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Medicaid News Curator: Volume 3

Reading and highlighting the Medicaid interwebs to save you time

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SourceURL: https://www.pressherald.com/2018/12/06/judge-denies-lepage-stay-request-in-medicaid-expansion-lawsuit-but-delays-enrollment-deadline/

Judge affirms Medicaid expansion, but sets deadline that LePage won't have to meet

While the ruling goes against the LePage administration, the judge pushes the enrollment date back to Feb. 1, when the governor will be Janet Mills, an advocate of expansion.

By Joe LawlorStaff Writer

Read Article

The judge deciding the Medicaid expansion lawsuit has denied a stay requested by the outgoing LePage administration, but set a new Feb. 1 deadline to begin enrolling people in the expanded health insurance program.

From a practical standpoint, the ruling makes the lawsuit moot. Gov.-elect Janet Mills, a Democrat who will be sworn in Jan. 2, has vowed to begin enrolling people as soon as possible after her administration takes over.

Maine voters approved Medicaid expansion in November 2017 by a 59-41 percent vote, but Republican Gov. Paul LePage, an expansion opponent, has refused to implement it. About 70,000 low-income Mainers will be eligible for Medicaid under the expansion.

The advocacy group behind the 2017 referendum, Maine Equal Justice Partners, sued the LePage administration this spring, arguing that the Maine Department of Health and Human Services was failing to follow the law by not implementing it.

The court agreed, but the law has been held up for months as the legal process has played out.

Thursday's ruling by Superior Court Justice Michaela Murphy will delay it even further, pushing the start date for enrollments from Dec. 5 to Feb. 1, but supporters are happy with the decision.

"This is good news in that the court is denying the request for a stay, at the same time the court is extending the deadline for rulemaking and enrollment to February 1st," said Robyn Merrill, executive director of Maine Equal Justice Partners, in a statement. "The extension and the deadline will ensure that the new administration that supports Medicaid expansion will be implementing the law so that it's done right, and people will get the care that they're eligible for."

Benefits will be retroactive to July 2, according to the ruling.

A LePage spokeswoman did not return messages from the Portland Press Herald seeking comment Thursday.

Murphy, the judge, wrote that on the central question in the case – whether eligible Mainers should be permitted to enroll in Medicaid despite the LePage administration's objections over funding – she is siding with Maine Equal Justice Partners.

"The court would emphasize that the extension of the deadline to comply should not be confused with a central holding of the prior order. The people of Maine enacted a law that requires payment of Medicaid benefits to an expanded class of Maine citizens, and any person who meets the qualifications clearly spelled out in the Expansion Act are entitled to those benefits as of July 2, 2018," Murphy wrote in Thursday's ruling.

Merrill said that the case sets an important precedent for future governors who may be reluctant to implement laws they don't like.

"In our democracy, the executive branch must follow the law and needs to be held accountable if they don't," Merrill said in a phone interview. "If they ignore the law and are not held accountable, the system falls apart."

Medicaid expansion is a key component of former President Obama's signature domestic legislation, the Affordable Care Act. Some conservative states have refused to adopt Medicaid expansion, but 37 states and the District of Columbia have done so.

The stay request, filed on Nov. 26 with the state's Business and Consumer Court, argued that implementing expansion would have "far-reaching negative consequences" and "prompt a fiscal crisis."

Murphy disagreed, calling the fiscal crisis claim "fiction."

Medicaid expansion will cost state taxpayers about $50 million to $60 million per year, but Maine will receive more than $500 million annually in federal funds to pay for the bulk of the new coverage. The Legislature approved $60 million for Medicaid expansion this summer, but LePage vetoed it, arguing that the funding package contained one-time "budget gimmicks."

Mainers earning as much as 138 percent of the federal poverty level – $16,753 for an individual and $34,638 for a family of four – were eligible to apply for

Medicaid coverage on July 2. Thousands did, only to receive letters of denial from DHHS.

Scott Ogden, a Mills spokesman, said the expansion will happen as soon as possible.

“Governor-elect Mills has vowed to begin implementing voter-approved Medicaid expansion as soon as she assumes office,” Ogden said in a statement. “It is her goal to see that eligible Mainers are able to enroll for coverage as soon as possible so that they may begin receiving the health care that will improve their lives quickly thereafter.”

House Speaker Sara Gideon, a Democrat, said the “end is in sight.”

“I am eager to work in partnership with Governor-elect Mills to ensure this law is followed and that more Mainers are accessing the care they deserve to be and stay well,” Gideon said in a statement.

