Medicaid News Curator: Volume 1

Contents

State News

Virginia facing high unexpected Medicaid costs

clay@mostlymedicaid.com | **919-727-9231**

SourceURL: https://apnews.com/6e731783cd4b4376846b99d2e70a85f2

By ALAN SUDERMANNovember 2, 2018

RICHMOND, Va. (AP) — Virginia is facing a huge bill for unexpected Medicaid costs that hamper proposed new spending on things like school improvements or tax breaks for the poor.

State officials said Friday that Virginia has about $460 million in unforeseen Medicaid costs.

The new costs, first reported by the Richmond Times-Dispatch, are unrelated to Virginia's recent decision to expand Medicaid eligibility to low-income adults under the Affordable Care Act.

Instead, Secretary of Finance Aubrey Layne said much of the new costs stem from faulty forecasts overestimating the benefits of having private health insurers cover a greater number of some of the state's more costly Medicaid recipients. Another reason for the increase is a higher-than-expected enrollment of children in the state's Medicaid program, he said.

Medicaid is a federal-state collaboration that provides publicly funded health care to poor and disabled people. Its share of the state budget has been steadily growing for several years, limiting Virginia's ability to spend in other areas like education and transportation.

The new Medicaid costs could complicate how lawmakers deal with projected windfalls when they take up the state budget during next year's legislative session. State revenues could grow by hundreds of millions of new dollars due to last year's federal tax overhaul and a court ruling that broadened the state's ability to tax online purchases.

Democratic Gov. Ralph Northam has announced he wants to use part of the extra state revenue from federal tax cuts to give a tax break to low- and moderate-income families. Northam wants to make the earned-income tax credit fully refundable.

Republican state Sen. Bill Stanley has been pushing to use new income from online sales taxes to repair and replace the state's aging public school buildings, many of which are in poor condition.

"I was kind of heartbroken on what effect that will have" on school spending, Stanley said when the governor told about the new Medicaid costs Thursday.

Northam spokeswoman Ofirah Yheskel said the governor and his team are still developing a proposed budget to present to lawmakers in December.

clay@mostlymedicaid.com | 919-727-9231

Medicaid Expansion Beneficiaries Signing Up Fast

SourceURL: https://fcnp.com/2018/11/07/medicaid-expansion-beneficiaries-signing-fast/

November 7, 2018 8:25 PM0 comments

By FCNP.com

According to the Virginia Dept. of Medical Assistance Services, between Oct. 29 and Nov. 3, the call center of Virginia's Medicaid Expansion program, Cover Virginia, took 19,000 calls and helped 3,200 people file applications for Medicaid expansion. On Nov. 5 and 6, DMAS received 7,500 paper applications based on the letters they sent to folks believed to be eligible.

Under the state's current Medicaid program, low-income childless adults with no disabilities are not eligible for coverage, and income for a family to qualify is capped at $6,900 a year and at $9,700 a year for a person with disabilities. Under Virginia's Medicaid Expansion program, which goes into effect Jan. 1, 2019, childless adults are now eligible and income caps for both persons with disabilities and families has been increased.

There are several ways to apply for coverage: 1) calling the call center at 1-855-242-8282; 2) applying through the online application portal at commonhelp.virginia.gov; 3) applying through your local Department of Social Services agency (City of Falls Church residents may apply through the Fairfax County Department of Family Services).

Medicaid expansion funding mandate moves from voters to Legislature

SourceURL: http://www.newspressnow.com/news/national/medicaid-expansion-funding-mandate-moves-from-voters-to-legislature/article_c8840fa9-1fe9-5721-a4b9-cfdf67a612ec.html

A yard sign promoting Initiative 427, the Medicaid expansion initiative.

Associated Press file photo

In the aftermath of a Republican sweep of statewide and congressional offices that spotlighted a growing rural-urban political divide, attention focused Wednesday on a changing landscape in the Legislature and funding of voter-approved Medicaid expansion.

Gov. Pete Ricketts, Sen. Deb Fischer and all three Republican House members were re-elected, but none of them won majorities in either Omaha or Lincoln.

The nonpartisan Legislature was revamped in a fashion that close observers believe increases the number of senators who could be described as politically moderate.

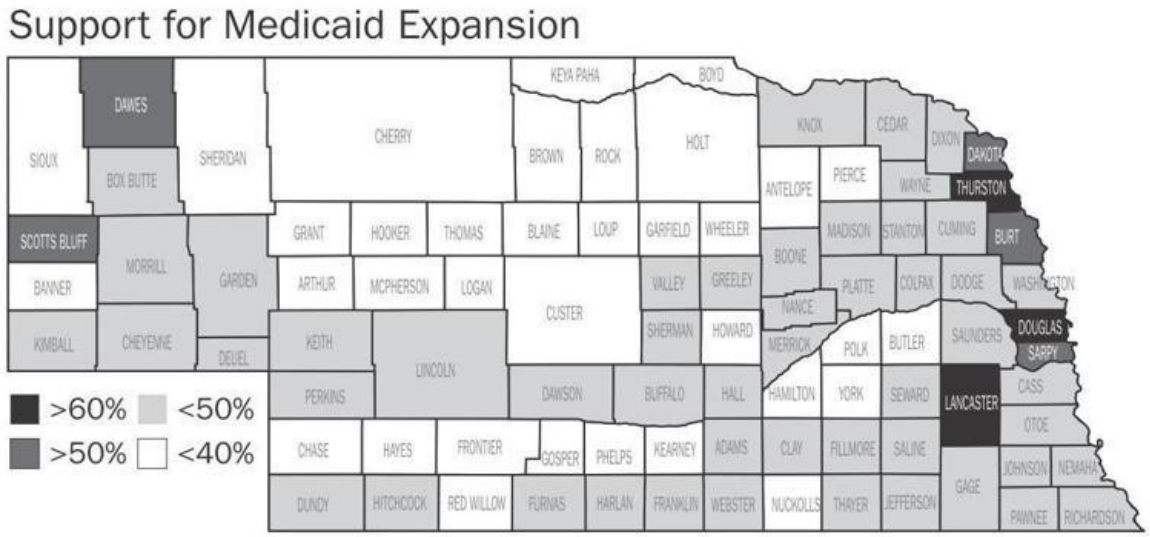
However, predicting how new senators ultimately will vote or behave is usually a fool's errand.

