Medicaid News Curator: Volume 7

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Medicaid News Curator: Volume 7

Reading and highlighting the Medicaid interwebs to save you time

2/14/2019

Idaho plans to track costs, benefits of Medicaid expansion

SourceURL: https://www.seattletimes.com/seattle-news/northwest/idaho-plans-to-track-costs-benefits-of-medicaid-expansion/

Idaho plans to track costs, benefits of Medicaid expansion

Originally published February 11, 2019 at 11:01 am

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By
The Associated Press

The Associated Press

BOISE, Idaho (AP) — Medicaid expansion in Idaho will be tracked as a stand-alone item so that lawmakers can see how much it's costing and where the money is going.

Medicaid Division Administrator Matt Wimmer also told lawmakers on the Joint Finance-Appropriations Committee on Monday that there will be decreases in the cost of some other state programs with the expansion.

Voters authorized Medicaid expansion with an initiative in November that passed with 61 percent approval after years of inaction by the Idaho Legislature.

The expansion will provide access to preventative health care services for about 91,000 low-income Idaho residents, according to a risk management company hired by the state.

The federal government would cover 90 percent of the estimated $400 million cost of Medicaid expansion, and Idaho lawmakers have to figure out how to pay the state's share.

Alaska’s backlog of Medicaid applications numbers nearly 16K

SourceURL: https://www.seattletimes.com/seattle-news/northwest/alaskas-backlog-of-medicaid-applications-numbers-nearly-16k/

Alaska’s backlog of Medicaid applications numbers nearly 16K

Originally published February 10, 2019 at 9:14 pm Updated February 11, 2019 at 6:26 am

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By
The Associated Press

The Associated Press

ANCHORAGE, Alaska (AP) — Alaska’s backlog of Medicaid applications numbered 15,639 at the end of last month, with about two-thirds of the cases filed last year.

The backlog is down from the more than 20,000 cases noted in a state report in May, and it’s down from the 30,000 cases reported the prior year, the Alaska Journal of Commerce reported last week.

The average wait time for an application to get approved is 55 days, said Clinton Bennett, media relations manager for the state Department of Health and Social Services. Some cases get processed quicker, he said.

“Cases that are tagged as emergent, involve a pregnant woman or adding a newborn to any case are being processed on average within 2 days,” Bennett said.

About 210,276 people are enrolled in Medicaid or the Children’s Health Insurance Program, about 24 percent of the state’s population, according to the Centers for Medicare and Medicaid Services. The state had 123,335 people enrolled in July 2015, before the Medicaid expansion took effect.

The state uses pre-enrollment eligibility verification that requires applicants’ income to be verified before they’re approved to enter the program, Bennett said. The state cooperates with the federally-facilitated marketplace to verify eligibility. If Healthcare.gov is unable to determine eligibility, the state will take over.

Alaska is among a few states that have extensive delays for processing applications, said Tricia Brooks, a senior fellow at Georgetown University’s Center for Children and Families. The federal standard is 45 days for non-disability Medicaid applications, and 90 days for disability Medicaid applications.

“Backlogs affect both new applications as well as renewals,” Brooks said. “If the state’s unable to keep up with renewals, they should not be automatically terminating someone because they’re not able to renew applications.”

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Information from: (Anchorage) Alaska Journal of Commerce, http://www.alaskajournal.com

Medicaid rolls fall in MIssouri, Tennessee, worrying advocates for poor

SourceURL: https://www.nbcnews.com/health/health-care/medicaid-rolls-fall-missouri-tennessee-worrying-advocates-poor-n968946

Medicaid rolls fall in Missouri, Tennessee, worrying advocates for poor

Social workers worry that the states' efforts to weed out improperly enrolled residents has led to wrongful terminations.

Feb. 7, 2019, 12:30 PM CST

By Phil Galewitz, Kaiser Health News

Tangunikia Ward, a single mom of two who has been unemployed for the past couple of years, was shocked when her St. Louis family was kicked off Missouri's Medicaid program without warning last fall.

She found out only when taking her son, Mario, 10, to a doctor to be treated for ringworm.

When Ward, 29, tried to contact the state to get reinstated, she said, it took several weeks just to have her calls returned. Then she waited again for the state to mail her a long form to fill out attesting to her income and family size, showing that she was still eligible for the state-federal health insurance program for the poor.

Mario, who is in third grade, missed much of school in December because Ward could not afford a doctor visit without Medicaid. His school would not let him

return without a doctor's note saying he was no longer infected.

In January, with the help of lawyers from Legal Services of Eastern Missouri, she was able to get back on Medicaid, take her son to a doctor and return him to school. "It was a real struggle as it seemed like everyone was giving me the runaround," Ward said. "I am upset because my son was out of school, and that pushed him behind."