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SourceURL: https://www.nhpr.org/post/new-medicaid-expansion-work-requirement-could-apply-many-15000-people#stream/0

New Medicaid Expansion Work Requirement Could Apply to As Many As 15,000 People

By Jason Moon • Dec 5, 2018

State officials say they are still working out how much it will cost to enforce a newly approved work requirement for some beneficiaries of New Hampshire's expanded Medicaid program.

Last week the federal government approved a plan by the state to require some Medicaid-expansion recipients to complete at least 100 hours of so-called "community engagement" work each month, or lose their coverage.

Verifying that people are in compliance with that new requirement will fall to the Department of Health and Human Services. Commissioner Jeffrey Meyers said his office is still working out how much extra staffing will be needed to handle the task. But he did have an early estimate for how many people could be subject to the new requirement.

“We believe that there could be between 15,000 or 20,000 individuals who may not have a statutory exemption and they may not be working sufficient hours presently," Meyers said.

Meyers stressed that the final number of people subject to the requirement will likely be lower than that after other exemptions -like participation in a drug-treatment program or pregnancy- are accounted for.

In the meantime, he said his department is working to get the word out about the new rules.

“We’re trying to publicize it as much as possible so that we can address the issue," he said. "So that we can answer people’s questions, we can educate them as to what the requirement is, what all the qualifying activities are, what the exemptions are, how they can file for exemptions, how they can document their hours and report them to us, without it being burdensome to them.”

Meyers said his office will send estimates for the administrative costs of enforcing the requirement to the legislature by the end of the year.

He said it’s still unclear when the work requirement will be put in to effect.

SourceURL: https://www.modernhealthcare.com/article/20181205/TRANSFORMATION01/181209961

N.H. Democrats blast Medicaid for changing work requirements

By Harris Meyer | December 5, 2018

New Hampshire's new Democratic legislative leaders are criticizing the CMS for revising the state's proposed Medicaid work requirement program without the state asking for the changes.

They suggested the new Democratic-controlled Legislature, which succeeds a Republican-controlled Legislature, would consider asking Republican Gov. Chris Sununu to renegotiate the waiver with the CMS.

"Both Democrats and Republicans don't like the fact that the Trump administration is changing the work requirement we negotiated on a bipartisan basis," said Democratic Sen. Dan Feltes, the incoming state Senate majority leader. Still, he said he and his colleagues were not seeking to roll back the work mandate.

New Hampshire Democrats are not the only politicians gaining power following the November elections who are threatening to fight the Trump administration's push for tough Medicaid work requirements. Newly elected Democratic governors in Wisconsin and Michigan also have expressed dissatisfaction with Medicaid work requirement waivers pushed through by their Republican predecessors and approved by the CMS.

Incoming Democratic Gov. Tony Evers of Wisconsin has said he's considering ending the state's waiver. But on Wednesday, the state's GOP-controlled Legislature, during a lame-duck session, passed a bill that would block him from doing so.

On Friday, the CMS approved New Hampshire's five-year Granite Advantage Health Care Program waiver, replacing the previous waiver, which sunsets this month. Under a bill passed in June, the state is transitioning the nearly 52,000 expansion enrollees from managed-care coverage through the Affordable Care Act exchange to new Medicaid managed-care plans. Those contracts start next July. The change required new CMS waiver approval.

"The community engagement and work requirement will help bring more people into the workforce, empowering individuals with the dignity of work, self-reliability and access to high-quality healthcare," Sununu said in a written statement Friday.

The state's first waiver, approved last May, has some of the toughest provisions of any of the five so-called community engagement demonstrations approved by the CMS so far. It applies to low-income, nondisabled adults from ages 19 to 64 who are eligible for the program, including parents of children ages 6 and older.

The waiver requires beneficiaries to report at least 100 hours per month of work, job training, education or volunteer activities, compared to 80 hours in other states. The work requirement starts 75 calendar days after the program launches.

Beneficiaries will face suspension from Medicaid the month after failing to report the required level of community-engagement activities, rather than losing coverage only after repeated months of failure to comply, as in other states.

The state's waiver proposal would have allowed beneficiaries to "cure" a shortage of hours in one month by making those hours up in subsequent months. That's considered important because many low-wage workers have part-time and seasonal jobs with varying hours.

In the CMS' biggest revision of the state's request, the agency will not allow such cures over more than one month starting in May 2020, according to an analysis by the Center on Budget and Policy Priorities, which opposes work requirements.

"I am unhappy with the Trump administration's changes," said Democratic Rep. Steve Shurtleff, the new speaker of the House. "If someone did more work in the spring and summer than in the winter, their average would come up. Now it will be watched over a shorter period of time, and that could drop people off the program."