The Medicaid expansion vote dramatically spotlighted how difficult it is to define or pigeon-hole political sentiment.

Nebraska, a red state with an overwhelming Republican voting majority, approved an initiative that will extend Medicaid coverage to an estimated 90,000 adults who can be broadly defined as the working poor, despite warnings from the governor that it could imperil property tax relief and popular state programs.

That vote divided urban and rural Nebraska, with 85 of 93 counties opposing the proposal, while Lincoln and Omaha gave it overwhelming approval and pushed the proposal over the finish line with room to spare.

+1



The final vote count: 345,837 for, 304,253 against.

The next chapter will be written in the 2019 Legislature, where some opponents already have hinted at slow-walking or even attempting to block funding of Medicaid expansion.

The state's share of costs has been estimated at $19.8 million during the first fiscal year and $32.2 million in the second year.

In an interview with the Associated Press, Ricketts said "this is going to have to fit into the budget with all of our other priorities" since he will not consider any tax increase.

"That means that other priorities we have in the budget -- things like K-12 education, higher education, property tax relief, potentially even roads -- are all going to have less money available," the governor said.

Sen. John Stinner of Gering, chairman of the Legislature's Appropriations Committee, earlier signaled that tentative planning was underway to consider those costs in case the initiative was approved.

Sen. Adam Morfeld of Lincoln, who led this year's legislative effort to expand Medicaid, said he and other sponsors of the initiative will go to court if opponents in next year's legislative session attempt to block funding.

"The funding requirement is crystal-clear in the language" of the initiative approved by Nebraska voters, he said Wednesday.

"There is no legal room not to fund it," Morfeld said.

"The budget won't pass next year if it is not funded," he added.

"It is going to get funded and people are going to get those services."

Morfeld pointed to a possible revenue source that soon will be available to help fund state government programs and services once the Legislature enacts legislation requiring collection of state sales taxes that already are owed on online sales.

Half of the anticipated new revenue from that source would "cover new Medicaid costs easily," he said.

"After two or three years, Medicaid will pay for itself," Morfeld said, as it triggers new economic activity across the state.

During the first two years, Medicaid expansion would generate $786.5 million in federal funding, according to the legislative fiscal analysis. An additional $572.8 million would be coming to Nebraska in the third year.

The fiscal analysis prepared for Stinner and Sen. Kate Bolz of Lincoln assumed a July 1, 2019, implementation date while noting that "the actual start date may be different" depending on the language of legislation.

Under terms of the initiative, the state's Department of Health and Human Services is required to submit a state plan for expanding Medicaid coverage by April 1, 2019.

"The state shall amend its Medicaid state plan to expand eligibility," the initiative mandates. And the department is required to "take all actions necessary to mandate federal financial participation."

Morfeld said warnings by opponents that Medicaid expansion would take funding away from state school aid, property tax relief or other priorities are bogus.

"That would only be the case if we want it to be," he said.

In a statement three weeks before the election, 11 state senators warned that the costs of expanding Medicaid assistance "would make property tax relief nearly impossible" and endanger funding for local schools, the University of Nebraska and current Medicaid recipients.

Ricketts earlier expressed the same concerns.

The initiative launched by Insure the Good Life collected more than 100,000 signatures from Nebraskans on petitions to place the issue on the November ballot.

Tuesday's vote count showed huge majorities in Lincoln and Omaha carrying the issue to victory with assistance from majority votes in Burt, Dakota, Dawes, Sarpy, Scotts Bluff and Thurston counties.

The issue ultimately was approved statewide by approximately 42,000 votes after piling up a 47,000-vote majority in Omaha and Douglas County, along with a 26,000-vote margin in Lincoln and Lancaster County.

New Medicaid assistance would be extended to Nebraskans who work at jobs that earn them less than $17,000 a year, including food service and retail workers.

Medicaid rides delayed, leaving patients sick, stranded

SourceURL: https://www.wfla.com/8-on-your-side/investigations/medicaid-rides-delayed-leaving-patients-sick-and-stranded/1579746703

L. Cockerham claims his Medicaid ride to the doctor is routinely late. [+ -]

Melissa Morris of Best Treatment Network claims patients cancel at least a couple of times each week due to their Medicaid rides being so late. [+ -]

Johanna Spaninato is angry that her Medicaid transportation is unreliable. [+ -]

prev

next

NEW PORT RICHEY, Fla. (WFLA) - Providing transportation to get Medicaid patients like Diana Luczynski to the Pinellas Cancer Center for treatment has cost Florida about $100 million so far this year.

According to the Pinellas Cancer Center, a company by the name of Logisticare is Luczynski's transportation provider.

"They drop me off on time, they just don't pick me up when they're supposed to, so I have to wait each time longer and longer," Luczynski explained.