Ward and her children are among tens of thousands of Medicaid enrollees who were dropped by Missouri and Tennessee last year as both states stepped up efforts to verify members' eligibility.

Last year, Medicaid enrollment in those two states declined far faster than in other states, and most of those losing coverage are children, according to state data.

State health officials say several factors, including the improved economy, are behind last year's drop of 7 percent in Missouri and 9 percent in Tennessee.

But advocates for the poor think the states' efforts to weed out residents who are improperly enrolled, or the difficulty of re-enrolling, has led to people being forced off the rolls. For example, Tennessee sent packets to enrollees that could be as long as 47 pages to verify their re-enrollment. In Missouri, people faced hours-long waits on the state's phone lines to get help in enrolling.

Medicaid enrollment nationally was down about 1.5 percent from January to October last year, according to the latest enrollment data available from the federal government's Centers for Medicare and Medicaid Services.

Herb Kuhn, president and chief executive of the Missouri Hospital Association, said the state's efforts to verify Medicaid eligibility could be tied to an increase in the number of people without coverage that hospitals are seeing.

"When we see over 50,000 children come off the Medicaid rolls, it raises some questions about whether the state is doing its verifications appropriately," he said. "Those who are truly entitled to the service should get to keep it."

In 2018, Missouri Medicaid began automating its verification system. People who were identified as ineligible, for income or other reasons, were sent a letter asking

them to provide updated documentation. Those who did not respond or could not prove their eligibility were dropped.

The state does not know how many letters it sent or how many people responded, said Rebecca Woelfel, spokeswoman for the Missouri Department of Social Services, which oversees Medicaid. She said Missouri Medicaid enrollees were given 10 days to respond.

Woelfel cited the new eligibility system, the improved economy and the rescinded federal tax penalty for people who lack insurance as factors behind the decline in enrollment.

Missouri's unemployment rate dropped from 3.7 percent in January 2018 to 3.1 percent in December as the number of unemployed people fell by about 17,000.

Missouri Medicaid had almost 906,000 people enrolled as of December, down from more than 977,000 in January 2018, according to state data. About two-thirds of those enrolled are children or pregnant women.

Timothy McBride, a health economist at Washington University in St. Louis who heads a Missouri Medicaid advisory board, said the state's eligibility system has made it too difficult for people to stay enrolled. Since low-income people move or may be homeless, their mailing addresses may be inaccurate. Plus, many don't read their mail or may not understand what was required to stay enrolled, he added.

"I worry some people are still eligible but just did not respond, and the next time they need health care they will show up with their Medicaid card and find out they are not covered," McBride said.

Tennessee's Medicaid enrollment fell from 1.48 million in January 2018 to 1.35 million in December, according to state data. Tennessee Medicaid spokeswoman Kelly Gunderson credits a healthy job market. The state's unemployment rate was relatively stable last year at under 4 percent.

"Tennessee is experiencing a state economy that continues to increase at what appears to be near-historic rates," she said, which is improving Tennesseans' lives and decreasing their need for Medicaid coverage and the Children's Health Insurance Program.

She added that the state has a "robust appeals process" for anyone who was found ineligible by the state's reverification system.

The Tennessee Justice Center, an advocacy group, has worked with hundreds of families in the past year trying to restore their Medicaid coverage. The verification process will make Medicaid rolls smaller and save money, "and that's a poor way for the state to measure success," said Michele Johnson, executive director of the nonprofit group. It's penny-wise and pound-foolish, she added, because it leads to patients showing up at emergency rooms without coverage — and hospitals have to pass on those costs to everyone else.

After rapid growth since 2014, when the Affordable Care Act expanded health insurance coverage to millions of Americans, Medicaid enrollment nationally started to fall, declining from 74 million in January 2018 to about 73 million in October, according to the latest enrollment data released by the federal Medicaid agency.

Missouri and Tennessee are among 17 states that have not expanded Medicaid under Obamacare. But many of those non-expansion states nevertheless saw enrollment grow, because as people tried to sign up for insurance on the exchanges, those meeting state criteria were routed to Medicaid.

McBride, the health economist, said the steep drop is especially disconcerting because most of those affected are children. Because children are eligible for Medicaid or the Children's Health Insurance Program with family incomes as high as 300 percent of the federal poverty level, or $77,250 for a family of four, he said, it's unlikely that a parent's change in job would be enough for a child to lose eligibility.

Legal Services of Eastern Missouri, which advocates for low-income residents, estimates that nearly 57,000 of those dropped from the Medicaid rolls were children, a decline that is nine times the national average.

