Medicaid News Curator Volume 5

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Medicaid News Curator: Volume 5

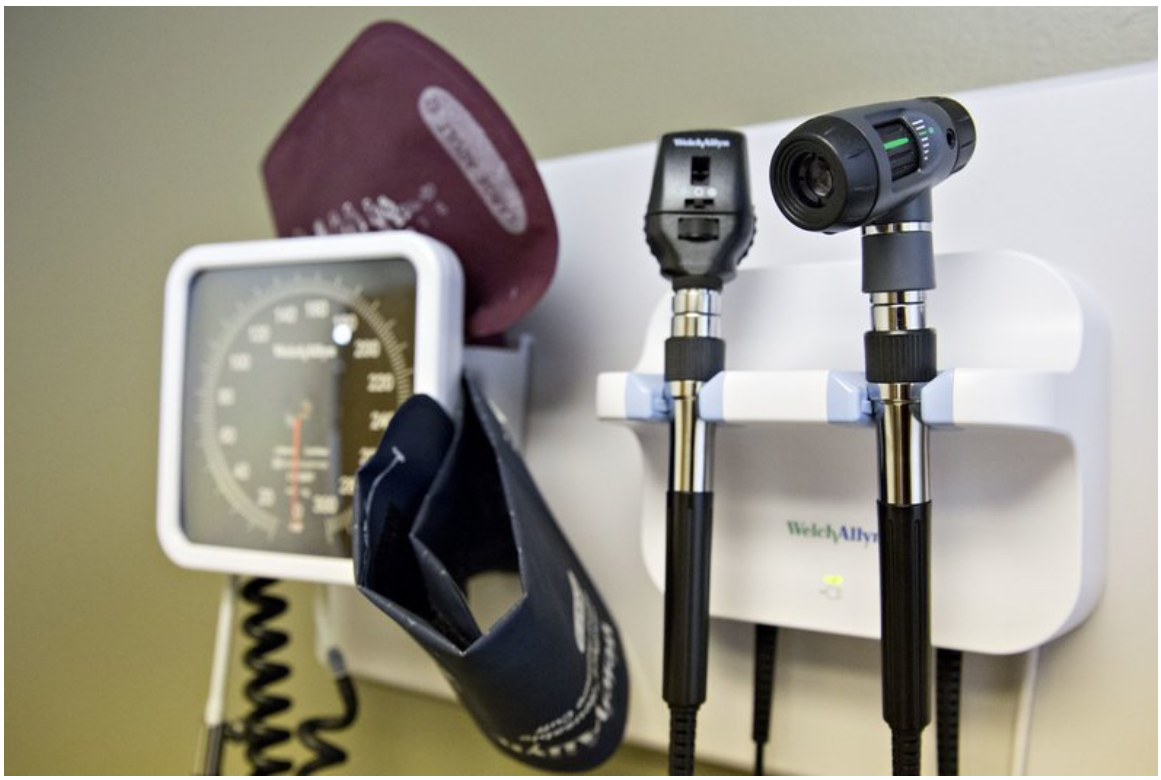
Reading and highlighting the Medicaid interwebs to save you time

1/18/2019

Cuomo expands Medicaid spending in nod to health industry

SourceURL: https://www.crainsnewyork.com/health-care/cuomo-expands-medicaid-spending-nod-health-industry

Cuomo expands Medicaid spending in nod to health industry



Bloomberg News

Gov. Andrew Cuomo in his executive budget released Tuesday increased the rate of spending on Medicaid, proposing a rise of 3.6% to $19.6 billion in fiscal 2020, which starts April 1, which is higher than the 3.1% increase the state would have granted to comply with a cap on costs.

"It will give the health care industry the help it needs to stabilize while we fight off these federal cuts in the meantime, which are, long-term, unsustainable for us," Cuomo said in his State of the State speech. The proposal is subject to debate in the state Legislature.

The cuts he is referring to include a reduction in Medicaid Disproportionate Share Hospital payments, which aims to offset the costs incurred by facilities that treat a

large share of Medicaid and uninsured patients. A delay to the DSH reduction, which were mandated by the Affordable Care Act, will expire Oct. 1, unleashing $4 billion in cuts to hospitals. Cuomo estimated the impact on New York hospitals at $2.5 billion.

The boost to Medicaid represents the first time the governor has allowed Medicaid to exceed a state-mandated cap on spending since 2011. The global cap requires Medicaid growth to stay within the 10-year rolling average of medical inflation, which is 3.1%. The increase allows the state to increase Medicaid reimbursement rates to hospitals and nursing homes by 2% and 1.5%, respectively.

Kenneth Raske, president of the Greater New York Hospital Association, said the governor's proposed increase recognizes the constraints hospitals have operated under.

"Health care spending has consistently stayed within its 'global cap' restraints," Raske said in a statement. "That's been a huge challenge for New York's financially struggling safety-net hospitals."

George Gresham, president of 1199SEIU, said the support for Medicaid would help distressed providers keep their doors open. "These additional dollars will help maintain crucial access to quality care," he said.

