whom the state has been paying Medicaid benefits, 5 are not eligible (8%).

BATON ROUGE, La. —
An audit of Louisiana's Medicaid program found that the state could save more than $100 million per year if it starts verifying that recipients are eligible through income tax records. A report by Louisiana's Legislative Auditor indicates that for every 60 people to whom the state has been paying Medicaid benefits, 5 are not eligible (8%).

It is the second audit of Louisiana's Medicaid program, which was expanded by Governor John Bel Edwards in 2016.

The Louisiana Department of Health says that the state is now starting to automate its system for determining eligibility, which will cost nearly $178 million (mostly paid for with federal tax money).

The first report, released in November, focused solely on wage verification and estimated that the state was spending at least $85 million per year to ineligible recipients. The new report evaluates the overall process for determining eligibility in light of new federal guidelines for using modified adjusted gross income.

SourceURL: https://www.politico.com/story/2018/12/22/mississippi-medicaid-expansion-phil-bryant-obamacare-1050178

Mississippi's Republican governor quietly considering Medicaid expansion

The term-limited Phil Bryant has been holding secret talks after an election that showed strong support for the Obamacare program in red states.

By PAUL DEMKO

12/22/2018 06:46 AM EST

JACKSON, Miss. — Mississippi's Republican governor is considering Medicaid expansion, the first sign that long-held GOP opposition could be wilting in the Deep South after an election that was a big winner for the Obamacare program.

Republican Gov. Phil Bryant, entering his final year in office, has been engaged in quiet talks about adopting expansion after resisting for years, according to two sources familiar with the discussions.

The behind-the-scenes move comes as a surprisingly viable Democratic gubernatorial candidate is planning to make Medicaid expansion a central issue in the 2019 election. But in an even more unlikely scenario, Republicans could beat him to it and undercut a key Democratic message.

Until now, Medicaid expansion has largely been ignored in the Republican-dominated state, one of the sickest and the poorest in the country. Even Mississippi Democrats have largely dismissed it as politically unviable since a 2012 Supreme Court decision made the program optional for states.

Bryant has been exploring how the state could expand Medicaid to roughly 200,000 low-income adults with a conservative approach adopted in other red states. According to a Mississippi Today report this week that first cited Bryant's interest in Medicaid expansion, one of the states he's eyeing is Indiana, which under then-Gov. Mike Pence required enrollees in expanded Medicaid to pay premiums and co-pays.

"The governor's trying to figure out how to expand Medicaid without calling it expansion," said one source familiar with the discussions, speaking on background because of the sensitivity of the subject.

Publicly, Bryant's office is distancing the governor from Medicaid expansion discussions.

"The Mississippi Hospital Association approaches the Office of the Governor each year with a new plan to expand Medicaid," said Bryant spokesperson Knox Graham in an email. "We don't expect this to be a part of our legislative agenda."

Last month's election showed strong support for Medicaid expansion in deep red pockets of the country — voters in Idaho, Nebraska and Utah all easily approved ballot measures ordering Republican officials to adopt the optional program. However, it also showed there are limits to how far health care can carry Democrats in the South. Gubernatorial candidates Andrew Gillum in Florida and Stacey Abrams in Georgia both ran on expanding Medicaid and narrowly lost in states where hundreds of thousands of low-income adults have been shut out of the program.

Even if Bryant embraced Medicaid expansion, he would still need support from the Republican-dominated legislature — no sure bet, especially after a Texas judge last week ruled Obamacare was unconstitutional. The law remains in

effect, but the legal battle could drag into 2020, giving skeptical lawmakers political cover to keep refusing Medicaid expansion.

State Sen. Brice Wiggins, who chairs the Medicaid committee, said the debate over expansion is a "distraction" since the Legislature has never considered it. Instead, he said the state should focus on creative ways of bringing down costs for the existing program — the largest item in the state budget — through expanded telemedicine and emphasizing preventive care, among other ideas.

"Expansion alone is not going to solve the problems that we're facing," Wiggins told POLITICO during an interview in his office at the state Capitol. "We have to be creative and find other ways to address our situation."

In Mississippi, many Democrats thought Medicaid expansion was a lost cause. But four-term Mississippi Attorney General Jim Hood, a rare Democrat holding statewide office in the Deep South, decided to change that. He plans to make support for Medicaid expansion a major plank of his gubernatorial campaign next year — one of the few off-year races in the country.

"You saw what happened in the midterms," said Michael Rejebian, a senior adviser to Hood's campaign who's worked on every one of his previous statewide races. "Health care was *the* issue, and it will be *the* issue in this campaign."

Mississippi is among the unhealthiest states in the country, with high rates of diabetes, cancer deaths and heart disease. For the last five years, the state was last or next to last in a nationwide ranking of health metrics by the United Health Foundation.

The state's gubernatorial race could test whether the Deep South's Medicaid expansion firewall will begin to crack. In the region, only Arkansas and Louisiana have expanded Medicaid under Democratic governors.

Hood has already proven he could compete statewide in Mississippi, having won every race for attorney general by double digits. And he'll make the case that the state's beleaguered rural hospitals could only survive with the massive infusion of federal cash Medicaid expansion would deliver. Five have closed since Obamacare passed in 2010 and another four are in bankruptcy.

"When a rural hospital closes it destroys an entire community," Rejebian said. "What can we do to make sure that those rural hospitals stay open?"