Month in and month out, problems wth transportation are at or near the top of the Medicaid complaint list at the Florida Agency for Health Care Administration.

"I have to sit there and grin and bear it, grit my teeth," L. Cockerham said.

Cockerham, of New Port Richey, is disabled at the age of 60. He contends Logisticare rides are routinely late.

"I have an appointment for 1:30 to go out of county, I don't get there til 3 o'clock and sometimes they don't pick me up til 3 and I get there late," Cockerham stated.

He complains this problem has gone on for years.

"I don't get home til 7 in the evening sometimes, because of that," he added.

"It is a problem," Melissa Morris of Best Treatment Network in New Port Richey said.

Morris remembers one of Best Network Treatment's patients waited until midnight on a Logisticare ride home.

She claims unless a patient is outside waiting, drivers will stop for a moment or two then take off.

"Most of our patients are older and they can't sit outside in the heat," explained Morris

"It's horrible they don't care," Kim Faulkner, manager of the Pinellas Cancer Center, stated.

"If they cared, they would be here to pick them up. They would wait 10 minutes if the patient, you know, wasn't completely done. They wouldn't leave them in the parking lot. They wouldn't drive through the parking lot and not see anybody and keep going."

Logisticare says 99.8 percent of its trips in Florida go without complaints from Medicaid patients.

Johanna Spaninato, a cancer patient who's found herself waiting hours for Logisticare, has a message for the company's CEO.

"I would tell him to wake up and get to work and see what the hell is going on, in plain English, with your company and the people that work for you. They can't do their job, replace them," Spaninato said.

According to Morris and Faulkner, every week transportation snafus force patients to delay or cancel appointments for treatment.

If you know of something that should be investigated, call our 8 On Your Side Helpline at 1-800-338-0808. Contact Steve Andrews at sandrews@wfla.com.

Medicaid expansion fight centers on question of funding

SourceURL: https://www.mrt.com/news/article/Medicaid-expansion-fight-centers-on-question-of-13373968.php

Marina Villeneuve, Associated Press

Published 5:10 am CST, Thursday, November 8, 2018

PORTLAND, Maine (AP) — A judge said she will weigh in soon on the future of voter-approved Medicaid expansion, as the Democratic governor-elect Wednesday vowed to expand coverage as soon as she enters office in January.

Justice Michaela Murphy heard oral arguments Wednesday in Superior Court. Pro-expansion advocates continued arguing Republican Gov. Paul LePage's administration broke the law by stalling expansion, while the governor's outside lawyer argued the matter is up to lawmakers and not the courts.

Nearly three out of five Mainers last fall approved expanding Medicaid to 70,000 low-income residents, following five Medicaid expansion attempts that LePage vetoed. But the referendum didn't include a funding source for Maine's share, and LePage has opposed expansion over his financial concerns.

Democratic Attorney General Janet Mills, who won Tuesday's gubernatorial election, said Wednesday that she will "absolutely" propose a plan to fund Maine's share of Medicaid expansion, which could eventually cost Maine alone $54.5 million each year. LePage has informally proposed taxing hospitals to pay for expansion, though the idea has caught criticism from the Maine Hospital Association.

LePage vetoed a bill to fund Medicaid expansion's first year with budgetary surplus and one-time tobacco settlement funds. The governor dismissed the bill as relying on "budgetary gimmicks," and lawmakers failed to override his veto.

A pro-Medicaid expansion group says LePage's administration is violating the spirit of a recent court order to submit paperwork for $525 million in eventual annual federal funding for Medicaid expansion. Maine submitted the paperwork, but LePage urged federal regulators to reject it.

Justice Murphy is tasked with deciding whether lawmakers must specifically set aside money before expanding Medicaid. She will also weigh in on Medicaid expansion's official start date.

Maine has enough existing Medicaid funds in theory to cover expansion costs through May 2019, according to the Legislature's nonpartisan fiscal office.

But the LePage administration claims that the money could run out faster if enrollments exceed expectations.

A private lawyer for the LePage administration is also arguing that Maine lawmakers have at times specifically set aside money for previous Medicaid expansions.

"It was widely understood and was made explicit to voters that additional legislation was going to be necessary to implement the expansion of the program," attorney Patrick Strawbridge said.

The governor should implement the laws and then deal with budget questions later, argued Charles Dingman, lawyer for Maine Equal Justice Partners, which sued LePage's administration this spring for blocking expansion.

It comes down to whether Maine's executive branch has the authority to stall a law approved by voters at the polls simply because of a policy disagreement, argued lawyer James Kilbreth, lawyer for Maine Equal Justice Partners.

State government, he added, must implement laws rather than say: "'Never mind, I don't like this law.'"

Measure

Measure

Tobacco tax hike for Medicaid expansion rejected

SourceURL: https://nbcmontana.com/news/local/tobacco-tax-hike-for-medicaid-expansion-rejected

Medicaid News Curator: Volume 1

by The Associated Press

HELENA, Mont. —

Montana voters have rejected a ballot measure that sought to extend the state's Medicaid program and pay for it in part by raising the tobacco tax.

The result from Tuesday's election means the expanded Medicaid program covering 96,000 people will expire next year unless the Montana Legislature renews it.

One of the nation's largest tobacco companies led an expensive campaign to defeat the measure. Altria is the parent company of Philip Morris and poured more than $17 million into the race.

The initiative would have continued the expansion program indefinitely. Up to $26 million from the tobacco tax increase would have gone to offset the program's increasing costs to the state.

The tax hike would have raised the price on a pack of cigarettes by $2, raised snuff prices and taxed vaping products for the first time.