Cuomo did not create a structure for a single-payer health plan, which has previously been backed by the state Assembly. Instead his budget would create a "universal access commission" to advise the Departments of Health and Financial Services on how to achieve universal access to health care statewide. The heads of those departments would appoint health policy and insurance experts to the commission which will present a plan to Cuomo by Dec. 1.

The commission was cheered by groups that have opposed a single-payer health system, including Realities of Single Payer, made up of insurers, businesses and unions, and the hospital trade groups GNYHA and Healthcare Association of New York State.

Hospitals were less excited about a plan for the state Department of Health to study health care staffing. The New York State Nurses Association has lobbied the state for years to mandate staffing ratios in hospitals and nursing homes to avoid situations where nurses are stretched too thin.

"We have strongly opposed mandated nurse staffing ratios in the past, and continue to believe that inflexible mandates are the wrong approach," Bea Grause, president of the Healthcare Association of New York State, said in a statement.

The budget also authorizes $300 million for the second phase of the Statewide Health Care Facility Transformation. The program would support capital projects, debt retirement and activities that support mergers or acquisitions. The state accepted applications for that money last year but did not distribute it. The proposal says it must be awarded by May 1.

Among the other health care items in Cuomo's budget:

A call for passage of the Reproductive Health Act and the Comprehensive Contraceptive Coverage Act. "I believe we should pass a constitutional amendment," he said. "Let's write the rights of Roe v. Wade into the state constitution so it can never be changed no matter what happens politically."
Protections that would codify aspects of the Affordable Care Act, such as the state health insurance marketplace and prohibition on insurers discriminating against people with pre-existing conditions in state law.
A mandate that insurers cover in vitro fertilization.
A proposal for the state to regulate pharmacy benefit managers.
A provision to raise the state smoking age from 18 to 21. (It is already 21 in New York City.)
A pledge to invest $200 million to fight the ongoing opioid crisis. "It is moving like fire through dry grass," Cuomo said. Just last month, a federal judge struck down a state law crafted to raise $600 million through taxing manufacturers and distributors of opioids for treatment and enforcement, *Crain's* previously reported.

Mass. to survey Medicaid patients on quality of care - The Boston Globe

Massachusetts will ask Medicaid patients about quality of care

Suzanne Kreiter/Globe staff/file

Marylou Sudders, state secretary of health and human services, said a survey of Medicaid patients will be an effort to directly engage with them.

By Liz Kowalczyk Globe Staff January 15, 2019

Privately insured patients have been asked to rate their medical providers for years. Now, for the first time, Massachusetts is seeking the opinions of thousands of Medicaid recipients about their experiences in the doctor's office.

Beginning this month, nearly 250,000 low-income and disabled patients will be asked questions such as whether they or their children were able to get appointments when they needed them, whether doctors and office staff communicated respectfully, and whether their mental health treatment actually improved their ability to work or attend school.

The results will give state officials a window into how well Medicaid providers care for patients amid a significant restructuring of the program. And the information will allow the state to direct higher payments to better performers. Eventually, officials plan to publicly release some results, allowing Medicaid recipients to compare the quality of provider networks.

The disclosure will help close the information gap between middle-income residents with private, employer-based insurance and low-income patients on Medicaid, known in Massachusetts as MassHealth.

"This is a big step in engaging directly with consumers,'' said Health and Human Services Secretary Marylou Sudders.

The state plans to make results of the 2019 "patient experience'' survey public in early 2020, Sharon Torgerson, agency spokeswoman, said in an e-mail. But the public information will not be as detailed as it is for privately insured residents, and some say the state should go further to address this disparity.

The nationwide movement to make the cost and quality of health care more transparent has largely bypassed state Medicaid programs. Little is known about how well Medicaid providers do their jobs, despite the immensity of these programs.

Some states ask Medicaid recipients about the quality of their care, but it's rare to make that information public, said Dr. Michael Hochman, a professor at the University of Southern California who recently wrote about the topic for the journal Health Affairs. California, for example, reports quality measures for large health plans, but that is not useful for consumers looking for guidance on choosing a doctor.

"Historically, one concern is that the safety net sector is fragile and any extra pressure could cause providers to go under by embarrassing providers,'' Hochman said. "We can't push them too hard.''

Also, because Medicaid programs generally pay providers less than private insurers, doctors who treat large numbers of Medicaid patients traditionally could not afford the necessary computer technology to track patients' care. But Hochman said that is no longer the case.

Instead, he believes that Medicaid providers who provide poor care and have long waits for appointments simply don't want that exposed. "There are a lot of people who make a lot of money on the safety net,'' Hochman said.

Taxpayers have a stake in ensuring quality, too. MassHealth is the single largest chunk of the state budget, with costs of about $16 billion a year, although the federal government pays about half.

"This is really groundbreaking work on the part of the state,'' said Barbra Rabson, president of Massachusetts Health Quality Partners, a nonprofit group the state has hired to conduct the survey. But, she said, "it is one small piece of a very big puzzle.''