Lt. Gov. Tate Reeves, the likely Republican gubernatorial nominee, has staunchly opposed expanding Medicaid, arguing the state already typically struggles to fund the existing $1 billion-per-year Medicaid program. The federal government funds the vast majority of Medicaid expansion costs, but states handle a small portion and will eventually be on the hook for 10 percent.

Reeves has also backed new work requirements encouraged by the Trump administration that would undoubtedly force some poor adults off their Medicaid coverage.

Reeves spokesperson Laura Hipp said he was unavailable for an interview over the course of two weeks because of out-of-town travel. Reeves did not respond to written questions that were submitted at Hipp's request.

Richard Roberson, the Mississippi Hospital Association's vice president of policy and state advocacy, argued Medicaid expansion is crucial for the financial viability of hospitals, which have also been hit by Medicare reimbursement cuts in recent years.

"It's like a driving a car with three good tires," Roberson said. "At a certain point you've got to pull over and fix the tire."

Rachana Pradhan contributed to this report.

This story was produced with the support of the Dennis A. Hunt Fund for Health Journalism, a program of the USC Annenberg School of Journalism's Center for Health Journalism.

OHIO: Hearing on revealing CVS Medicaid-billing data is delayed for months

By Marty Schladen
The Columbus Dispatch
@martyschladen
Posted Dec 24, 2018 at 5:46 AM Updated Dec 24, 2018 at 5:46 AM

Important information in a report that the Ohio Department of Medicaid commissioned this year now will remain secret well into next year.

It will remain secret past the time when the legislature will consider a budget, billions of dollars of which might go to CVS, and possibly past the time when a federal judge in Washington, D.C., will decide whether to approve CVS's $70 billion merger with insurance giant Aetna.

The Medicaid department in July released a blockbuster report showing that CVS Caremark and another pharmacy benefit manager, OptumRx, were billing the state a quarter of a billion dollars more per year for Medicaid drugs than they were paying the pharmacists who dispensed them. However, the report was heavily redacted — including large blacked-out areas in which reimbursement rates to chain pharmacies that compete with CVS are listed.

Whether CVS was playing fair with those competitors could have an impact on many multibillion-dollar decisions now in the works.

Pharmacy benefit managers act as middlemen, billing insurance companies, paying pharmacies and negotiating rebates with drug manufacturers. Ohio lawmakers, including Sen. Bill Coley, R-Cincinnati, have questioned whether CVS has used its business as PBM to four of Ohio's five Medicaid managed-care plans to unfairly advantage its retail pharmacies over competitors.

Coley noted last week that the latest delay in the court fight over releasing the redacted information will push the matter past when Ohio's next budget is approved in June. At the same time, U.S. District Judge Richard Leon has paused the CVS/Aetna merger while he considers whether antitrust concerns raised by the American Medical Association and other groups have been sufficiently weighed.

The Medicaid department and its legal representative, the Ohio attorney general, have been arguing since summer that the entire report, produced for the Medicaid department by HealthPlan Data Solutions, should be made public. But in July, CVS and OptumRX sued, arguing that the document contained proprietary information.

The case dragged into December, but Franklin County Common Pleas Judge Jenifer French postponed the hearing until April 29 — 10 months after the redacted report was released.

It took lawyers in the case until Dec. 7 to agree to a method of protecting the confidentiality of the redacted information in the report, and now witnesses must be interviewed, said Dan Tierney, spokesman for Attorney General Mike DeWine.

Asked about the delay, Ohio Medicaid spokesman Tom Betti said, "Our position has not changed. We want this information to be released."

Perhaps undercutting the trade-secrets argument is that CVS and OptumRx asked to hide some — but not all — pharmacy reimbursement rates. Not blacked out were rows showing that CVS and OptumRx paid independent pharmacies more than they paid CVS pharmacies — a fact that CVS has made much of this year as independent pharmacies complained that CVS practices are putting them out of business.

CVS spokesman Michael DeAngelis was asked why only reimbursement rates to independent pharmacists were released. Does that mean CVS was paying competing chains less than it was its own pharmacies? He responded that reimbursements to independents already had been released when Ohio Medicaid released an initial summary of the report.

"We asked for the other information to be redacted, because the disclosure of our proprietary rates, formulas and negotiation strategy to lower the drug prices charged by pharmaceutical manufacturers would significantly impact our ability to negotiate the lowest rates and fees for our clients in a highly competitive

market, which would ultimately cost the state and the taxpayers more," DeAngelis said in an email.

Critics are skeptical.

"It's an interesting juxtaposition to see CVS rushing at breakneck speed past judges and regulators to clear a $70 billion merger, but on the other end dragging their feet on releasing 30 pages worth of redactions," said Antonio Ciaccia, spokesman for the Ohio Pharmacists Association. "Call me old-fashioned, but I think the public deserves to know how $2.6 billion (annual Ohio spending on Medicaid managed-care drugs) of their hard-earned taxpayer dollars are being spent."

mschladen@dispatch.com

@martyschladen

Why Pa.-based Amerihealth Caritas, Medicaid insurer, is offering to pay for members' GEDs

by Phil Galewitz, Updated: December 26, 2018- 5:31 PM

Emilia Ford became pregnant at 15 and, after her daughter was born, dropped out of high school.

As she held down different jobs during the last decade — including housekeeping and working in a relative's retail store — she always thought about going for her GED to show she met high school academic skills.

But the Brookhaven woman needed assistance finding tutors and paying for the set of four tests, which cost $30 each.