Missouri's 70,000-person drop in enrollment, he noted, marks the biggest single-year reduction since 2006, when the state instituted tighter eligibility levels for certain groups.

Joe Pierle, chief executive officer of the Missouri Primary Care Association, a trade group representing community health centers, said he doesn't think that the

state is doing anything "underhanded or nefarious." Nevertheless, he's not sure Medicaid officials did enough to reach out to people before dropping them.

"I suspect some people are falling through the cracks," he said.

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

'38 days of hell': Nursing home advocates lambast Medicaid transporter - News - McKnight's Long Term Care News

SourceURL: https://www.mcknights.com/news/38-days-of-hell-nursing-home-advocates-lambast-medicaid-transporter/

'38 days of hell': Nursing home advocates lambast Medicaid transporter

In the six weeks since Rhode Island switched to a new Medicaid transportation provider, nursing home advocates said every day has put residents at life-threatening risk.

"Someone is going to die," former state senator John Tassoni Jr. said at a recent hearing, according to the Providence Journal.

Rhode Island first moved from LogistiCare to Missouri-based Medical Transportation Management Jan. 1. That switch has been a bumpy ride, literally and figuratively, with a flood of missed appointments, delays and other problems, according to those who testified at a state committee meeting last Thursday.

More than 1,000 complaints have been filed, with many patients missing scheduled chemotherapy, dialysis, methadone treatment or doctor visits. Some local nursing homes leaders have transported residents using personal vehicles.

"Frankly, at this point it's become a fiasco," said Christopher Ryan, owner and administrator of the 71-bed Pine Grove Health Center nursing facility in Pascoag, RI. "At what point does this end?"

Tassoni, who is now an executive with the Mental Health Leadership Council of Rhode Island, called Medical Transportation Management's short tenure "38 days of hell."

In a statement submitted to the committee, the head of MTM apologized and committed to working on the issue, noting that the company is bringing new technology to Rhode Island, and the changeover has proved challenging. The company came under fire in Arkansas for a similar string of missed appointments, *McKnight's* reported in January.

Blue States Set to Test Trump Official on Medicaid, ACA

SourceURL: https://www.wsj.com/articles/a-top-trump-health-administrator-faces-test-from-newly-elected-democrats-11549803600

Blue States Set to Test Trump Official on Medicaid, ACA

Seema Verma, head of one of the most powerful federal health-care agencies, granted Republican states the authority to require that Medicaid recipients work to be eligible.

Now, after November midterm elections that saw Democrats flip seven governorships and retake the House of Representatives, Democratic-run states are poised to ask for approval to expand coverage, including statewide single-payer or public health options.

Ms. Verma has said her goal is to give states more authority over their own health-care markets. Some health analysts say the question now is whether that push for deregulation will also mean her agency approves bolder Democratic plans.

"It's really going to be a test," said Chris Sloan, a director at Avalere, a health-care consulting firm. "Does flexibility go to everyone or is it just for cheaper, less regulated insurance?" Mr. Sloan asks. "That has yet to be decided."

Ms. Verma, in an interview with the Wall Street Journal, stressed the importance of judging each idea on its merits. If a proposal is sound and good for consumers, and within legal and budgetary parameters, "our job is to help them get there," said Ms. Verma, who is administrator of the powerful Centers for Medicare and Medicaid Services, an agency with a $1 trillion budget that also oversees implementation of the Affordable Care Act and is the largest purchaser of health care in the U.S.

"There is no monopoly on good ideas," Ms. Verma said. "There is no effort on our end to not get them where they want to go."

For Ms. Verma, 2019 is a pivotal year. She has made decisions that will shape coverage for the roughly 127 million people on Medicare, Medicaid and the ACA

markets, and has said she wants to drive an agenda of increased transparency over health prices, better data sharing, and measures to assure the long-term viability of Medicare and Medicaid.

Patients, she said, should have the ability to compile all of their health histories and records from birth so that data can later be used for better, targeted treatments. She wants picking doctors to be like picking a restaurant, where consumers know costs and quality information before deciding where to go. That will spur competition that will help drive down prices, she says, a claim that some say is an open question.

Like other members of the Trump administration, Ms. Verma will have to juggle her agenda with increased scrutiny from Democrats in Congress. A House subcommittee this month held a hearing on the impact of the administration's policies rolling back the ACA, and more are planned. Some Democrats are plainly spoiling for a fight.

"Administrator Verma is the architect of President Trump's politically-motivated charge against America's health care," said Senate Minority Leader Chuck Schumer (D., N.Y.), adding that "the result of her tenure at CMS is higher health-care costs and less access to quality health care."