Measure

Measure

Gov Ricketts says no tax increase to pay for voter-approved Medicaid expansion

SourceURL: https://www.ketv.com/article/gov-ricketts-says-no-tax-increase-to-pay-for-voter-approved-medicaid-expansion/24804286

'It's going to have to fit in the budget. So everything else is going to get less money'

Hide Transcript Show Transcript

Nebraska voters joined two other "red states" Tuesday saying yes to expanding medicaid coverage.

The final vote was for Initiative 427 was 345,837 (53.2%) to 304,253 (46.8%).

Idaho and Utah also approved Medicaid expansion.

"I'm really happy that the voice of the people spoke in this state and said, we're going to take care of our own people," Lora Curry of Lincoln said.

The working, single mother of three is one of an estimated 90,ooo Nebraskans who could soon be covered by Medicaid.

"I have fallen in the gap several times in my life and I know several people who are in the gap," Curry said.

A gap of earning too much money to qualify for Medicaid but not enough to afford private health insurance.

"What if I develop some kind of illness and not able to get the treatment that I need. That can be really catastrophic," Curry said.

But her gain could be other people's loss, according to Gov. Pete Ricketts.

"I've been very clear we're not going to raise taxes. And so we've got other priorities in the budget, like K-12 education, higher education, property tax relief and potentially even roads, there's going to be less money for all those priorities because we have to fit Medicaid expansion into that budget," Ricketts said.

clay@mostlymedicaid.com | 919-727-9231

In order for Nebraska to receive federal funding, the state must match 10 percent, which is estimated at $50 million over the first two years.

"I'm sure that's going to be a lively debate on how that's going to get implemented but at the end of the day we have to live within our means just like every Nebraska family does and we're not going to raise taxes," Ricketts said.

Lincoln Sen. Adam Morfeld, a long time advocate of Medicaid expansion will be part of that debate.

"There's all kinds of ways we can pay for this. I personally feel we should do this in a way that doesn't impact current programs, doesn't impact K-12 education or other institutions and do it with the additional revenue from online sale tax," Morfeld said.

Internet sales tax revenue is expected to bring in $30 million to $40 million a year.

Morfeld believes expansion could lower premiums for everyone and help out Nebraska hospitals.

According to the Nebraska Hospital Association, the state's 90 hospitals had $1.2 billion in uncompensated health care services last year from uninsured patients.

Nearly half of the state's smaller rural facilities are under substantial financial stress.

"Studies from the University of Nebraska Kearney and other economists clearly showed that Medicaid expansion starts paying for itself in two or three years," Morfeld said.

Jessica Shelburn of Nebraskans for Prosperity are concerned current medicaid recipients will be hurt.

"Sixty percent of our state has a provider shortage. So when you have a provider shortage and they already take a limited amount of Medicaid patients in those offices and now you're adding 90,000 individuals, it crowds out services to the most vulnerable," Shelburn said.

But Curry can't wait until she and others will finally have health insurance.

" I'm hopeful and optimistic that they can get it going and there won't be a lot of stalling," Curry said.

Before it went on the ballot and was passed, efforts to expand Medicaid in the Legislature failed six times.

Supporters say the earliest people could start receiving coverage would be July 2019.

Medicaid changes the N.H. Health Protection Program

SourceURL: https://www.omaha.com/livewellnebraska/rural-urban-divide-shows-in-nebraska-vote-to-approve-medicaid/article_f29089d8-82ae-5d3c-b713-30cd4215cdd7.html

New Hampshire residents who get their health insurance through the New Hampshire Health Protection Program will need to choose a new plan by Dec. 3 at 4 p.m.

Affordable Healthcare Assister Beth Dyson at White Mountain Community Health Center can provide free help with this process for those who need it.

The New Hampshire Health Protection Program covers adults making up to 138 percent of the federal poverty level, and is also known as “expanded Medicaid.”

In the past, people with New Hampshire Health Protection Program health coverage were instructed to choose a private insurance plan on the Marketplace. The program covered the premium of this plan, as well as any deductibles and other out-of-pocket costs. The one exception was copayments for certain services that enrollees making above the federal poverty level were responsible for.

Now, those with the New Hampshire Health Protection Program will instead choose a Medicaid care management health plan, similar to other Medicaid enrollees.

The two options for 2019 are New Hampshire Healthy Families and Well Sense Health Plan. Those who do not choose a plan by Dec. 3 will be assigned a plan, but can still change their plan through Dec. 28. Once the new plan is chosen, members will then choose a primary care provider.

Current New Hampshire Health Protection Program members should have received a letter from the Department of Health and Human Services about how to choose a new plan and PCP.

Coverage through the new plan will begin on Jan. 1, 2019. Cards will come in the mail for the new plan. However, until the cards come, members may continue to use their blue Medicaid cards for health services.

If you are unsure which plan to choose, make a list of your current doctors, hospitals, other providers and prescriptions. Then, contact each plan to see if everything on the list are in the plan’s network. Contact information for the plans is as follows: New Hampshire Healthy Families, (866) 769-3085, nhhealthyfamilies.org; and Well Sense Health Plan, (877) 957-1300, wellsense.org.

If you would like help finding information to help you decide between the plans, or completing the process to choose a plan, free assistance is available at White Mountain Community Health Center. To make an appointment with Affordable Healthcare Assister Beth Dyson, call the front office at (603) 447-8900.

The health center is located on Route 16 just north of Conway Village.

If you are coming for an appointment to choose an New Hampshire Health Protection Program plan, bring a list of current medications, doctors and other providers, along with login information for the NH Easy website if you already have an account.