She found help at the time from an unexpected source: her Keystone First Medicaid plan.

Its parent, AmeriHealth Caritas, majority owned by Philadelphia-based Independence Blue Cross with two million Medicaid members in Pennsylvania and five other states, helps connect members with nonprofit groups providing GED test preparation classes. The insurer also offers telephone coaching to keep members on track, and pays $120 for each person to take all four parts of the GED. Child care and transportation are provided if needed, while some employees even provide coaching.

Ford is one of 62 plan members who have earned a GED certificate since the benefit began in 2013.

"I could not believe this was something a health insurance company would do," said Ford, 25. "I thought health insurers only paid for medical costs."

Not anymore.

Medicaid health plans are starting to pay for nontraditional services such as meals, transportation, housing, and other forms of assistance to improve members' health and reduce medical costs.

That change follows efforts by state Medicaid programs to give health plans financial incentives to control spending, said Jill Rosenthal, senior program director for the National Academy for State Health Policy.

Rather than continue to pay a set fee each month to cover members' health costs, many states are implementing policies that let health plans share in any savings they can demonstrate. That provides motivation for insurers to address factors such as literacy and poor housing, which can drive up health costs.

"Health plans now have incentives for them to find the root causes of problems that will reduce costs that will benefit the plan, its beneficiaries, and the states," Rosenthal said.

AmeriHealth Caritas CEO Paul Tufano said studies show people with lower educational levels tend to be in poorer health. "Helping members attain their GED can be incredibly consequential for them to live the kind of life they want to live," he said.

But Tufano acknowledged that only a small fraction of people who need the assistance reach out for it. About 1,000 members have started GED training through the insurer in Pennsylvania, Louisiana, South Carolina, and Delaware.

"Many of our members are just surviving to keep their heads over water, holding onto jobs and dealing with issues like safe housing, access to food, and transportation to get to work or doctor," he said.

AmeriHealth Caritas is one of just a handful of Medicaid health plans that offer a GED benefit.

WellCare, which covers 2.2 million Medicaid recipients in Missouri, Nebraska, Georgia, Kentucky, Hawaii, and Illinois, had 226 members sit for their GED

exams since the plan began paying for that in 2012, said spokeswoman Alissa Lawver. The Tampa-based plan does not know how many passed.

A Wellcare survey of its Medicaid adult members in Georgia in 2012 found that about 20 percent did not have a high school diploma or a GED.

"There is a significant relationship between education and health," Wendy Morriarty, president of WellCare's 'Ohana Health Plan in Hawaii, said when launching the benefit in 2016. "A GED is a tool that can lead to increased opportunities for our members to attend college, seek higher-paying jobs, and find stable housing. This benefit has the ability to improve the health and well-being of local families and communities."

Advocates for Medicaid praise the health plans' efforts.

"I think this sets the standard for the unique role of Medicaid managed care in bridging health care and social services," said Sara Rosenbaum, health law and policy professor at George Washington University.

Ford said having a coach at AmeriHealth walk her through the sign-up process for GED classes, help her register for tests, and call her twice a week to keep her motivated was vital to her success. The program also offered child care and transportation to the prep classes and exam sites. She started in May 2017, taking two classes a week, and passed her exams last summer.

When she finished, AmeriHealth hired Ford as an intern in its member services department. In December 2017, the insurer hired Ford to a full-time position — with health benefits — to work as a GED coach for other Medicaid members.

The job meant Ford became the first of nine siblings to get off Medicaid and find employer-based coverage.

"I feel like I was saved from the struggle I was going through," Ford said. "This is something big that my family was proud of." While she was growing up, she said, her father drove a school bus and her mom took care of the kids.

In the past year, Ford has helped 12 plan members earn their GEDs, and she's coaching 30 more.

"I can tell them I have been where you are on the other side of the phone and can share my experience, and it helps give them more trust in me," Ford said.

"The hardest thing is not giving up even after failing a test, and being able to get back up and push yourself and get over the discouragement," she said. "There is always something good that you can take from a bad situation."

Kaiser Health News (KHN) is a nonprofit news service covering health issues. It is an editorially independent program of the Kaiser Family Foundation that is not affiliated with Kaiser Permanente.

Ohio Medicaid plan that saves $21 million a year is mysteriously delayed

By Catherine Candisky
The Columbus Dispatch
@ccandisky
Posted Dec 25, 2018 at 8:02 AM

The Ohio Department of Medicaid has abruptly dropped long-planned changes to its prescription drug program projected to save taxpayers $42 million over two years.

Medicaid officials announced earlier this month they "delayed indefinitely" a plan unveiled two years ago by Gov. John Kasich to implement a single or unified

preferred drug list — those medications covered without prior authorization — for all beneficiaries.

"The initiative to implement a unified (drug list) on Jan. 1, 2019, has been delayed indefinitely," the Department of Medicaid wrote in a memo to all managed care plan providers.

The announcement was an about-face from Kasich's last budget plan and an October 2018 memo from the Department of Medicaid's reminding service providers the change would take effect starting next year.

"We decided to concentrate our efforts on behavioral health and substance use disorder," said Medicaid spokesman Tom Betti. He declined to provide any further explanation about the decision. The Columbus Dispatch, a sister publication of The Canton Repository, has filed a public records request for all department communications on the matter.

The state's $25 billion Medicaid program provides health coverage to about 3 million poor and disabled Ohioans.