Ms. Verma counters: "Just look at the results, right? The rates have gone down, we've brought more insurers to the market."

Two Sides

The federal Centers for Medicare and Medicaid Services is responsible for approving Medicaid and Affordable Care Act waivers. States want different conditions, reflecting a national ideological divide over health care.

Red states have asked for:

Work requirements for Medicaid recipients
Temporarily locking some Medicaid beneficiaries out of coverage
Higher copays in Medicaid
Blue states want:

Single-payer system at the state level
Expanded Medicaid eligibility

To add a government-sponsored insurance option on the ACA exchange
Expanded eligibility for ACA subsidies

Some health analysts say rates on the ACA markets would have gone down more this year if it hadn't been for the administration's actions. They also say President Trump's decision in 2017 to end billions of dollars in payments to insurers led to higher premiums last year.

Some critics say her approval of work requirements—which makes Medicaid conditional on some beneficiaries being employed, in job training, or involved in community service—has led to a decrease in coverage. Arkansas has seen more than 18,000 people lose benefits because they didn't meet work and reporting requirements.

She defends her approval of work requirements in Medicaid as moving people out of poverty and into jobs. She opposes letting Medicare negotiate drug pricing, saying it would deprive some people of certain medications. She also said she is against Medicare for All, which she says would put health care into an already bloated government bureaucratic system.

"It took us three years to cover diabetic pumps that are being covered in the private market," she said. "That's the government."

Republicans, including Sen. Lamar Alexander (R., Tenn.), said she is doing much of what they couldn't accomplish in their failed 2017 bid to repeal the health law. "She's been good at listening to the concerns of states," added Republican Utah Gov. Gary Herbert. "I appreciate the fact that Seema understands how I do it in Utah will be different than in California."

What isn't clear is how different Ms. Verma will allow blue states to be. California's Democratic Gov. Gavin Newsom has asked to create a single-payer system. Maryland, Colorado and Nevada are considering offering Medicaid plans to consumers who buy in.

Ms. Verma, a mother of two, went in 2016 from being a health-care consultant to directing the sprawling agency with about 6,400 federal employees. She commutes from her home in Carmel, Indiana, leaving at 3:30 a.m. on Mondays to be in Washington by morning. She has worked quietly to temper some White House efforts to upend the ACA markets, according to several people familiar with the discussions.

Ms. Verma, who is close with Vice President Mike Pence, argued unsuccessfully against ending the payments to insurers, they said. She also pushed back against a White House idea to end automatic re-enrollment on the ACA exchange. Ms. Verma argued it could weaken the markets and create hassles for states, sources said. Insurers expressed relief in January when CMS announced no change would be likely until at least 2021.

"She is a voice of restraint on more extreme ideas out of the White House," said Nicholas Bagley, a University of Michigan law professor whose opinions are sought by ACA supporters.

And yet, "my impression is that she's done overall what the administration wants her to do: Weaken the ACA and create a situation where it's easier to topple."

Write to Stephanie Armour at stephanie.armour@wsj.com

Whitmer to seek changes in Mich. Medicaid work rules

SourceURL: https://www.detroitnews.com/story/news/local/michigan/2019/02/09/medicaid-work-requirements-changes-gretchen-whitmer/39031095/

Whitmer to seek changes in Mich. Medicaid work rules

David Eggert, Associated Press Published 9:12 a.m. ET Feb. 9, 2019 | Updated 9:14 a.m. ET Feb. 9, 2019
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Lansing – Democratic Gov. Gretchen Whitmer said Friday that she will ask the Republican-led Legislature to change newly enacted work or job-related requirements to qualify for Michigan's Medicaid expansion program, saying that between 61,000 and 183,000 residents could lose coverage should the rules take effect in 2020, as scheduled.


Gov. Gretchen Whitmer (Photo: AP)

Whitmer disclosed her plan in a letter to Seema Verma, administrator of the federal Centers for Medicare and Medicaid Services. The Trump administration in December approved the state's requirements and signed off on a waiver that then-Gov. Rick Snyder said would also extend the Medicaid expansion, known as Healthy Michigan, through 2023.

"As governor, I am committed to doing everything in my power to defend Healthy Michigan and protect coverage for the 680,000 Michiganders who rely on it for quality care," Whitmer said in a statement. "That's why I plan to take steps in the coming weeks to work with our partners in the Legislature to change the Healthy Michigan Plan so that it preserves coverage, promotes work, reduces red tape and minimizes administrative costs."

Messages seeking comment were left with GOP legislative leaders, who likely will resist changing work rules that became law in June.