Measure

Measure

Medicaid Reform News

What Does the Outcome of the Midterm Elections Mean for Medicaid Expansion?

SourceURL: https://www.kff.org/medicaid/fact-sheet/what-does-the-outcome-of-the-midterm-elections-mean-for-medicaid-expansion/

Published: Nov 07, 2018

While not typically an election issue, Medicaid — particularly the Medicaid expansion created under the Affordable Care Act (ACA) — was an important issue in the 2018 midterm elections in a number of campaigns throughout the country. Following the election, 37 states including the District of Columbia have adopted the ACA's Medicaid expansion. States may implement the expansion at any time, and while they can no longer receive 100% federal financing for three years, they remain eligible for enhanced federal financing of 93% in 2019 and 90% in 2020 and beyond. Many studies on the effects of the ACA Medicaid expansion point to positive effects on coverage, access to care, service utilization, and state budgets and economies. This fact sheet highlights key states in which the results of the 2018 midterm elections have implications for Medicaid expansion adoption or implementation. States examined include those that had Medicaid expansion ballot initiatives and states in which governor races have potential implications for Medicaid expansion. In states that had governor races with implications for Medicaid expansion, changes in the composition of state legislatures are also important as governors in most states will need to work with their legislatures in order to adopt the expansion.

Key Midterm Election Results with Implications for Medicaid Expansion

Outcome of Medicaid Expansion Ballot Measures

Four states voted on Medicaid expansion ballot initiatives.

Idaho. Idahoans voted in favor of Idaho Proposition 2, a ballot initiative that requires the state to submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to implement the Medicaid expansion no later than 90 days after the approval of the act. The Idaho Department of Health and Welfare is required and authorized to take all actions necessary to implement the provisions of this section as soon as practicable. Outgoing Governor Butch Otter endorsed the ballot initiative less than a week before the election,[1] and Republican Governor-elect Brad Little has said he will implement the initiative.[2]

Montana. Montanans voted down Montana I-185 after spending on campaigns for and against the initiative made it the most expensive ballot measure race in Montana history. The measure proposed raising taxes on all tobacco products (including e-cigarettes and vaping products) and dedicating a percentage of increased tax revenues for Montana's current Medicaid program; veterans' services; smoking prevention and cessation programs; and long-term care services for seniors and people with disabilities. The initiative also would have eliminated the sunset date for the Medicaid expansion, which is set to expire on June 30, 2019. The Montana State Legislature, which remains in Republican control following the 2018 midterm election,[3] could take action to continue the expansion program beyond June 2019 despite the ballot measure's failure. As of late October, tobacco companies had spent more than $17 million on advertising and other efforts to oppose the ballot measure, most of which came from cigarette maker Altria.[4] In comparison, I-185 supporters had spent nearly $8 million, primarily from the Montana Hospital Association.[5]

Nebraska. Nebraskans voted in favor of Nebraska Initiative 427, which requires the state to submit a state plan amendment or documents seeking waiver approval to CMS on or before April 1, 2019 to implement the Medicaid expansion. The initiative calls for the state Department of Human Services to "take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section". Although Governor Pete Ricketts, who was just re-elected for a second term, has been a vocal opponent of expansion,[6] he previously stated that if expansion made it onto the ballot it would be up to voters to decide.[7]

Utah. Voters approved Utah Proposition 3, which calls for the state to expand Medicaid coverage under the ACA beginning April 1, 2019. In addition, the initiative prohibits future changes to Medicaid and CHIP that would reduce coverage, benefits, and payment rates below policies in place on January 1, 2017. Proposition 3 calls for a 0.15% increase (from 4.70% to 4.85% of the state sales tax except for groceries) to finance the expansion or Medicaid and CHIP more broadly. [8] Utah Governor Gary Herbert did not support the initiative (he instead favored the Legislature's more limited approach of seeking a federal waiver to expand Medicaid just to the poverty line).[9]

clay@mostlymedicaid.com | 919-727-9231

SourceURL: https://www.healthcarefinancenews.com/news/medicaid-expansion-gains-passage-three-states

CMS is developing a rule that could curtail Medicaid transportation access

SourceURL: https://www.modernhealthcare.com/article/20181107/NEWS/181109932

By Virgil Dickson | November 7, 2018

The CMS is drafting a proposed rule that would make it easier for states to stop paying for non-emergent medical transportation for Medicaid beneficiaries, a move that could drastically cut into providers' revenue.

While details of the potential rulemaking are scarce, a notice on the White House's Office of Management and Budget website said the regulation is projected to be released in May 2019.

Just the suggestion that states could cut Medicaid transportation to medical appointments already has providers on edge. Annual Medicaid spending for these trips is around $3 billion, with roughly 103 million non-emergent medical trips each year, according to researchers.

Medicaid enrollees already have a high no-show rate, and that could get worse if the CMS finalizes the rule, according to Dr. Theresa Rohr-Kirchgraber, a practicing pediatrician in Indianapolis and associate professor of clinical internal medicine and pediatrics at Indiana University.

Many Medicaid enrollees lack access to vehicles due to their low incomes. There are also few public transportation options in Indiana, especially in rural areas, Rohr-Kirchgraber said.

clay@mostlymedicaid.com | 919-727-9231

"Our feet are really held to the fire that we have high productivity in terms of the number of patients we have to see," she said. "We're the ones that are making the money for our institutions, and we can't we can't afford to keep our doors open if we can't get our patients in."

Currently, states have to obtain a waiver from the CMS if they don't offer non-emergent transportation services. The Trump administration first floated the idea of changing that policy earlier this year in its 2019 budget proposals.