Most are enrolled in one of five managed care plans, each which pays a pharmacy benefits manager to negotiate prices and rebates with drug companies, create preferred drug lists, and pay pharmacies to fill prescriptions for beneficiaries.

For those not enrolled in a managed care plan, like many nursing home residents, Medicaid's fee-for-service program also has its own preferred drug list.

Under the governor's plan, Medicaid fee-for-service and managed care plans would use the same preferred drug list and prior authorization policies.

"A single (preferred drug list) increases Medicaid's bargaining power with manufacturers to seek higher supplemental rebates," said Kasich's 2018-2019 budget proposal, which also projected the $42 million savings.

Rebates help lower overall drug costs; however deals negotiated by pharmacy benefit managers are kept secret, so while state officials know how much rebate money is passed along to them, they have no idea how much is kept by the PBM.

"Rebate amounts are confidential, so the health plans do not know the state's after-rebate cost for drugs and are not able to choose preferred drug lists that have the best net cost to the state," according to the governor's proposal.

In its October memo detailing the plan, Medicaid officials wrote: "The Ohio Department of Medicaid, in partnership with the Medicaid managed care plans (MCPs), is moving toward creating a unified preferred drug list ... beginning Jan. 1, 2019, all Ohio Medicaid MCPs will prefer the same medications and use the same prior authorization criteria for diabetes (insulin and non-insulin) hepatitis C drugs, and medication assisted treatment (MAT) for opioid disorder. ODM is using a phased-in approach to build a unified PDL, adding more categories to it later in 2019."

Managed care plans and their PBMs have handled drug benefits for Medicaid since 2011.

The plans opposed the change.

"Ohio's health plans were concerned about the cost impact to the Medicaid program and the impact on member care," said Miranda Motter, president and CEO of the Ohio Association of Health Plans.

Sen. David Burke, R-Marysville and chairman of the Joint Medicaid Oversight Commission, said it makes some sense to delay implementation.

"They ran the numbers and realized it might not have the impact they thought it would," Burke said.

He also noted starting Jan. 1, Ohio Medicaid will abandon its secretive prescription drug-pricing system and move to a transparent system that for the first time will disclose exactly how billions in taxpayer dollars are being spent.

The new system abolishes "spread pricing," which has allowed PBMs to pocket millions by billing managed-care companies more than they pay pharmacists to fill prescriptions and keeping the rest to cover their expenses plus a profit that a state consultant says is three to six times the industry standard.

Under the new "pass-through" model, PBMs will be paid an administrative fee and be forced to pay pharmacists the same as the PBM bills the state. It also for the first time will require PBMs to disclose all revenue they receive, including fees, rebates and other money from manufacturers.

"Why guess when you can know," Burke said. "Starting Jan. 1, we will know actual costs."

Medicaid Dollars Will Help Hawaii's Homeless Find Housing

Federal money will be available to help certain Medicaid recipients with the search for housing, but not to pay rent.

Homeless people in Hawaii who are enrolled in Med-QUEST, the state's Medicaid program, will have access to housing support services starting Jan. 1 that were previously offered to only a handful.

Medicaid dollars can't pay for rent, but under a waiver granted to the state by the federal government in October, Med-QUEST plans will cover the cost for caseworkers who do the legwork of getting people into housing and keeping them housed.

It's the "supportive" part of "permanent supportive housing" programs and typically involves getting paperwork and identification together, convincing landlords to accept a homeless tenant, and helping newly housed people access resources so they don't fall back into homelessness.

"A lot of the outreach and case management services that right now get paid out of state or city general fund dollars could be paid for through the Medicaid health plans," said Scott Morishige, the state's homeless coordinator. "It's a pretty groundbreaking thing that only a small number of states have."

Dr. Judy Mohr Peterson, the Med-QUEST administrator, spent two years working on an application to amend a waiver to loosen restrictions on how federal Medicaid dollars can be spent on housing support services.

Cory Lum/Civil Beat

At least eight other states have requested waivers from the federal Centers for Medicare & Medicaid Services that would loosen restrictions on Medicaid spending, allowing them to use Medicaid funds for housing support, according to the Corporation for Supportive Housing.

State and city funds freed up through the waiver can be used to build housing or offer rental assistance to more people, Morishige said.

Med-QUEST has offered tenant support services through a 1115 waiver granted to the state in 1994, but only people who were diagnosed with mental illness and unable to perform daily activities, like bathing or feeding themselves, were eligible.

Med-QUEST administrator Dr. Judy Mohr Peterson called it a "pretty high bar" to qualify, and said a few hundred people were able to access the services over the course of four years.

Peterson worked to amend the waiver so that more people would qualify.

Now, the service is available to people who are homeless or at risk of being homeless and who also have a mental illness, chronic health problem or substance use disorder.

"Before we had a more narrow set of services for a very narrow population, but this expanded it to a much broader and more meaningful population," Peterson said.

The new service, Peterson said, is meant to target the estimated 1,714 people in Hawaii who meet the U.S. Department of Housing and Urban Development's definition of "chronically homeless," meaning they have a disability, chronic illness, serious mental illness or substance abuse disorder and have been homeless for a certain amount of time.

The majority of this population is also eligible for Medicaid, Peterson said.

In 2019, Peterson estimates Medicaid can serve 10 percent of Hawaii's chronically homeless population but as health care providers and social service agencies collaborate to make the service more accessible, she hopes within three to five years the entire population can get housing support through Medicaid.