MassHealth signed a $4.4 million three-year contract with the group, which will survey MassHealth members enrolled in one of 17 newly formed "accountable care organizations'' — networks of doctors and hospitals that work to tightly manage patients' care. The focus will be on primary care, behavioral health care, and long-term services and support, such as speech and occupational therapy.

MHQP has been releasing primary care provider ratings for privately insured patients on its website since 2005. Providers who treat both commercially insured and Medicaid patients may already be publicly rated by their commercial patients.

State officials restructured the MassHealth program last year, enrolling 850,000 of the 1.86 million recipients to tightly controlled networks in an attempt to control costs and improve care.

One question is whether providers treat privately insured patients and Medicaid patients differently during appointments. That will be hard to answer using the new survey. MHQP publishes data about primary care practices with three or more providers who have patients in one of four large health plans. It does not release ratings for individual doctors.

MassHeath will make public quality data about each of the 17 accountable care organizations. Each one includes many primary care practices. The more detailed

the survey, the more expensive it is — and potentially the more useful to patients.

The state's primary goal is "to hold [these organizations] financially accountable for member experience,'' Torgerson said.

The member satisfaction survey was not necessarily intended to help recipients choose providers, state officials said. But they said they will evaluate releasing more detailed data in future years.

Colin Killick, deputy director of the Disability Policy Consortium, said collecting data on accountable care organizations is "absolutely useful'' but doesn't go far enough. Medicaid insures disabled people as well as low-income residents.

For those with disabilities, "it's critical that their providers listen effectively, treat them with respect, and work collaboratively with them to achieve their health and independence goals,'' he said. It "would be useful for members of our community to know which practices are judged more effective in these areas. More transparency is better.''

Liz Kowalczyk can be reached at kowalczyk@globe.com.

DHS Transitioning to Second-Lowest Bidder for Medicaid

Transportation in 4 Regions

SourceURL: https://www.kark.com/news/state-news/dhs-transitioning-to-second-lowest-bidder-for-medicaid-transportation-in-4-regions/1708326627

DHS Transitioning to Second-Lowest Bidder for Medicaid Transportation in 4 Regions

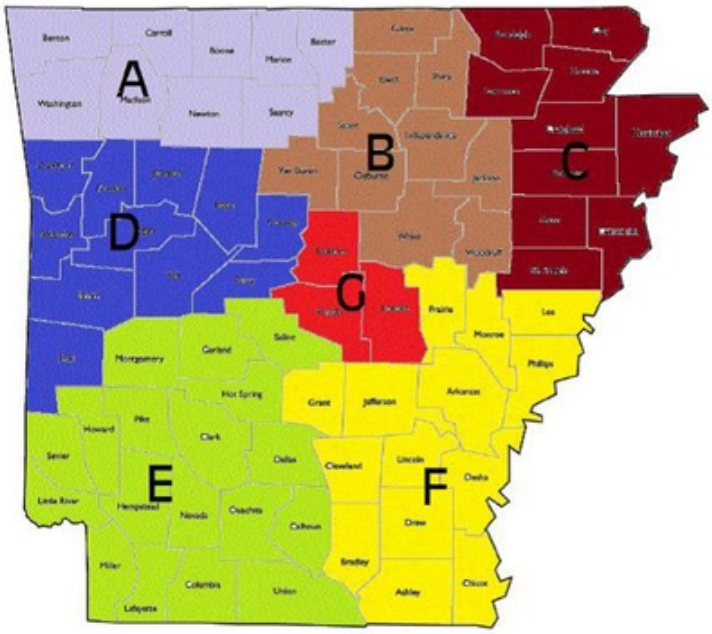
Posted: Jan 17, 2019 03:24 PM CST

Updated: Jan 17, 2019 03:24 PM CST

LITTLE ROCK, Ark. (News Release)- The Arkansas Department of Human Services (DHS) notified Medical Transportation Management (MTM) on Thursday that DHS is canceling its contracts for non-emergency medical transportation and day treatment transportation for Medicaid beneficiaries in four regions of the state effective Jan. 31.

DHS will transition to the second-lowest bidder for those services as allowed by Arkansas state procurement law.

“MTM has not been able to consistently provide the level of services required in its contract,” said DHS Director Cindy Gillespie. “MTM has committed to making this transition as smooth as possible and to working with the new vendor.”



Southeastrans, which provides non-emergency medical transportation and day treatment transportation on separate contracts in a western region (Region D) of the state, was the second lowest bidder for the regions that MTM is serving (Regions A, B, C, and G). Southeastrans has agreed to begin providing transport for dialysis and other urgent appointments in those regions starting Saturday, Jan. 19. It will take over transportation for all beneficiaries and appointments, including day treatment, in those regions starting Feb. 1.

DHS will amend Southeastrans' existing contracts to include the additional regions.