Non-emergent transport to medical appointments has been a mandatory Medicaid benefit since the program's inception in 1965.

Iowa and Indiana are the only states with a waiver to opt out of providing transportation. Kentucky and Massachusetts have both asked the CMS for similar permission.

It's unclear whether patients' health declines if Medicaid doesn't pay for rides to medical care. A February 2016 report from the Lewin Group said the impact of the transportation benefit waiver in Indiana has been minimal. Most beneficiaries could find other forms of transportation not paid for by Medicaid. Of the 286 beneficiaries interviewed, 11% cited lack of transportation as their reason for missing appointments. A report from Iowa had similar findings.

But the Medical Transportation Access Coalition, a group made up of advocates, transportation providers and managed-care plans, noted that these waivers largely targeted adults who became eligible under Medicaid expansion and had not previously relied on the non-emergency transportation benefit.

The group insists that making it easier for states to opt out of offering these services will harm access to care.

Medicaid enrollees regularly use the benefit to get to dialysis, substance abuse treatments and chronic care visits for diabetes. A survey of Medicaid enrollees last summer by the coalition revealed that low-income patients found it critical to their day-to-day lives.

"Over half the trips taken today are for life-sustaining treatments," said Tricia Beckmann, a director at Faegre Baker Daniels and adviser to the coalition. "Some said that they would die or probably die if they didn't have transportation." Medicaid saved more than $40 million in hospitalization and other medical costs for patients receiving rides to dialysis and wound care treatments, according to a report by the coalition.

It's unclear if the CMS has the authority to make this change to transportation benefits, according to Eliot Fishman, who oversaw 1115 waivers under the Obama administration and is now senior director of health policy at Families USA.

"Making NEMT optional hasn't been tested in court," Fishman said. "If the administration goes in that direction, I expect there will be a legal challenge."

The CMS does not comment on pending rulemakings, according to a spokesman.

Letters: Work requirements for assistance a must

SourceURL: https://www.theadvocate.com/baton_rouge/opinion/letters/article_da517e24-e151-11e8-bc68-b39a029c821a.html

FILE - In this Nov. 29, 2017 file photo, Seema Verma, administrator of the Centers for Medicare and Medicaid Services, speaks during a news conference in Newark, N.J. The Trump administration says it's offering a path for states that want to seek work requirements for Medicaid recipients, and that's a major policy shift toward low-income people. (AP Photo/Julio Cortez) ORG XMIT: WX102

Julio Cortez

The value of studying history is so that future generations don't make the same mistakes as our forefathers. Having said that, it was stunning to watch the political tug-of-war that took place in Baton Rouge this past legislative session trying to add work requirements for Medicaid beneficiaries that now represent one-third of the state. Bills in both the House and the Senate stalled in committee as the legislative session ended, as Democrats fought it tooth and nail. So what does history tell us about this issue?

In 1935 President Franklin Roosevelt implemented work programs tied to government assistance after The Great Depression since, as he stated, "the lessons of history show

conclusively that continued dependency upon relief induces a spiritual and moral disintegration fundamentally destructive to the national fiber." Roosevelt knew that citizens must work for their government assistance.

Guest column: Get adults off SNAP and back to work

Yet in 1965, President Lyndon Johnson chose to ignore Roosevelt's "lessons of history" work warnings, as well as the warnings from Daniel Patrick Moynihan that the president's "Great Society" welfare programs could lead to the disintegration of the black family unit, resulting in many social problems. Instead, Johnson proceeded forward with his "War on Poverty," with one of his stated goals being to "make America's poor more self-sufficient." Here we are more than 50 years later, and we see that the war has been an abject failure as there are now substantial increases in dependency, idleness, and out-of-wedlock childbirths which have resulted in a spiritual and moral disintegration that is indeed destroying America.

In spite of the blatant failure of the war on poverty, President Barack Obama doubled down and put the nation's welfare/no work programs on steroids. The result has been social chaos in our disadvantaged neighborhoods. Saul Alinsky couldn't have done it any better.

As we watch America's national fiber being fundamentally destroyed before our very eyes, one can't help but ask what history has to say about our political leaders who are intentionally disregarding the "lessons of history." In 1787, Benjamin Franklin warned us that "when you make a place of honor also a place of money and power, man will move heaven and earth to obtain them." In 2018, we saw the governor and Senate Democrats move "heaven and earth" to legislatively protect Medicaid fraud (and potential votes).

Steve Gardes

CPA

U.S. approval of Arkansas' Medicaid work rules illegal, filing says

SourceURL: https://www.arkansasonline.com/news/2018/nov/07/u-s-approval-of-arkansas-medicaid-work--1/

Medicaid News Curator: Volume 1

by Andy Davis | November 7, 2018 at 4:30 a.m. 0comments

In allowing a work requirement for Arkansas' Medicaid program, President Donald Trump's administration violated federal law in the same way it did in approving a similar requirement in Kentucky, attorneys challenging Arkansas' requirement contend.

The attorneys representing nine Arkansas Works enrollees made the argument in a court filing in Washington, D.C., late Monday, asking U.S. District Judge James Boasberg to overturn the government's approval of Arkansas' requirement for the same reasons he blocked Kentucky's from taking effect.

In both cases, the attorneys argue, the administration failed to consider the impact on the Medicaid program's goal of providing medical assistance to low-income people.

Regarding Arkansas, they said U.S. Health and Human Services Secretary Alex Azar "ignored substantial evidence" that a work requirement would have the opposite effect -- reducing the number of people enrolled -- and didn't attempt to predict how big the coverage losses would be.