At the time the federal waiver was issued, Snyder's office said the requirements could affect about 400,000 of the 663,000 people who were covered through the

expansion program. Many, however, will probably qualify for one of many exemptions.

Whitmer, however, pointed to a report released this week by Manatt Health, which estimates that 61,000 to 183,000 – or between 9 percent and 27 percent of the Medicaid expansion population – will lose coverage over a one-year period. The study was funded by State Health and Value Strategies, a program of the Robert Wood Johnson Foundation. The estimate is higher than one made last year by the nonpartisan House Fiscal Agency, which said caseloads could drop by between 5 percent and 10 percent.

At the time Michigan's law was enacted, Whitmer wrote, its effects were "speculation" because work rules in other states had not taken effect. She said in Arkansas, 18,000 people lost their insurance in the first seven months – "and Michigan's statute is more sweeping … threatening a broader range of adults with more exacting reporting demands."

In Michigan, able-bodied adults ages 18 to 62 who want to keep their coverage will have to show workforce engagement averaging 80 hours a month – through work, school, job training or vocational training, an internship, substance abuse treatment or community service.

Republican lawmakers have defended the law, saying it will help fill job openings.

Critics say eliminating retrospective eligibility to Medicaid is one more barrier the Trump administration has erected to make public benefits harder to access.

New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients

By Harris Meyer | February 9, 2019

Last year, Jackson Memorial Hospital in Miami admitted an uninsured, low-income patient who stayed in the hospital for 86 days and ran up total charges of more than $1 million.

It took the public hospital's staff 65 days to complete a Medicaid application for the patient. Once it was approved, the Florida Medicaid agency covered bills for the previous 90 days, as per federal Medicaid policy in effect across the country since 1972. Jackson received a payment of $82,000, based on the state's limit of 45 covered hospital days per year.

But on Feb. 1, Florida ended retrospective Medicaid eligibility under a waiver granted by the CMS in November and effective through June, which likely will be extended. Now it will only cover claims back to the first day of the month in which an application is filed. The state projects this will save it and the federal government $100 million a year. The Trump administration so far has granted similar waivers to five other states.

If the waiver had been in effect last year, Jackson would have eaten that patient's entire bill. It estimates the new policy will cost the hospital at least $4 million a year in uncompensated care, and likely far more.

“We get trauma cases where we can't identify the patient or get documentation for weeks,” said Myriam Torres, Jackson's vice president of revenue cycle. “This will save Medicaid dollars at providers' and patients' expense.”

A costly incentive

Over the past two years, despite strong objections from hospitals and other provider groups, the CMS has granted waivers of 90-day retrospective eligibility to Arizona, Arkansas, Florida, Iowa and Kentucky. Some were part of broader Medicaid Section 1115 demonstrations of work requirements. Maine also received a waiver but its new Democratic governor announced she won't implement it. The CMS is considering similar waiver requests from Ohio and other states.

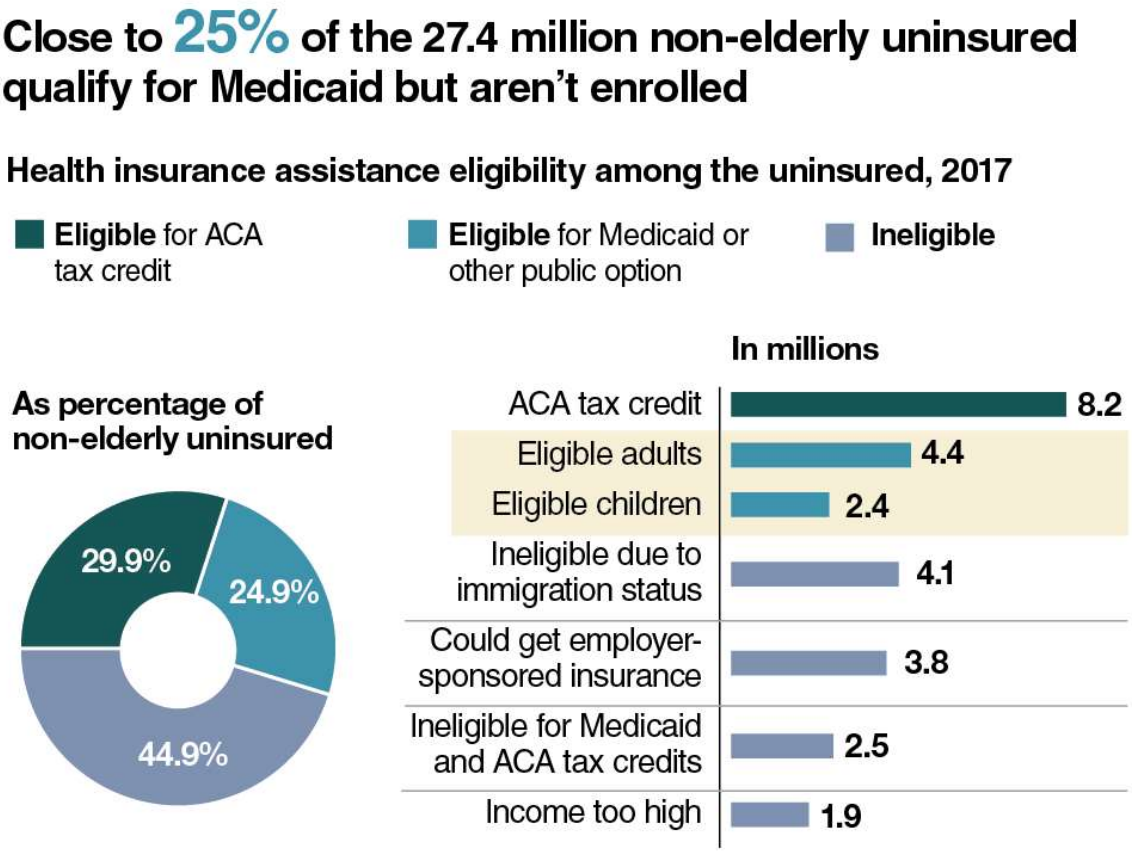
In its approval letters, the CMS argued that demonstrations ending 90-day retrospective eligibility will test whether that gives beneficiaries an incentive to enroll in Medicaid before they need healthcare services, so they can receive preventive services and stay healthier. It also says the change will facilitate a smoother transition of beneficiaries into commercial health plans, which don't offer retroactive coverage.