The CMS, Sununu's office and the New Hampshire Department of Health and Human Services did not respond to requests for comment.

In a waiver change that particularly displeases providers, expansion enrollees will not be eligible for Medicaid's standard 90-day retroactive coverage from the time they first receive care to the time they officially enroll in Medicaid.

"We will continue to review the waiver's work and community engagement requirements to ensure that they do not become barriers to Medicaid beneficiaries accessing the kind of primary, preventive healthcare services that Medicaid expansion was designed to provide," said Steve Ahnen, CEO of the New Hampshire Hospital Association.

While the new CMS waiver approval allows the work requirement to start as soon as Jan. 1, it's likely to begin later than that. The state Legislature won't finalize the rules for the program until late this month. Beneficiary notification efforts are still in process. And contracts for the new Medicaid managed-care plans won't be finalized until well into 2019.

Shurtleff said Democratic lawmakers also want the state to provide more funding to train Medicaid expansion enrollees for employment. The previous GOP-controlled Legislature provided limited funding to help enrollees participate in work activities, and that was only for people receiving Temporary Assistance for

Needy Families. And no funding was provided for the state's additional administrative and staffing needs to run the work program.

Beyond that, New Hampshire policymakers and advocates are closely watching the status of federal lawsuits challenging CMS approval of similar Medicaid work requirement waivers in Kentucky and Arkansas. A federal judge blocked the Kentucky waiver in June, and is now hearing a challenge to Arkansas' program, which already has resulted in more than 12,000 losing coverage.

"We don't want New Hampshire to be the next state to make this mistake of undermining healthcare for people who need it," said Dawn McKinney, policy director for New Hampshire Legal Assistance, which opposes the work requirement. "We hope our Legislature will look at what happened in Arkansas and decide to change course."

There is particular concern about the impact of possible coverage losses on addiction treatment in New Hampshire, which has been rocked by a high rate of opioid addiction and overdose deaths. It's estimated that 11,000 Medicaid beneficiaries have received treatment for substance use disorders under the expansion program.

In its new approval letter Friday, the CMS downplayed concerns expressed by public commenters about coverage losses, saying far more people would lose benefits if the demonstration were not approved. That's because New Hampshire state law established the work requirement as part of the expansion program, and because the state is not obligated to cover the expansion population, the agency argued.

If the waiver wasn't approved, the Legislature and the governor "could then respond by seeking to scale back or even end coverage for the ACA expansion population," the CMS wrote. "Thus, the ACA adult expansion could be eliminated if the state is unable to implement the demonstration project."

Expansion supporters scoffed at that reasoning. "I don't think that's a good argument for CMS to rationalize approving work requirements," said McKinney, who declined to say whether her agency is considering filing a lawsuit challenging the New Hampshire waiver program. "Ending the program is not a genuine threat in our state."

SourceURL: http://www.governing.com/topics/health-human-services/tns-medicaid-coverage-changes-florida.html

Medicaid Changes Give Patients Less Time to Apply for Coverage in Florida

by Tribune News Service | December 5, 2018

By Elizabeth Koh

Floridians will now have less time to apply for Medicaid coverage if they want healthcare costs retroactively covered, after federal officials approved a state request Friday to shorten how far back the state's program can pick up the bill.

The change, which critics have charged will limit access to healthcare for the poor, elderly and those with disabilities, means those who qualify for the safety-net program now have up to 30 days of retroactive eligibility once they qualify for Medicaid, as opposed to the original 90 days. After approval from the federal Centers for Medicare & Medicaid Services, which oversees the safety net

program, the 30-day policy will go into effect Feb. 1 and remain in place until June 30 unless state lawmakers vote to extend the change.

The state Agency for Health Care Administration requested the policy change in the spring, after lawmakers earlier this year voted to support shortening the retroactive eligibility period over the objections of some Democratic colleagues. State Medicaid officials had previously estimated the eligibility would affect about 39,000 people annually -- with pregnant women and children exempt -- and amount to $98 million. The agency also contended that the change would not harm applicants so long as they submitted their paperwork on time.

But during a public comment period, the federal agency received hundreds of comments, all critical of the change: that it would financially hurt providers and patients, impede continuous care or limit access to healthcare services for older patients and those with disabilities in particular.

Some also contended that limiting retroactive eligibility to the start of the month a patient applied for benefits could harm those who became eligible late in the month, shrinking the window they had to submit their paperwork.

In the letter giving the state approval, Seema Verma, Centers for Medicare & Medicaid Services administrator, acknowledged the comments but wrote the state would be required to have a "robust outreach and communication strategy" with providers and beneficiaries that would also be posted on the website.