Beneficiaries in these regions who need to schedule appointments can contact 1 (888) 822-6155. Beneficiaries with general questions or concerns about non-emergency transportation and day treatment transportation can call 1 (888) 987-1200, option 2.

Year End Review: December State Data for Medicaid Work Requirements in Arkansas

SourceURL: https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

December State Data for Medicaid Work Requirements in Arkansas

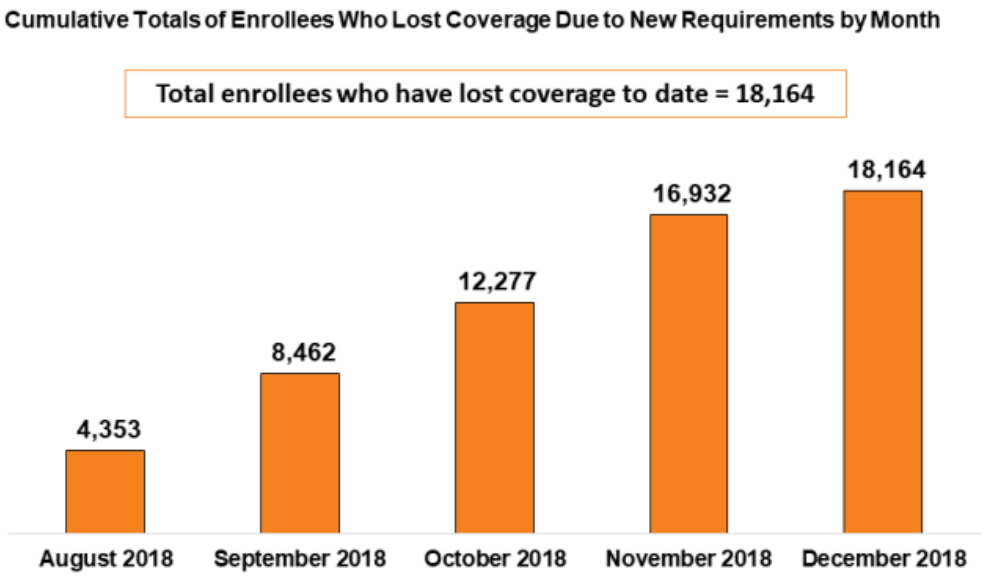
Arkansas is one of seven states for which CMS has approved a Section 1115 waiver to condition Medicaid eligibility on meeting work and reporting requirements and the first state to implement this type of waiver.[1] CMS approved Arkansas' waiver on March 5, 2018, and the new requirements took effect for the initial group of beneficiaries (those ages 30-49) on June 1, 2018. Unless exempt, enrollees must engage in 80 hours of work or other qualifying activities each month and must report their work or exemption status by the 5th of the following month using an online portal; as of mid-December, they also may report by phone.[2] A review of monthly data related to the new requirements released by the Arkansas Department of Human Services shows that from September through December 2018, over 18,000 people were disenrolled for failure to comply with the new requirements for three months. In January, enrollees who were disenrolled can regain coverage (if they reapply) and enrollees ages 19 to 29 will be subject to the requirements for the first time. Those who fail to comply with the requirements for three months could lose coverage in April 2019. This brief looks at data for December 2018. Separate reports look at early implementation of the new requirements and enrollee experiences.

How many individuals have lost coverage due to the work and reporting requirements?

A total of 18,164 individuals have lost coverage since September 2018, due to failing to meet the work and reporting requirements (Figure 1). The most recent round of closures, effective December 31, 2018, for failure to comply for any three months between June and December 2018, includes 1,232 people as of January 7th. Under the waiver, enrollees lose coverage for the rest of the calendar year after not meeting the requirements for any three months and are barred from reapplying for coverage until the following January. Unlike prior months, the state did not report those with one or two months of non-compliance in December 2018, because the clock starts again in January for non-compliance. April 2019 will be the first month in which enrollees are at risk for losing coverage for failure to comply for any three months in the new plan year. Individuals who lost coverage in 2018, including those disenrolled at the end of December, can reapply for coverage effective in January 2019.[3]

Figure 1

Over 18,000 AR Works enrollees have lost Medicaid coverage for failure to meet work and reporting requirements.



SOURCES: Ark. Dep't of Human Servs., Ark. Works Program, Dec 2018 Report (data as of Jan. 7, released on January 15, 2019) Nov. 2018 Report (data as of Dec. 7, 2018, released Dec. 17, 2018); Oct. 2018 Report (data as of Nov. 7, 2018, released Nov. 15, 2018); Sept. 2018 Report (data as of Oct. 8, 2018, released Oct. 15, 2018); Aug. 2018 Report (data as of Sept. 9, 2018, released Sept. 12, 2018).

Figure 1: Over 18,000 AR Works enrollees have lost Medicaid coverage for failure to meet work and reporting requirements.