The CMS is requiring states to develop outreach and education strategies to encourage providers and beneficiaries to submit Medicaid applications as early as possible, though providers say they haven't seen any significant new state activity there.

A CMS spokesman said that as in all Section 1115 demonstration waivers, the agency is requiring states to monitor and regularly report the outcomes and financial impact.

But experts say there's no evidence that eliminating retrospective eligibility encourages Medicaid-eligible people to sign up earlier, and there are plenty of reasons why that hypothesis is implausible.

“Many people who aren't enrolled are not aware they are eligible or they have difficulty with the enrollment process,” said Dr. Benjamin Sommers, an associate professor of health policy and economics at Harvard University. “The notion that most people will sign up by getting rid of retrospective eligibility is unlikely. They typically do not even understand it.”



Critics say eliminating retrospective eligibility is one more administrative barrier the Trump administration has erected to make Medicaid and other public benefits harder to access. These include work and reporting requirements, premium payments, healthy behavior incentives, benefit lockouts, and proposed penalties for legal immigrants who use public programs. States like Arkansas that have added new hurdles have seen sharp drops in Medicaid enrollment.

"Shortening the (retrospective eligibility) window gives people less time to figure out they'd be eligible," said Pamela Herd, a public policy professor at Georgetown University, who calls that form of administrative burden a learning cost. "Republicans have employed these types of changes to reduce use of social welfare programs."

Changing nature of waivers

Under previous administrations, Delaware, Indiana, Maryland, Massachusetts, New Hampshire and Tennessee received waivers of the federal requirement for retrospective eligibility, typically as part of coverage expansions. In contrast, the Trump administration's waivers have been part of programs to restrict coverage.

Most of these waivers retain retroactive coverage for pregnant women, infants, disabled people and those in nursing homes. Florida's waiver, however, excludes such coverage for the nursing home population.

Herd and other experts say that if the goal is to get people to enroll as soon as they are eligible, there are proven ways to achieve that, such as streamlining the enrollment process and doing more aggressive outreach. The Trump administration has sharply cut funding for enrollment education and assistance.

On the other hand, if the goal is to reduce federal and state spending on Medicaid and shift costs to providers and patients, eliminating retroactive eligibility likely is effective.

Actuarial analyses of Medicaid payments have shown that about 5% of Medicaid payments occur during the retrospective eligibility period. Ending retrospective coverage would reduce Medicaid outlays by an estimated $13.3 billion from 2017 to 2026, according to the Commonwealth Fund.

In 2016, Indiana reported that 14% of beneficiaries to whom the waiver applied ran up significant out-of-pocket medical expenses as a result, averaging more than $1,500 per person. Sixteen percent of providers said they saw charity cases and bad debt increase as a result of the policy.

“If this is really an experiment, what is the policy goal other than to reduce program costs?” asked Joseph Antos, a conservative health policy analyst at the American Enterprise Institute. “Presumably this should have something to do with patient outcomes or efficiencies. I don't see the word efficiency in any of this. I see cut.”