Medicaid coverage would also date back to the first day of the month an application was filed, even if there was a delay in processing, according to the letter, "which may help mitigate these concerns."

Verma also asserted that the change, requested under an amendment process that is meant to encourage "innovative" healthcare, would enable the state to determine if shortening the retroactive eligibility period could stop people from only intermittently having coverage.

"Florida will be required to test its hypothesis that the waiver will incentivize individuals to obtain and maintain health coverage, even when healthy, or to apply for coverage as soon as possible after the finding or diagnosis that gives rise to their Medicaid eligibility," she wrote. The federal agency is also requiring the state to conduct an independent evaluation within four months of the approval.

The federal agency has approved similar changes in Iowa and Kentucky, though both states also expanded Medicaid eligibility under the Affordable Care Act to include able-bodied adults. Florida has not expanded who is eligible for the program.

The federal agency also approved several other Medicaid changes the state had proposed, from providing a new state Medicaid managed dental plan to making changes to the Low Income Pool, a Medicaid funding program.

The agency approved community behavioral health providers as participants in the funding program, which could expand their access to funding for services treating mental health and substance abuse. It also agreed to a reclassification of regional perinatal care centers, which serve women with high-risk pregnancies and newborns with special health needs, allowing them to access more funding.

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SourceURL: https://www.myarklamiss.com/news/local-news/louisiana-debuts-state-of-the-art-medicaid-enrollment-system/1643066116

Louisiana debuts state-of-the-art Medicaid enrollment system

(WVLA) - (12/06/18) BATON ROUGE, La (LOCAL 33) (FOX 44) - Following many years of development, Louisiana finally launched a brand new Medicaid

enrollment system on Wednesday.

According to The Advocate, workers no longer have to key functions into an antiquated, circa-1992 disk operating system that created tons of individual determinations and paperwork.

With this new registration arrangement, counselors can guide people through the now state-of-the-art website and those interested in applying can now do so on their own.

We're told the upgraded enrollment system is so advanced its now being considered as one of the most modernized Medicaid structures in the nation.

"We needed this system. This was something we knew was an issue at the very beginning of this administration," said Louisiana Health Secretary Dr. Rebekah Gee.

"It's a total transformation of what we had."

SourceURL: https://www.modernhealthcare.com/article/20181205/NEWS/181209966

Idaho Medicaid expansion heads to state Supreme Court

By Susannah Luthi | December 5, 2018

(Updated at 3 p.m. ET)

Idaho's highest court on Wednesday agreed to consider a lawsuit seeking to reverse the state's voter-approved Medicaid expansion.

On Jan. 29, justices in the GOP-majority state will consider the Idaho Freedom Foundation's complaint that Medicaid expansion is unconstitutional. Idahoans passed a ballot measure with a 60% majority in November to expand the healthcare program.

"A sweeping and general delegation of legislative power with uncontrolled, unrestricted or unguided discretionary power exceeds constitutional limits, as does a delegation of lawmaking authority to a state executive branch or the federal government to make future laws governing the issue," the lawsuit said.

A court official said that despite reports that the oral arguments have been expedited, "there is nothing unusual" about the timing.

"It's proceeding just like a usual action that would come to the Supreme Court," said Sara Thomas, administrative director of the courts.

Niki Forbing-Orr, spokesperson for the state's health department, said the target date to unroll the expansion is July 1, 2020. The department expects an appropriation from the Legislature by July 1, 2019, which is the start of the next fiscal year.

The actuarial firm Milliman estimated that expansion will cost Idaho about $45 million a year for its small share of the total funding, but will generate about $40 million in state and local funds.

"The single year net cost to the state will vary year over year, but the net total 10-year cost estimate from state fiscal year 2020-2030 in state funds is $105.1 million, once costs and savings are accounted for," the Idaho's Department of Health and Welfare said in a blog post.

The movement to expand Medicaid gained momentum as Idaho's leaders also mulled alternatives for insuring more people in the largely rural state. A push for a so-called "super-waiver"—a combination of an Affordable Care Act 1332 state innovation waiver and 1115 Medicaid waiver—fell apart in the Legislature last February even though it was touted as an alternative to Medicaid expansion that could bridge the coverage gap.

On the eve of November's vote, outgoing GOP Gov. Butch Otter made news when he endorsed the ballot initiative and urged Idahoans to approve expansion.