> *"I'm looking forward to a time where we consider housing a form of health care." – Lt. Gov. Josh Green*

The waiver might also help nonprofits save money.

The Institute for Human Services and other social service nonprofits offer tenancy support through various programs they operate under state and city contracts. The administrative budgets of those contracts, which pay for the salaries of housing specialists, seem to be decreasing every year, said Kimo Carvalho, community relations director at IHS. The nonprofit relies on money from private donors to supplement contracts and the Medicaid funding will now offer another source of funds.

Carvalho also said getting people into housing and keeping them housed can ultimately reduce Medicaid expenses

Living on the streets exacerbates chronic diseases such as hypertension, asthma, diabetes and mental illnesses, according to the National Health Care for the Homeless Council.

Heath care costs drop once people are housed, said Hawaii Lt. Gov. Josh Green, an emergency room doctor. Some homeless people also frequent emergency rooms to manage their health problems, which is more costly than preventative care.

Gary Grinker, a homeless man who received services through IHS, went to the hospital 241 times in 2017, making him the most frequent user of the emergency room at Queen's Medical Center and costing Medicaid $1.2 million that year, according to Carvalho.

"He was using the emergency room as a place to take care of basic health needs," Carvalho said.

Green said the waiver is a step in the right direction.

In 2017, Green, then a state senator, introduced a bill that would classify chronic homelessness as a medical condition. Insurance companies would need to pay for the treatment, and Green envisioned the state's Medicaid budget paying for housing.

"I'm looking forward to a time where we consider housing a form of health care," Green said. "Our concept of what is needed for a safety net has to also evolve."

Missouri could be next battleground over Medicaid work requirements

JEFFERSON CITY ● Republicans who control Missouri's Legislature may again try to push through a controversial plan that could strip tens of thousands of low-income people of their health care benefits.

Rep. Curtis Trent, R-Springfield, and Sen. David Sater, R-Cassville, have introduced proposals requiring some Medicaid recipients to work, attend school, search for a job or volunteer at least 80 hours a month to keep their health insurance through the publicly funded program.

If approved, and the federal government signs off, Missouri would join a handful of other states that have attempted to impose the controversial requirements on their poorer residents.

In Arkansas, where more than 12,000 residents have lost their benefits since the change took effect in June, the requirements are being challenged in court. Oklahoma is awaiting approval for its plan from President Donald Trump's administration.

Sater said the legislation is written to affect only recipients who can work. It would apply to participants who are between the ages of 19 and 64, who are not medically frail or pregnant or caring for a child under the age of 1.

"Businesses are having a hard time finding workers. There are plenty of jobs out there," Sater said. "This is for able-bodied adults. It's not for (the) disabled."

Trent said the plan would likely affect between 70,000 and 90,000 of the more than 900,000 people who are enrolled in Medicaid.

"The idea here is to encourage people who are able-bodied to get back into the workforce. It's not really a novel kind of idea. The economy is doing well. It's a

good time to make this transition," Trent said.

Supporters say requiring low-income people to work as a condition of receiving benefits will help them move up the economic ladder and cut costs for the state. "It's really kind of a gentle encouragement," Trent said.

Opponents say it could force people to seek care at emergency rooms, as well as add costs to the state by forcing officials to hire more people to manage the program.

Former state Rep. Jeanette Mott Oxford, D-St. Louis, called the proposal "really, really cruel."

"We expected these would be back," said Mott Oxford, who heads Empower Missouri, which lobbies on behalf of low-income Missourians. "We're sorry to see Senator Sater bring this up again."

Sater said he doesn't believe the change would create a financial burden on state coffers. "The burden is people not working," Sater said.

Added Trent, "I don't envision a lot of people getting kicked off the rolls. I think most people will just comply with the requirements."

Similar legislation advanced through the public hearing process last year, but did not win final approval in either chamber before lawmakers went home in May.

In addition to targeting Medicaid recipients, lawmakers also are expected to consider expanding similar work requirements for people receiving food stamps.

The Supplemental Nutrition Assistance Program, or SNAP, pays out an average benefit of about $120 per month.

An analysis of a similar measure that failed to advance last spring noted that about 42,000 people would be barred from receiving the benefits if the legislation had been approved.

Like the Mo HealthNet work requirement, Mott Oxford said there is no guarantee the change to food stamps would save any money.

Not only would a tracking system have to be put in place, but additional government employees would have to be hired to monitor the recipients.

"The state needs to acknowledge there will be a cost," Mott Oxford said.

In recent years, the Legislature has decreased the number of Missourians receiving public benefits in an attempt to control costs.

A 2015 law cut welfare rolls, for example. In the years since, about 23,000 fewer children have received benefits.

Nearly 200,000 Virginians have enrolled in expanded Medicaid. But 'we're still not getting to everybody,' state says

Alicia Pabillo 52, signs the Medicaid application during the two-day Celebrate Healthcare Mega Health Insurance Marketplace. (John Sudbrink / Daily Press)

Kenneth Young hasn't been taking his heart medication.

Work has been slow for the 53-year-old plumber from Hampton, and he doesn't have insurance, so he can't afford treatment.

"My heart skips a beat," he explained.

Inside the Hampton Roads Convention Center, where a two-day health care enrollment fair was taking place on Dec. 14, Young spent 15 minutes on the phone getting enrolled in Medicaid for the first time.

Starting Jan. 1, his heart medication will be covered.