A history lesson and the impact on beneficiaries

Retrospective eligibility was built into federal Medicaid law early on as a safety net protection for very low-income people and their medical providers. It encourages providers to treat patients knowing they'll get paid and to help them sign up quickly for the program.

Another key rationale is that unlike in private insurance, many Medicaid beneficiaries “churn” on and off coverage due to changes in income and because

states impose a demanding annual eligibility redetermination process. It's estimated that 25% or more of beneficiaries are at least temporarily disenrolled as a result of the redetermination process and other factors.

Many other people aren't even aware they are eligible. The Kaiser Family Foundation recently reported that 6.8 million uninsured adults and children were eligible for Medicaid but were uninsured in 2017.

All these factors leading to loss of coverage for eligible people makes retrospective eligibility an important backstop, patient advocates say.

But some state and federal officials long have complained about the cost of retroactive coverage, which generally can't be passed on to the private Medicaid plans that administer most state programs.

Tennessee received a waiver in 1994 as part of its major Medicaid coverage expansion program known as TennCare. Even though that program largely has been rolled back and the state has not expanded Medicaid under the Affordable Care Act, the elimination of 90-day retroactive coverage remains in place for nearly all beneficiaries.

That has led to many Medicaid-eligible people incurring large medical bills before their Medicaid applications are approved, with some facing lifetime debt, said Michele Johnson, executive director of the Tennessee Justice Center, which tries to help people clear up these bills.

The problem was exacerbated by a recent major computer glitch in the state's Medicaid enrollment system, which left thousands unable to file their annual enrollment redetermination applications online.

Before her Medicaid application was approved, one Memphis woman racked up $250,000 in bills resulting from her baby being born with severe health problems. “She said that was the hardest thing in her life—going home with a disabled child and being consigned to poverty for the rest of her life,” said Johnson, whose group helped with her case.

After a nine-month court fight, the woman finally got Tennessee's Medicaid program to pick up the entire bill.

Yet there has never been a study of the policy's impact in Tennessee. “It hasn't led people to sign up ahead of time,” Johnson said. “All these other policies make it

almost impossible to sign up. If the state were interested in that, they would make the whole process less bureaucratic."

In 2017, Iowa received a CMS waiver of the 90-day retrospective eligibility requirement, including for nursing home residents, despite warnings that nursing homes would refuse to admit people who were awaiting Medicaid eligibility. Last year, under pressure from nursing homes, the state Legislature restored retroactive coverage for that population.

Brent Willett, CEO of the Iowa Health Care Association, said it takes an average of 71 days to assemble complicated income and assets information, file the application, and receive approval for Medicaid nursing home coverage. Under the policy the state reversed, facilities only received payment back to the first day of the month when the application was filed, even though they may have admitted the resident many weeks earlier.

The association projected that policy would cost Iowa nursing homes $7 million in the first year. "It sounds nice that people should start the application process early and we agree, but it's not practical in practice," Willett said. "If we are maintaining a system to ensure coverage for people who don't have assets for care, it makes no sense to penalize providers for providing that care. That policy wasn't cost containment, it was a cost shift to providers."

Iowa hospitals looking for a reversal

As to the broader group of beneficiaries affected by Iowa's waiver, the Iowa Hospital Association is pushing to have 90-day retroactive eligibility reinstated this year. The policy hurts urban trauma centers that provide intensive care to people before an application can be completed, as well as rural hospitals that lack a profit cushion to absorb those unexpected costs, said Scott McIntyre, the association's vice president of communications.

The Legislature ordered it as a cost-containment measure, with the state projecting it would affect nearly 40,000 Iowans and save it and the feds $36.7 million a year. The CMS waiver required the state to provide outreach and education to the public to ensure that eligible people apply for Medicaid as soon as possible.

But McIntyre said the state has not ramped up enrollment outreach to mitigate the end of retrospective eligibility.

In addition, Iowa, which expanded Medicaid in 2014, has not conducted any review of the cost savings to the government or of the financial impact on providers and beneficiaries, according to a spokesman for the Iowa Department of Human Services. The CMS, he said, did not require the state to conduct such a report on the impact of eliminating retrospective eligibility. “We've made so much progress with Medicaid expansion to reduce uncompensated care, and this really undermines that progress,” McIntyre lamented.

There's already an effort to roll back the new retrospective eligibility waiver in Florida, which didn't expand Medicaid, so that it applies to nursing home residents and all other Medicaid eligibles except pregnant women and children.

It's basically impossible for many people who may need a nursing home placement to apply for Medicaid ahead of time because they're living in the community and don't qualify until they enter institutional care, explained Tom Parker, director of reimbursement for the Florida Health Care Association.