Susannah Luthi covers health policy and politics in Congress for Modern Healthcare. Most recently, Luthi covered health reform and the Affordable Care Act exchanges for Inside Health Policy. She returned to journalism from a stint abroad exporting vanilla in Polynesia. She has a bachelor's degree in Classics and journalism from Hillsdale College in Michigan and a master's in professional writing from the University of Southern California.

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SourceURL: https://www.washingtonexaminer.com/policy/healthcare/wisconsin-republicans-lock-in-medicaid-work-requirements-to-block-incoming-democratic-governor

Wisconsin Republicans lock in Medicaid work requirements to block incoming Democratic governor

by Kimberly Leonard

| December 05, 2018 08:25 AM

Wisconsin Republican state lawmakers have approved a Medicaid work requirement during the legislature's lame-duck session in an effort to block the incoming Democratic governor from abandoning the changes set by his GOP predecessor.

The vote, which occurred early Wednesday morning, makes official a provision that will require certain Medicaid beneficiaries to work, volunteer, or take classes for 80 hours a month. If enrollees fail to follow the requirement for 48 months in a row they will be dropped from coverage.

All Democrats and one Republican, Rep. Todd Novak, voted against it.

The changes have the support of GOP Gov. Scott Walker, who lost re-election this year to Gov.-elect Tony Evers and will be leaving office in five weeks. The Trump administration approved the work requirement plan Oct. 31, but Evers said he planned to stop the policy from going into effect. The legislature's move will allow the work requirements to go forward.

It also codifies other parts of the plan. The new requirement will obligate certain people to pay premiums, of about $8 a month, and also to pay out-of-pocket costs of $8 when they go to the emergency room for care. People enrolled in Medicaid would also undergo a health risk assessment that will include asking about drug use.

The plan will cover residential treatment for substance abuse disorder, and people will be able to reduce their premiums by making healthy lifestyle choices such as wearing a seatbelt, maintaining a healthy weight, and not smoking.

Under Obamacare, states were allowed to expand government-funded Medicaid coverage to people of under specific income level, of roughly $17,000 a year, regardless of whether they are working. Medicaid otherwise covers pregnant women, people with disabilities, people in nursing homes, and children, a group that members of the Trump administration and conservatives say should remain the focus of the program.

Though the work requirements contain multiple exemptions for people undergoing treatment for addiction and for caregivers, among other groups, critics say people will be unable to keep up with the reporting requirements and become uninsured. They have said that tracking the work requirement is more expensive than healthcare coverage.

A work requirement enacted in Arkansas resulted in more than 12,000 people being removed from Medicaid. The state removes enrollees after they have failed to report their hours for three months in a row. The program is facing a legal challenge but is still in effect.

SourceURL: http://www.roi-nj.com/2018/12/06/healthcare/sources-minimum-wage-proposal-would-force-state-to-increase-medicaid-reimbursement-by-200-million/

Sources: Minimum wage proposal would force state to increase Medicaid reimbursement by $200 million

The $15 minimum wage legislation introduced Thursday by Assembly Speaker Craig Coughlin (D-Woodbridge) is already creating a stir.

The strategy for home health aides and those who care for the elderly, who are typically reimbursed by Medicaid, is also of interest.

Multiple sources told ROI-NJ Thursday that the proposed bill would increase the Medicaid spend in the FY 2020 budget.

One source said that number was an increase of $200 million.

This is not news to Gov. Murphy's administration.

Another source told ROI-NJ the increased Medicaid budget, which is a 50 percent match from the federal government, already has been discussed with the administration.

Coughlin's bill calls for the expected raise from $8.60 to $8.85 per hour to occur in January, followed by an increase for the non-carveout workers to $9.55 on July 1.

SourceURL: https://thehill.com/opinion/healthcare/419488-data-proves-that-medicaid-needs-work-requirements

Data proves that Medicaid needs work requirements

By Rea S. Hederman Jr. and Andrew J. Kidd, opinion contributor — 12/03/18

Lost in the current debate over imposing "work requirements" for Medicaid eligibility has been how such requirements might actually benefit recipients and what "work-free Medicaid" actually costs them. It is time for states to reassess those true costs and benefits.

When the Medicaid expansion under the Affordable Care Act (ACA) added healthy, able-bodied adults without dependent children to the list of

beneficiaries, policymakers overlooked the substantial price paid by these recipients who, as the Congressional Budget Office once forecasted, forego hourly wages and earnings in order to maintain their Medicaid eligibility. Without a work requirement for able-bodied adults to receive Medicaid, studies have shown that the program tacitly encourages such recipients to stay home and not go to work. And, as it turns out, Medicaid's non-work incentive has some not-so-healthy consequences.