"Tellingly, in just the first two months of the State terminating individuals for noncompliance with the work requirement, over 8,400 Arkansans have lost Medicaid coverage--a number that will grow as the roll-out of the Amendment continues," the attorneys wrote.

The filing was submitted by the National Health Law Program and the Southern Poverty Law Center, which filed the lawsuit that led Boasberg to block Kentucky's work requirement, and Jonesboro-based Legal Aid of Arkansas in their Aug. 14 lawsuit challenging Arkansas' requirement.

The Social Security Act allows the Health and Human Services secretary to waive certain requirements in the law to allow a project that is likely to "assist in promoting the objectives" of the Medicaid program, which is funded by the federal government and states.

But in a June 29 ruling, Boasberg found that Azar failed to consider a central objective -- providing medical assistance to needy residents -- in approving Kentucky's work requirement in January.

Kentucky officials had estimated that the work requirement and other provisions in the waiver Boasberg rejected would have reduced the state's Medicaid enrollment by 95,000 people over five years.

Arkansas officials didn't make a similar projection in their waiver request, but have estimated potential savings to the state budget.

For instance, in an internal estimate obtained under the state Freedom of Information Act, a Department of Human Services official projected that the work rule would reduce state and

federal spending by $31 million this fiscal year, which ends June 30, if 20 percent of those subject to it left the program as a result of finding new jobs or being removed for noncompliance.

In Monday's filing, the attorneys challenging Arkansas' requirement noted that about a quarter of enrollees have failed to comply each month since the state started phasing in the rule in June.

The requirement "is harming thousands of people, including Plaintiffs, who have lost or are at risk of losing Medicaid coverage when they cannot find or maintain work or submit monthly reports as required," the attorneys wrote.

In allowing the state to require enrollees to use a state website to report on their compliance with the work requirement, Azar also violated a provision in the 2010 Patient Protection and Affordable Care Act mandating that enrollees be allowed to submit information by mail or over the phone, the attorneys wrote.

That provision isn't one that the Health and Human Services secretary is allowed to waive, the attorneys wrote.

The attorneys accused the administration of attempting to circumvent Congress, which failed to approve Republican-backed legislation last year that would have repealed the Affordable Care Act and added language to the Social Security Act allowing Medicaid work requirements.

"In sum, if the Secretary and Arkansas want to radically restructure the decades-old Medicaid program, then they must secure the consent of Congress," the attorneys wrote. "It is not for them to achieve that end by administrative fiat."

Arkansas is the only state in the more than 60-year history of Medicaid to implement a work requirement for some of its enrollees. Indiana, New Hampshire and Wisconsin have received approval to implement similar requirements next year.

Arkansas' requirement applies to enrollees in Arkansas Works, which covers people who became eligible for Medicaid when the state extended eligibility in 2014 to adults with incomes of up to 138 percent of the poverty level.

Most of the program's more than 252,000 enrollees receive the coverage through private plans, with the Medicaid program paying some or all of the premium.

The requirement to spend 80 hours a month on work or other approved activities was phased in this year for participants age 30-49 and will apply next year to those age 19-29. Enrollees who fail to comply for three months during a year are terminated from the program and barred from re-enrolling for the rest of the year.

Monday's filing asks Boasberg to rule that Azar's approval of the requirement in March violated the federal Administrative Procedure Act. A response from federal officials is due by Nov. 30.

Metro on 11/07/2018

clay@mostlymedicaid.com | 919-727-9231

Measure

Measure

MCO News

Two Medicaid managed care insurers become one

SourceURL: https://www.chicagobusiness.com/health-care/two-medicaid-managed-care-insurers-become-one

The state's overhauled Medicaid managed care program is back to six insurers with the consolidation of two health plans. Meanwhile, sanctions against the largest insurer in the state have been amended.

Getty Images/iStockphoto

And then there were six … again.

The state's overhauled Medicaid managed care program is back down to six insurers following the consolidation of two health plans.

Harmony Health Plan is becoming part of Meridian Health Plan following WellCare's $2.5 billion acquisition of Meridian. Harmony members will automatically be enrolled with Meridian on Jan. 1, unless they request otherwise.

The consolidation came at a good time for Harmony. In a May letter to the health plan, the state said it would no longer automatically enroll members in the plan since Harmony didn't have enough doctors and hospitals in its network to ensure adequate access.

clay@mostlymedicaid.com | 919-727-9231

"During this time, we are committed to providing a seamless transition for our members, providers and state partners, WellCare said in a statement. "As a result of these changes, our provider partners will be able to operate with one combined plan, which will grant broader network access to our members in Illinois."

WellCare spokeswoman Patti Flesher said in an email that Meridian will not inherit Harmony's sanctions.

The Illinois Department of Healthcare & Family Services oversees HealthChoice Illinois, the state's nearly one-year-old Medicaid managed care program, in which private insurers administer Medicaid benefits.

Meanwhile, the state has eased sanctions against another participating insurer, Blue Cross & Blue Shield of Illinois. As of last month, Medicaid enrollees can once again select plans from the largest insurer in the state.

Blue Cross was placed on an enrollment hold in April for not having enough doctors and hospitals in its network to ensure adequate access for members in certain areas, and failing to address a backlog of grievances and appeals from members.

Despite demonstrating "changes the health plan has made to come into compliance," Blue Cross remains on a corrective action plan and members will not be automatically enrolled, according to a letter Healthcare & Family Services sent the insurer on Oct. 19.