Few individuals have been found to have good cause for failing to meet the work and reporting requirements to date. Individuals who fail to complete 80 hours of qualifying work activities and/or fail to timely report their activities each month can request a good cause exception. The state reviewed 156 good cause requests in December 2018; of these, 106 were granted.[4] From June through

December 2018, the state reviewed a total of 904 good cause requests; of these, the state granted 577, denied 64 and determined that 263 were "not a good cause issue."[5]

How many did not report work activities for December?

The large majority (90%, or 54,593 people) were exempt from the reporting requirement for December 2018, while 78% of those not exempt (4,776 out of 6,087) did not report 80 hours of qualifying work activities (Figure 2). Nearly all of those 4,776 enrollees did not report any work activities. This could mean that they did not create and link the online accounts required to enable them to report or experienced difficulty accessing or navigating the online portal.

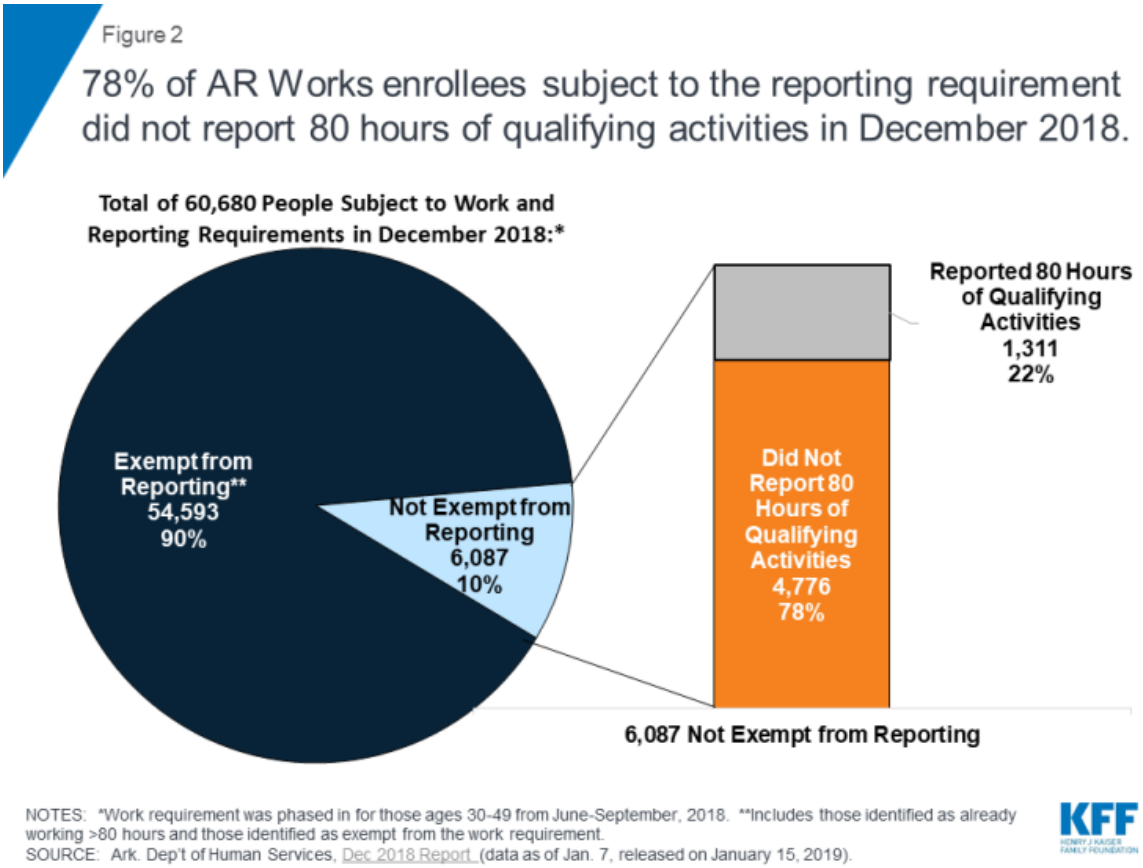


Figure 2: 78% of AR Works enrollees subject to the reporting requirement did not report 80 hours of qualifying activities in December 2018.

A small number of enrollees (73 out of the 4,776) did report some work activities but not 80 hours of qualifying activities for December. Of those 73 enrollees, 10 reported 80 or more hours of job search or job search training; however, in each month, enrollees are only able to count 39 hours of job search

or job search training toward the required 80 hours of qualifying work activities, which means that those engaged in job search or job search training also must complete 41 hours of another qualifying activity or activities to meet the monthly requirement. Twenty-nine (29) out of the 73 enrollees reported work that fell short of the 80-hour requirement in December, including 6 with at least 61 but fewer than 80 hours of work.

How many enrollees were exempt from the new requirements and why?

Most of the 54,593 enrollees exempt from the reporting or work requirement in December were already working at least 80 hours per month. These 54,593 enrollees represent 98% of those who met the requirements in December (because they were exempt). These enrollees were identified through a data match conducted by the state and therefore do not have to report their monthly work hours or exemption status using the online portal. They should have received a notice indicating that they were subject to the work requirement, but exempt from the reporting requirement. Overall, most exempt enrollees fell into four categories: those who were already working at least 80 hours per month (46%), followed by those currently exempt from SNAP employment and training requirements (19%), those with a dependent child in the household (12%), and those who have been identified as medically frail (15%) (Figure 3).[6] The shares in each of these groups were stable from June through December.