In Healthy and Working: Benefits of Work Requirements for Medicaid Recipients, we explain that healthy and single Medicaid recipients working less than 20 hours per week, afraid to work more at the risk of losing their benefits, may actually sacrifice hundreds of thousands of dollars in earnings over their lifetime — more than $212,000 for women and more than $323,000 for men. We even found that those who would start on Medicaid but continue to work until they leave the Medicaid program altogether stand to earn nearly a million dollars more over their working years than if they had limited their work and simply remained on Medicaid.

Such significant lost earnings should not be terribly surprising. Work experience and time in the workforce are key factors that often determine how much employees are paid. Time on the job makes employees more knowledgeable, more skilled, more qualified, more valuable to current employers and more marketable to future ones.

Conversely, those who leave the workforce for any extended period diminish their job skills, become less marketable and attractive to employers and find it harder to find new work the longer they stay at home. State policymakers know this, which is why states restrict how long able-bodied adults may collect state-funded unemployment insurance — to encourage healthy workers to go back to work. And states participating in the ACA's Medicaid expansion should consider adopting work requirements for new, healthy working-age Medicaid enrollees for precisely the same reasons.

Adopting work and "community engagement" requirements, such as education and job training, is nothing new. Republicans and Democrats both know that such requirements tend to keep government benefits recipients participating in the workforce, helping them to gain valuable work experience and generate more income over the long-term. FDR acknowledged as much during the Great Depression citing "the moral and spiritual value" of work and Bill ClintonWilliam (Bill) Jefferson ClintonFeds received whistleblower evidence in 2017 alleging Clinton Foundation wrongdoing Dem strategist says Trump should not have

attended George H.W. Bush's funeral Six touching moments during George HW Bush's state funeral MORE made work requirements a key component of welfare reform more than 20 years ago.

In the long-run, requiring able-bodied Medicaid enrollees to work or work more will contribute to their financial and physical well-being. Not only will work requirements yield higher lifetime earnings, but research also shows a strong correlation between income and health. More money can often mean a healthier lifestyle and higher quality health care, which just happen to be Medicaid's core objectives.

Requiring some recipients to work for their Medicaid benefits will go a long way toward helping the recipients themselves. Creating incentives for healthy, able-bodied adults to return to or remain in the workforce can have significant, lasting effects on the lives — and bank accounts — of countless constituents that should not be lost or forgotten in the fight over Medicaid reform.

Rea S. Hederman Jr. is the executive director of the Economic Research Center at The Buckeye Institute and vice president of policy. Andrew J. Kidd, Ph.D., is an economist with the Economic Research Center. They are co-authors of Healthy and Working: Benefits of Work Requirements for Medicaid Recipients.

Medicaid Changes For Florida's Most Vulnerable Children

By Julio Ochoa • Dec 5, 2018

Originally published on December 3, 2018 8:00 am

The state starts rolling out new Medicaid managed care plans on Saturday and some are worried about the impacts to Florida's most vulnerable children.

The state entered into five-year contracts with private companies to manage its Medicaid plans earlier this year. The changes will impact roughly 600,000 of the more than 3 million Medicaid enrollees.

And for the first time, private insurance companies will manage the medical foster care plan and early intervention services for infants and toddlers.

About 300 children with complex medical conditions are covered in Medicaid's medical foster care plan. Early intervention services, also known as Early Steps, covers children up to 36 months old who have developmental issues.

"It's a complicated population," Swerlick said. "It's not one you want to be experimenting on how well privatization works on this population."

Those who care for these children will have to determine whether they can keep the same providers. The providers will have to negotiate with multiple plans and determine whether they will continue to be reimbursed. The private insurance companies will now be in charge of deciding whether the services are medically necessary, Swerlick said.

In the case of the medical foster care patients, the providers include foster parents.

"They will have to be interacting with insurance companies to become part of their network and to get paid," Swerlick said. "They are responsible for taking

care of the most vulnerable kids with medically complex issue that are in our foster care system."

Those who care for these children have not been given enough notice to prepare for the change, she said.

The state told the News Service of Florida that it planned to mail letters in October to Medicaid recipients in the regions where the new plans would first be rolled out. That includes Miami-Dade, Broward, Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties.

For a complete schedule of when the new plans will start across Florida, **click here**.

"These families are just struggling to make sure their kids get what they need," Swerlick said. "And especially for young kids and infants, the timing of getting these services is so critical to their development and likelihood of success as adults."

The new Medicaid plans will be required to reimburse for care provided by the former plans' providers for up to 60 days.

The state could not be reached for comment.