“I would think that undercuts the main argument for this policy,” he said.

MEDICAID BLOCK GRANT LEGISLATION PROPOSED

SourceURL: http://1057news.com/2019/02/10/16/23/21/medicaid-block-grant-legislation-proposed/

MEDICAID BLOCK GRANT LEGISLATION PROPOSED

Senator Paul Bailey (R-Sparta) and Rep. Timothy Hill (R-Blountville) have introduced legislation that calls for submission of a block grant-waiver amendment to the Federal Centers for Medicare and Medicaid Services. The proposed move would extend Tennessee's financial successes to the state's TennCare program. House Bill 1280 was filed February 6; Senate Bill 1428 was filed February 7.

Bailey called Tennessee one of the "best financially managed" states in the nation, and added a block grant would provide the regulatory flexibility to design an innovative plan that works best for citizens of Tennessee, without having to rely on a cookie-cutter plan from Washington, D.C.

He went on to say this flexibility would enable the state to cut costs and be more efficient with existing Medicaid funds, to permit better-quality care for citizens.

Bailey is chair of the Senate Commerce and Labor Committee. Hill chairs the House Commerce Committee.

Department of Human Services secretary releases Medicaid data dashboard | Abington Journal

SourceURL: https://www.theabingtonjournal.com/news/local/38981/department-of-human-services-secretary-releases-medicaid-data-dashboard

Department of Human Services secretary releases Medicaid data dashboard

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HARRISBURG — Department of Human Services (DHS) Secretary Teresa Miller marked the fourth anniversary of Governor Tom Wolf's Medicaid expansion by releasing a Medicaid data dashboard and updated Medicaid expansion report highlighting data trends and the impacts of Medicaid coverage. Since 2015, more than 1 in 10 Pennsylvanians have been covered at some point because of Medicaid expansion, which currently provides coverage for nearly 700,000 Pennsylvanians.

"Four years ago, Governor Wolf announced that Pennsylvania would expand Medicaid under the Affordable Care Act," Sec. Miller said. "Through this coverage expansion, 1.4 million Pennsylvanians have accessed health coverage through Medicaid since 2015, and our uninsured rate is down to 5.5 percent – the lowest in Pennsylvania's history."

Medicaid expansion helps working Pennsylvanians access comprehensive health care coverage that would otherwise be unaffordable. The updated 2019 Medicaid Expansion Report builds upon a first report issued in 2016 to show the positive

effects Medicaid expansion has had on Pennsylvania's uninsured rate, uncompensated care for hospitals, and improved access to preventive screenings and substance use disorder treatment. These results showcase the improved access coupled with a reduction in uncompensated care – a trend that helps bend health care costs in both the private and public market.

In addition to the report, DHS released a Medicaid data dashboard, an online tool that outlines and visualizes data from both the Medicaid expansion and general Medicaid population. The dashboard includes information on who accesses Medicaid in Pennsylvania, enrollment, and spending data. Data currently available on the dashboard serves as its initial launch, and more information on coverage, service utilization, and personal stories of Medicaid recipients will be added over time.

"It is important that we understand how our programs serve people and the role they play in their lives," said Secretary Miller. "I hope the report and dashboard will serve as resources to help more people understand the critical role Medicaid plays for more than 2.8 million Pennsylvanians and they keep their stories in mind moving forward."

Secretary Miller also highlighted a report published by the University of Pennsylvania to study the Medicaid population and how a work requirement would affect this population. The study found that a Medicaid work requirement would likely affect more than 800,000 Pennsylvanians. However, when you remove individuals who would receive an exemption, are already working, or have been on Medicaid for less than a year, about 90,000 people would remain.

"A work requirement does not automatically give people the skills they need to succeed in a family-sustaining job, and making work a requirement for health care access will either keep them in a cycle of low-wage jobs that keep people reliant on public assistance programs or jeopardize access to health care completely," said Secretary Miller. "Meeting a person's health needs is an important first step to helping them excel in education, training, and the workforce."

Secretary Miller was also joined by Cindy Jennings, who was able to get coverage through Medicaid expansion following a divorce and loss of benefits. While covered through Medicaid expansion, a routine screening identified pre-cancerous polyps. Medicaid expansion helped Jennings access treatment, and she now has coverage through a new employer.

“Having access to affordable health care was one less worry for me. It allowed me to focus on finding work that would allow me to pay our bills and meet the needs of my son with disabilities,” said Jennings. “Medicaid expansion provided me with access to what turned out to be life-saving preventive health care. It enabled me to stay healthy so I could be there for my children and ensure their health.”