Earlier this year, the General Assembly voted to increase the number of Virginians who qualify for Medicaid, the federal program that provides health insurance for poor and disabled people, among others. State Medicaid Director Jennifer Lee said so far, the state is on track to enroll 360,000 people in the first 12 months.

Jazmen Farrow a representative for Medassist Bon Secours Patient Services helps local residents with information abouting signing up for Medicaid during the two-day Celebrate Healthcare Mega Health Insurance Marketplace. (John Sudbrink / Daily Press)

As of Wednesday, 196,135 people had enrolled. The expansion, based on qualifying incomes, now allows a family of three that makes $28,677 a year eligible for Medicaid.

"There is so much demand," Lee said in a phone interview on Dec. 18, adding call center staff has more than doubled in anticipation of high enrollment numbers.

"Workers are packed in there, they are working overtime," she said.

Terri Phillips, a benefits program manager with the Hampton Department of Human Services, said her staff's caseloads have "exploded."

"Our only challenge is the volume of work," she said. She expects 6,000 new enrollees in Hampton.

To ease the workload, Lee said her department is working on more automated processes that reduce the manual data entry when enrolling people.

Jazmen Farrow and Larhonda Johnson, who work for a company called MedAssist that helps enroll people in Medicaid, said the process has gotten easier now that more people qualify.

"It's a lot harder to tell them there's nothing we can do for them," Farrow said.

Despite enrollment being on track, Lee said there's still a need to get the word out that Medicaid enrollment is open and ongoing — unlike open enrollment for the individual health care marketplace, which closed Dec. 15, Virginians can enroll in Medicaid at any time.

"We're still not getting to everybody, and I know that because I've been out in the community, and they don't know (they qualify)," she said.

Work requirements, which Republicans in the General Assembly demanded as a condition of expansion, are still up in the air.

Lee said the waiver application that would let Virginia require Medicaid enrollees to provide proof of work is in the hands of the federal government, which has allowed public comment on the waiver until Jan. 6.

After that, Lee said, the federal Medicaid officials will work with her department until the waiver is approved.

Attorney General Mark Herring has also raised concerns that Medicaid expansion could be wiped out if a ruling by a federal judge in Texas sticks.

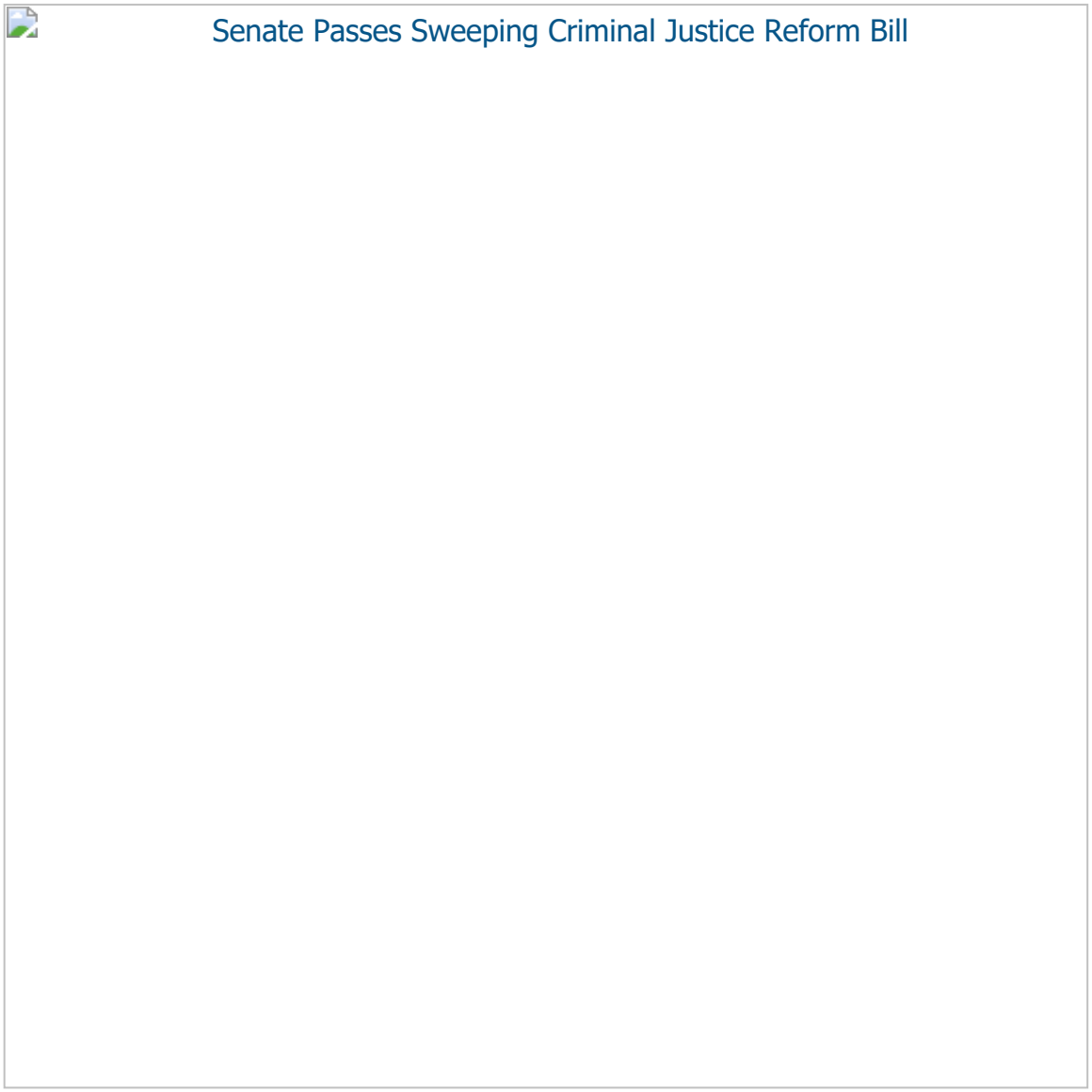
Judge Reed O'Connor said on Dec. 15 the Affordable Care Act, which offered states the chance to expand Medicaid, was unconstitutional.