A follow-up audit and file review is scheduled to take place next month. If Blue Cross does not show "necessary improvement," the department can reinstate the full enrollment hold and impose a performance penalty starting at $50,000, the letter states.

"We demonstrated our commitment to make things right for our members and we continue to make improvements in our technology, process, staffing and training," Blue Cross spokeswoman Colleen Miller said in an email.

As of Sept. 1, Blue Cross had enrolled about 416,000 people, which is 19 percent of total HealthChoice Illinois enrollment, state data shows. Meridian leads the board with about 609,000 people or 27 percent of total enrollment—not including Harmony's nearly 247,000 enrollees.

It hasn't been unusual to see fines since the program launched. Blue Cross, Molina Healthcare of Illinois and NextLevel Health have all been fined at least $100,000 for failing to submit complete and comprehensive encounter data, or records of covered health care services.

As Healthcare & Family Services employees have today off work for Election Day, the department did not immediately respond to a request for comment.

Measure

Measure

CMS News

CMS selects Qlarant as fraud, waste investigator

SourceURL: https://www.stardem.com/spotlight/cms-selects-qlarant-as-fraud-waste-investigator/article_3ae404b8-e7c6-5b2e-9060-8512a3f87255.html

EASTON — The Centers for Medicare & Medicaid Services (CMS) has selected Qlarant as the Investigations Medicare Drug Integrity Contractor (I-MEDIC) to detect, prevent, and proactively deter fraud, waste, and abuse in Medicare programs. This designation will allow Qlarant to perform these functions in the plans commonly known as Parts C & D.

“We are extremely excited to have this opportunity,” Carrie Ward, senior vice president of Qlarant, said. “We have a dedicated team of professionals comprised of investigators, pharmacists, nurses, and data analysts who bring extensive experience and subject matter expertise to the work at hand. We are ready and prepared to do this important work.”

Under CMS direction, Qlarant will perform various functions related to potential fraud, waste and abuse from prescribers, pharmacies, and beneficiaries. The primary focus will be on complaint intake and response, data analysis, assessing leads, investigative action, administrative actions and program integrity. The program is required to work in compliance with all federal and state laws, regulations, and CMS requirements.

Qlarant, headquartered in Easton, is a national leader in battling fraud, waste and abuse and has offices and home-based associates across the country.

“We look forward to the opportunity to continue working to ensure Medicare and Medicaid funds are properly protected,” Sandy Love, president, Qlarant Integrity Solutions, said.

CMS’ goals are to achieve enhanced fraud, waste and abuse detection and prevention, ultimately saving millions of dollars annually. Qlarant uses a combination of advanced technology, data analytics, and expert evaluation to provide a powerful process consistent with CMS’s goals and expectations, which will ultimately benefit Medicare beneficiaries and recipients.

Qlarant employs nearly 500 people and has a 45-year record of accomplishment improving the performance of some of the nation’s most important programs. www.Qlarant.com

Miscellany

Access to Hormonal Breast Cancer Therapy Increased in Medicaid-Expanded States

SourceURL: https://www.specialtypharmacytimes.com/news/access-to-hormonal-breast-cancer-therapy-increased-in-medicaid-expanded-states

Access to Hormonal Breast Cancer Therapy Increased in Medicaid-Expanded States

Jennifer Barrett, Associate Editor

Publish Date: Wednesday, November 07, 2018

Coverage of hormonal breast cancer therapies increased in states that expanded Medicaid compared with non-expansion states during 2011 to 2017, according to a new study.

The findings were presented at the 11th AACR Conference on The Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved.

For the study, the researchers used data from the Medicaid State Drug Utilization Database (SDUD), which was compiled by the Centers for Medicare and Medicaid Services. They analyzed outpatient prescription rates and associated payments for hormonal therapies tamoxifen and aromatase inhibitors for patients with breast cancer enrolled in Medicaid programs.

According to the data, prescriptions for all hormonal therapy medications and aromatase inhibitors increased by 27% and 29%, respectively, in Medicaid programs among states that expanded Medicaid, compared with Medicaid programs in non-expansion states. The study included both generic and branded prescriptions.

Hormonal therapies can reduce an individual's chance of their breast cancer returning and should be taken for 3 to 5 years to be most effective, the researchers noted. The study also

found that the difference in the rate of hormonal therapy between states that underwent Medicaid expansion and those that did not continued to rise over the course of more than a year following Medicaid expansion. The researchers noted that limitations of the study include reliance on state level Medicaid prescription data.

“This highlights that getting the coverage for as a 1-time event isn’t enough; there has to be a process where breast cancer survivors can work with their health care providers and get educated about the importance of this treatment,” Michael Halpern, MD, PhD, associate professor at Temple University College of Public Health, said in a statement.

According to Dr Halpern, the findings indicate that states that expanded Medicaid funded increased access to these hormonal therapies and that use of these therapies increased among women who were previously uninsured and did not have access.

“We need to be better at making sure that cancer survivors, particularly those who are in underserved populations, continue to have access to high-quality care and are able to receive the services and the medications that they need to prevent their cancer from coming back,” Dr Halpern said.

A previous study indicated that Medicaid expansion could also improve breast cancer screening rates. The study showed that low-income women were more likely to receive a mammogram compared with women in states without Medicaid expansion.

Reference

Coverage of Hormonal Breast Cancer Therapies Increased in States That Expanded Medicaid [news release]. AACR’s website. https://bit.ly/2Ovctco. Accessed November 5, 2018.

Click here to sign up for free for the bi-monthly Specialty Pharmacy Times print journal delivered to your address.

clay@mostlymedicaid.com | 919-727-9231