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SourceURL: https://wreg.com/2018/12/05/mississippi-medicaid-increasing-visits-to-doctors-offices/

Mississippi Medicaid increasing visits to doctors' offices

Posted 5:31 am, December 5, 2018, by AP

JACKSON, Miss. — Mississippi's Medicaid program will soon start covering more doctors' office visits for its recipients in a move that officials hope will ultimately save the state some money.

Starting Jan. 1, most recipients can see a physician up to 16 times a year. That is an increase from the current limit of 12. The Division of Medicaid announced the new policy Tuesday, months after Gov. Phil Bryant signed a law authorizing several changes in Medicaid services.

Legislators have said lifting the cap on physicians' visits could encourage Medicaid recipients to seek preventative health care rather than waiting to seek more expensive care in emergency rooms after serious conditions develop. Division of Medicaid spokesman Matt Westerfield said it's difficult to estimate how often people will change where and when they seek medical services.

Medicaid officials estimate that covering additional doctors' office visits could cost less than $1 million, and there could be savings from a decrease in emergency room visits, Westerfield said in response to questions from The Associated Press.

"We are hopeful that improving beneficiary access to care in the most appropriate, lowest cost setting will result in better health outcomes and significant financial benefit to taxpayers," he said Tuesday.

Some Mississippi Medicaid recipients already are eligible for larger numbers of doctors' office visits. Those in nursing homes receive 36 per year, and those in managed care don't have a limit.

Medicaid is a government health insurance program for the needy, aged, blind and disabled. It covers nearly 675,000 people in Mississippi, or about 22 percent of the state's 3 million residents. The federal government pays for more than 75

percent of Medicaid expenses in Mississippi, one of the poorest states in the nation.

During the state budget year that ended in June 2016, about 8 percent of eligible Mississippi Medicaid beneficiaries reached the limit of 12 physicians' visits, Westerfield said.

Mississippi is among the 14 states that have not expanded Medicaid coverage to adults who earn up to 138 percent of the federal poverty level, or an income of $28,676 for a family of three. Medicaid expansion is an option under the health overhaul law signed in 2010 by then-President Barack Obama. Bryant and Republican legislative leaders in Mississippi have said they don't want to increase the number of people enrolled in a government program.

SourceURL: https://www.washingtonexaminer.com/policy/healthcare/california-democrats-plan-to-extend-medicaid-to-illegal-immigrants

California Democrats plan to extend Medicaid to illegal immigrants

by Kimberly Leonard

| December 03, 2018 10:32 PM

A California lawmaker has pledged to re-introduce a bill that would allow adults who live in the state illegally to receive medical care paid for by the government.

State Assembly member Joaquin Arambula, a Democrat and a doctor, announced the plans Monday as the legislature convened at the state capitol, according to the Los Angeles Times.

Should the bill advance, California would become the first state to extend Medicaid coverage regardless of immigration status. State projections for last year's bill found that 1.8 million people in California are uninsured and reside there illegally; roughly 1.2 million would qualify for Medi-Cal, the name of the state's Medicaid program.

The legislation is being introduced ahead of a new governor entering office. Gov.-elect Gavin Newsom initially had vowed to seek a single-payer healthcare system for the state, but tamped down his rhetoric later in the campaign, focusing instead on extending coverage to the uninsured. Single-payer systems refer to one source of payment for all medical services, usually the government.

Arambula introduced a similar bill last session alongside state Sen. Ricardo Lara, but the final versions would have covered fewer people than they had both originally envisioned. They were narrowed to young adults, between the ages of 19 and 26, and to immigrants over the age of 65. Outgoing Democratic Gov. Jerry Brown refused to fund the provisions in the state budget.

The latest plan would carry an estimated price tag of $3 billion a year, according to California's Legislative Analyst's Office, which would be paid for by the state's general fund. Medicaid is otherwise jointly funded by the state and federal governments.

Critics have questioned whether people in the U.S. illegally would move to California to receive healthcare benefits, which would increase state spending.

Under a Medicaid provision in Obamacare, anyone making less than roughly $17,000 a year qualifies for coverage. That provision, however, doesn't apply to people who are in the U.S. illegally. Emergency departments provide medical care for people regardless of immigration status.

California has already extended Medicaid to people younger than 19 who are in the state illegally.

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Kansas House Republicans pick conservative leader who opposes Medicaid expansion

By Jonathan Shorman

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Rep. Dan Hawkins after winning House Majority Leader on Monday. Jonathan Shorman The Wichita Eagle

TOPEKA
A staunch opponent of Medicaid expansion will lead Republicans in the Kansas House next year – a possible obstacle to Gov-elect Laura Kelly's promise to

change the program.