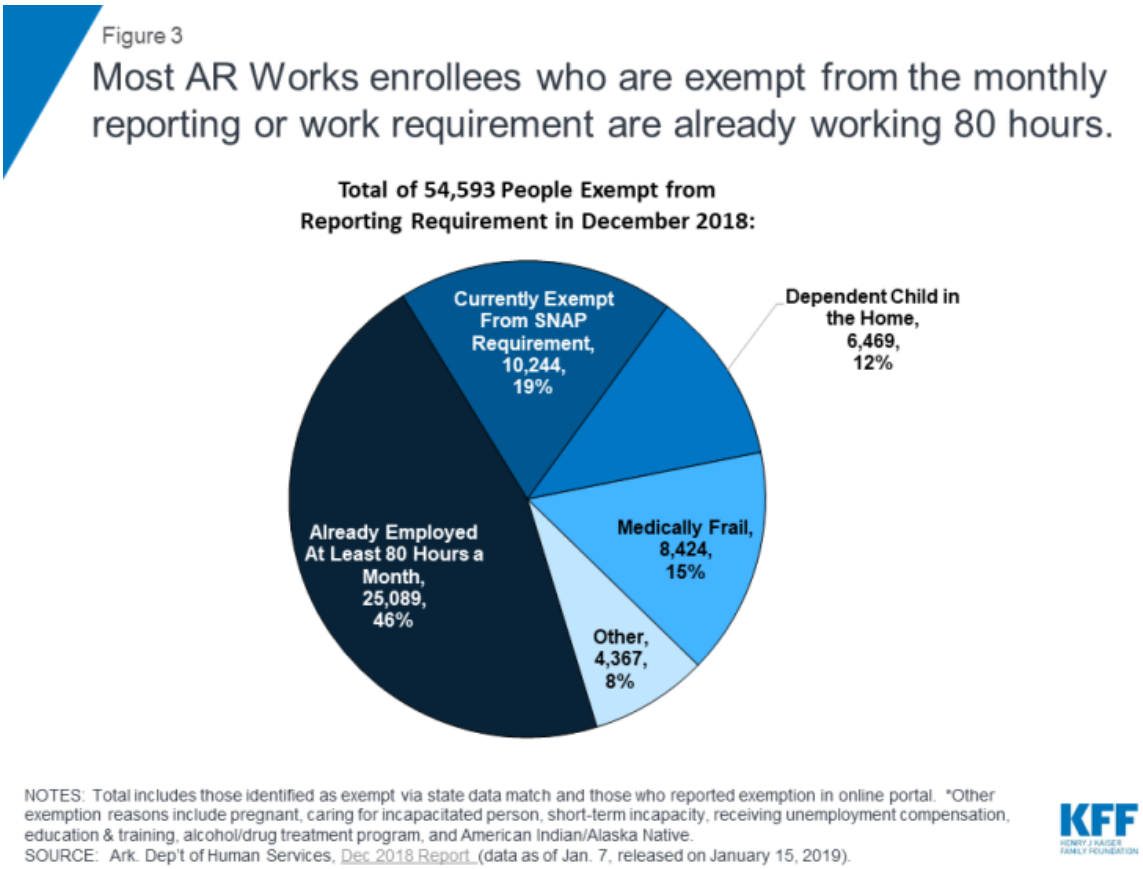


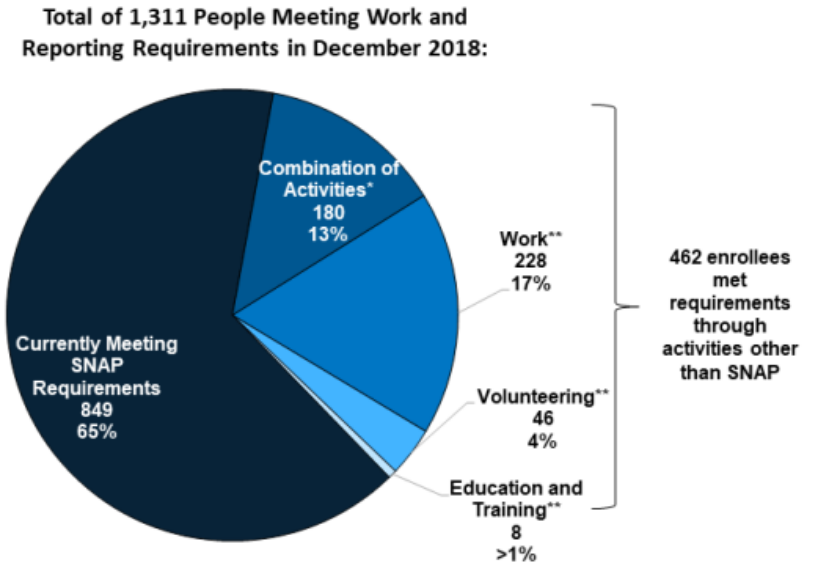
Figure 3: Most AR Works enrollees who are exempt from the monthly reporting or work requirement are already working 80 hours.