On Dec. 17, Herring and 16 other attorneys general asked the deciding judge for clarification on his ruling. They are also trying to appeal the Texas judge's decision.

“If this decision takes effect, millions of Virginians and Americans with pre-existing conditions will lose critical protections, Medicaid expansion will be under threat, and millions of Americans will suffer from reduced access and higher costs. The stake are too high to let this decision stand without a fight,” he said in a news release.

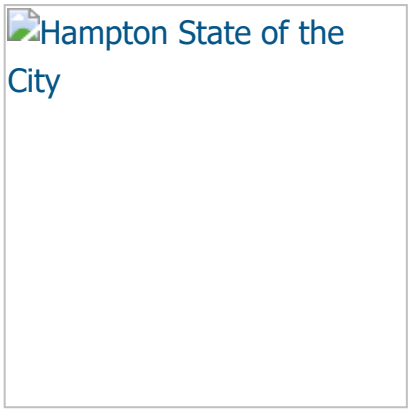
Lee stressed the ruling isn’t final, so Virginians who enroll in Medicaid won’t be affected as long as the lawsuit continues in the courts.

“At this point, we’re not concerned,” she said.



CAPTION

CAPTION



CAPTION


Elaine Luria claims victory against Scott Taylor

CAPTION


Democrats Win the House in Midterm Elections, Republicans Hold the Senate

CAPTION

CAPTION

Marie Albiges, 757-247-4962, malbiges@dailypress.com, @Mariealbiges

NH: Work requirement back in forefront of Medicaid debate

CONCORD — Continuing the expansion of Medicaid health insurance to more than 50,000 low-income New Hampshire residents was supposed to be last year's legislative battle. But as 2019 dawns, the program now known as Granite Advantage Health Care is again atop the legislative agenda.

In one of her first acts as a state senator, former state Rep. Cindy Rosenwald, D-Nashua, will soon introduce legislation dealing with work requirements for Medicaid beneficiaries. The bill has been "filed confidentially" according to a state Senate spokesman, and its language is not yet ready for public release.

One bill that has been filed publicly by newly elected Concord state Rep. Rebecca McWilliams would remove the work requirement from the Granite Advantage program.

At issue is the question of whether able-bodied adults not involved in caring for a dependent child should be required to work or engage in community service or job training for at least 100 hours a month to qualify for the federally funded health insurance.

That work requirement was a key part of the deal struck between Republicans and Democrats in 2018 to extend the program, seen as essential in the fight against opioid addiction, for at least another five years. It was scheduled to sunset on Dec. 31.

The federal government, through the Centers for Medicaid and Medicare, approved the work requirement last week, but with some changes to the rules governing eligibility.

That set off a firestorm in Concord, where Democrats accused the Trump administration of tinkering with a carefully crafted compromise in the hope of dumping eligible recipients off their health insurance.

Fears of confusion

The changes will be "expensive to administer and cause confusion, chaos and loss of coverage for thousands of people," according to Dawn McKinney, policy director at N.H. Legal Assistance, which advocates for low-income families.

Rosenwald's bill will "codify New Hampshire-specific rules in state law," according to a statement from the Senate Democrats, in an attempt to push back on the

federal changes.

Republicans at the State House say the federal changes are minor and consistent with principles both parties agreed to in passing Senate Bill 313, the expanded Medicaid reauthorization. They want the state to accept the federal rules and move on, warning that any state challenge to the changes puts the federal approval at risk.

Department of Health and Human Services Commissioner Jeffrey Meyers also thinks the federal changes can be accommodated without violating the spirit of the SB 313 compromise.

Republican leaders in the State House in the days before Christmas suggested that Democrats never really liked the work requirement and were trying to use the rules process to upend it.

"This was negotiated in good faith, and compromises were reached on both sides," said House Minority Leader Dick Hinch, R-Merrimack. "Clearly, this is an organized effort by Democrats to bypass the bipartisan agreements made just this year."

The key question is, how onerous are the federal changes? Both sides are far apart on that analysis, and the details are incredibly complex.

Vote applauded

McKinney applauded the Dec. 20 vote by the Joint Legislative Committee on Administrative Rules to object to the federal changes.

"The rejected rule would subject some people who rely on Medicaid for their health coverage to harsh work reporting requirements," she said. "Objecting to the proposed work requirement rule was a responsible decision, given the potential ramifications."

According to McKinney, almost 17,000 people have lost their Medicaid coverage in Arkansas since September, due to that state's work requirement.

"Kentucky has been mired in litigation over this issue for months with no resolution in sight," she said. "New Hampshire Legal Assistance is working hard

with our partners in other organizations to make sure the same thing doesn't happen here."