House Republicans elected Rep. Dan Hawkins as Majority Leader on Monday. The Wichita lawmaker has worked next to Kelly for years on health and welfare issues, but the two often hold sharply different views.

Meanwhile, Democrats chose Rep. Tom Sawyer, of Wichita, to serve as Minority Leader. The veteran lawmaker is known for his easygoing manner and ability to compromise.

The selection of Hawkins reflects a Republican caucus that shifted to the right in the fall's elections.

"We still have to govern. It's not just conservatives, moderates. It's Republicans. And that's the way we've got to look at it," Hawkins said.

For Democrats, Sawyer contends he can forge a good working relationship with Republicans amid Kelly's calls for renewed bipartisanship in the Statehouse.

Sawyer will be the third minority leader for House Democrats in the past six years. With a Democratic governor, working with Republicans will become even more important to passing legislation, he said.

"We want to work together with Republicans to pass good legislation for Kansas, rather than take the approach of just being bomb throwers and oppose everything," Sawyer said.

Republicans and Democrats both rejected their past leadership, with current Majority Leader Don Hineman and Minority Leader Jim Ward losing bids to retain their positions. House Speaker Ron Ryckamn, an Olathe Republican, easily retained the speakership, however.

Hawkins defeated Hineman, 48-35. Sawyer defeated Ward, 24-16.

Hawkins has often focused on health and welfare issues since joining the Legislature in 2013. He currently chairs the House Health and Human Services Committee, and currently chairs the KanCare Oversight Committee, which keeps tabs on the state's Medicaid program.

Hawkins and Kelly have served together on those committees for years. They have appeared to have a collegial relationship, even though Hawkins opposes Medicaid expansion and Kelly opposes welfare eligibility restrictions supported by Hawkins.

Kelly made Medicaid expansion a central promise of her campaign. Since her election, she has said she plans to develop her own expansion plan using a task force.

"It's not up to me to pass Medicaid expansion, it's up to the Legislature to do that and I fully expect that they will address that issue this (next) year and if they put a bill on my desk and it does what it needs to do, I will sign it," Kelly said in a recent interview.

In a statement Monday, Kelly congratulated the new legislative leaders and said she looks forward to working with them.

Kelly's expectation that lawmakers will pass expansion will put her at odds with Hawkins. In the days following her election, Hawkins said it was a "foregone conclusion" that Medicaid expansion would go through.

But on Monday, he sounded a different note.

"I've not heard a whole clamoring in the body yet for a Medicaid expansion bill. I've heard a lot in the press, I've heard a lot from other places but in the people I've been talking to, I've not heard a lot of people say, 'let's go spend all of our money on Medicaid expansion," Hawkins said.

Hawkins also said that if a Medicaid expansion bill comes forward, it may be more conservative because of the Republican caucus is now more conservative.

Medicaid is a federal program run by the states. States that expand eligibility up to 138 percent of the federal poverty line ($34,638 in annual income) receive additional funding from the federal government to help pay for the costs of expansion.

The federal government pays 90 percent of the cost, while the states pay 10 percent. Estimates vary, but expansion could cost Kansas an additional $26 million or more every year.

Supporters passed legislation in 2017 that was vetoed by then-Gov. Sam Brownback. They came up short when they tried to override the veto in the House, which requires two-thirds of the votes.

But supporters are hopeful that they can pass expansion in 2019 because this time they will need only a simple majority of votes.

Under Hawkins, conservative Republicans will exercise more influence in the House. Hineman, a moderate, was selected as majority leader in 2016 after the election of a wave of moderate Republicans were elected to the Legislature. Several of those moderate Republicans lost their bids for re-election this year.

Hineman said the Republican caucus shifted to the right. He also said the Democratic caucus moved to the left as well.

Still, Rep. Russ Jennings, a moderate Republican from Lakin, said neither conservative Republicans nor Democrats alone have enough votes to pass bills.

"I think moderate Republicans in this state will have some influence on policy. We may not hold leadership positions by title, but that title doesn't mean you can't be involved in leadership," Jennings said.

With Sawyer as their leader, Democrats are turning to a lawmaker first elected in 1987 who has previously served as minority leader.

And while both Ward and Sawyer are veteran lawmakers, Ward has been more prone to fiery speeches and statements than Sawyer. Sawyer, by contrast, rarely gives impassioned floor speeches.

"This is a tremendous opportunity to help govern and to help pass laws that will greatly benefit Kansas," Sawyer said. "But to do that we need to build coalitions with Republicans and work closely with Republicans."

Ward declined to comment on the vote.