How many enrollees met the work and reporting requirements and through what activities?

Only 2% (1,311 enrollees) met the requirements by actively reporting activities in December 2018, with the majority of this group (849, or 65%) attributable to meeting comparable SNAP requirements (Figure 4). This pattern also has been consistent since June. Seventeen percent of those reporting were meeting the requirements through work, four percent through volunteer activities, and less than one percent through education and training. The remaining 13 percent were meeting the requirements through a combination of activities that include work, volunteer activities, education and training, job search, and/or job search training.

Figure 4

Most of AR Works enrollees meeting the new work and reporting requirements were already meeting comparable SNAP requirements.



NOTES: *Combination of activities may include work, volunteer activities, education and training, job search, and/or job search training. **Work, Volunteering, and Education and Training include those for whom state data show enrollee met requirement by reporting 81+ hours in that category. SOURCE: Ark. Dep't of Human Services, Dec 2018 Report (data as of Jan. 7, released on January 15 2019).

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Figure 4: Most of AR Works enrollees meeting the new work and reporting requirements were already meeting comparable SNAP requirements.

A small number (462 enrollees) of those who met the work and reporting requirements in December reported doing so by working, volunteering, or another activity, other than meeting SNAP requirements. The data do not indicate whether these enrollees started working as a result of the new requirements. They already could have been engaged in work or another activity, but the state did not have this information. This is a small share of enrollees compared to the 18,164 people who have lost Medicaid coverage to date due to failure to comply with work or reporting requirements (Figure 5).

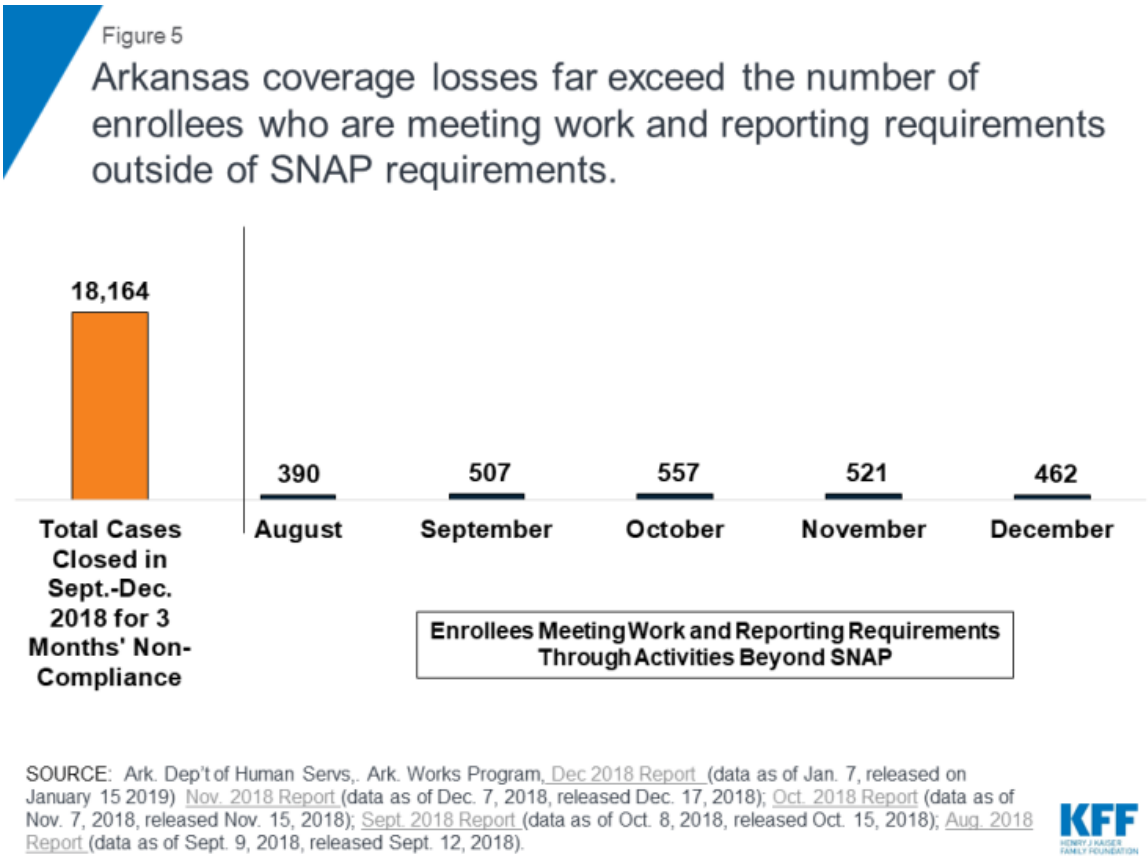

Figure 5: Arkansas coverage losses far exceed the number of enrollees who are meeting work and reporting requirements outside of SNAP requirements.