According to DHHS figures, about 45 percent of the population on expanded Medicaid is already working full- or part-time, and another group will qualify for one of several exemptions from the requirement, leaving as many as 15,000 recipients facing the work or community service mandate.

Despite warning alarms sounded by Republicans, McKinney, Meyers and others maintain the state's pushback on the federal rule change will not jeopardize Medicaid coverage scheduled to take effect on Jan. 1.

"Our state leaders have time now to develop a common-sense, bipartisan New Hampshire solution," says McKinney. "Hard-working New Hampshire families don't need any more red tape. They need health care coverage so they can stay healthy and continue to provide for their families."

dsolomon@unionleader.com

SourceURL: https://lmtribune.com/northwest/idaho-preparing-for-medicaid-expansion/article_30785001-be2e-5edf-bda9-9ba8df0c0f9a.html

Idaho preparing for Medicaid expansion

With path cleared, funding and legal hurdles remain for measure that is critical to coming legislative session

Scott Bedke

Despite legal challenges at the state and federal level, the Idaho Department of Health and Welfare is moving ahead with a citizen-directed Medicaid expansion effort.

Health and Welfare spokeswoman Niki Forbing-Orr said the agency expects to submit its amended state Medicaid plan to the federal government for approval by Feb. 15.

Voters authorized the move in November, after years of inaction on the part of the Idaho Legislature, when they approved the Prop 2 Medicaid expansion initiative by a margin of 61 percent to 39 percent.

The measure directs the state to expand Medicaid eligibility rules to include anyone earning less than 133 percent of the federal poverty level. That will provide access to preventative health care services for about 62,000 low-income Idahoans.

Barring any hiccups, Forbing-Orr said, the new rules should take effect Jan. 1, 2020.

Legislative approval isn't needed to amend the state plan. However, once the 2019 session begins Jan. 7, lawmakers will need to adopt a budget authorizing the expenditure of federal Medicaid dollars. They also have to decide how to fund the state's 10 percent matching share of the expansion costs.

Given Republican concerns about entitlement programs, there's also talk about adding conditions to the rules, such as work requirements and/or personal responsibility measures.

If they go that route, Forbing-Orr said, lawmakers will have to pass a separate waiver request. Like the amended state plan, that waiver would be subject to approval by the federal Centers for Medicare and Medicaid Services.

House Speaker Scott Bedke, R-Oakley, said Medicaid expansion is certain to be a major topic of discussion during the 2019 session.

"Everyone has an idea," he said. "I don't have a good feel for how it's going to play out, but it's on the 'must address' list for everyone."

Adding to the complexity, a federal judge in Texas recently ruled that core pieces of the Affordable Care Act — which authorized Medicaid expansion — are unconstitutional. That ruling almost certainly will be appealed.

Another lawsuit in Idaho seeks to block implementation of Prop 2 by claiming it delegates too much authority to the federal government. The Idaho Supreme Court will hold oral arguments in that case Jan. 29.

Given these unresolved legal challenges, some Republicans may try to delay any action on Prop 2.

"They've been using (the legality of the ACA) as an excuse forever, so I wouldn't be surprised if that continues," said House Minority Leader Mat Erpelding, D-Boise. "I don't expect there to be any movement until after Jan. 29. For us (Democrats), the focus will be on implementing the will of the people."

Spence may be contacted at bspence@lmtribune.com or (208) 791-9168.

SourceURL: https://www.kxly.com/news/changes-coming-for-spokane-medicaid-clients-in-2019/952531114

WA: Changes coming for Spokane Medicaid clients in 2019

prev

next

SPOKANE, Wash. - Healthcare for your body and mind - together and easier. Beginning January 1, Washington State Health Care Authority said its Medicaid clients will have a new way to get the care they need in our area. The approach is designed to have a single health plan for people to get the help for their physical problems, and also mental health and drug treatment.

The whole-person care system is an integrated medical and behavioral program. They've been doing this since 2016 in southwest Washington. Come 2019, Spokane will be as well.

Medicaid clients in Spokane will soon have an easier time with their health care thanks to a brand new system coming eastern Washington.

"Instead of trying to figure out do I qualify for this benefit, or do I qualify for that benefit - and kind of flailing their way around the system the way all of us do when we're not sure," said Alice Lind, Washington State Health Care Authority.

HCA, which runs Apple Health, is combining medical and mental health programs. Right now, they're separate.

"They were enrolled in one manage care organization for mental health and drug treatment and they were enrolled in a second insurance company manage care plan for their medical treatment," Lind said.

The change could save you some cash as well.

"Might at the end of the day, save some money. Through avoiding duplication of services and better care coordination," Lind said.

The hope is that this new approach will make it easier for clients to get what they need.

"They can call their health plan care coordinator and ask directly - who can I go to fir this kind of care, do I qualify for it," Lind said.

This same plan, integrated managed care, has been in place in southwest Washington since 2016. The results are good.

"Improvement in terms of people getting access to care, so we're really happy about the change and keeping a close eye on it, so people don't fall through the cracks," Lind said.

Current Medicaid clients will stay enrolled in their current plan, unless that plan will not be an option in 2019 or 2020. If that happens, HCA will auto-enroll clients to one of the offered plans.

If you're a Medicaid client with questions about your plan - you can call the customer care line at 800-562-3022.

Get your weather forecast from people that actually live in your community. We update with short, easy-to-use video forecasts you can watch on your phone every day. Download the **iOS** or **Android** app here.