The number of enrollees reporting work has decreased since October 2018 (Figure 6). The new requirements were phased in for those ages 30 to 49 from June through September 2018. After the phase-in was completed, the number of enrollees meeting the new requirements who actively reported any work hours peaked at 401 in October 2018, and subsequently decreased, to 371 in November, and 313 in December. The subset of enrollees actively reporting that they satisfied their entire monthly requirement through work (81+ hours), as opposed to other qualifying activities, similarly peaked, at 254 enrollees, in October 2018, and subsequently declined to 248 enrollees in November, and 228 in December.

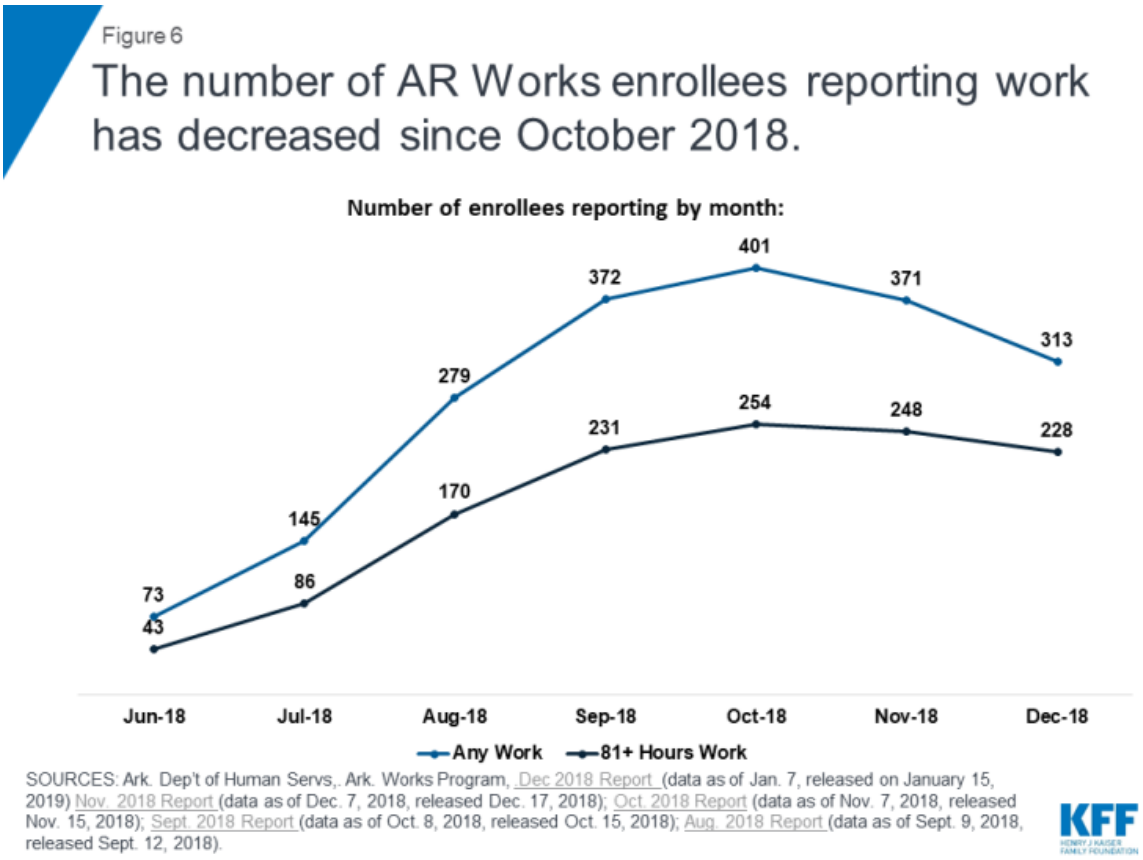

Figure 6: The number of AR Works enrollees reporting work has decreased since October 2018.

What will future data reporting and research show?

Looking ahead, it will be important to understand more about the group of enrollees who lost coverage. A November 8th letter to Secretary Azar from the Medicaid and CHIP Payment and Access Commission (MACPAC) raised concerns about the pace of disenrollment and the state's lack of a CMS approved waiver evaluation plan. CMS and the state have not paused the demonstration, resulting in over 18,000 people losing coverage in Arkansas for failure to comply with the new requirements over the first seven months of implementation. An early look at implementation found that many enrollees have not been successfully contacted about the new requirements, despite substantial outreach and education efforts, and concern that many who remain eligible could lose coverage for failure to navigate the process to verify work status or qualify for an exemption. On December 12, 2018, the state issued a press release indicating that beginning on December 19, enrollees would be able to report work activity by phone with DHS[7] and that DHS will be launching an advertising campaign to provide additional outreach to enrollees as the younger group of enrollees is

phased in during early 2019. DHS also plans to work with higher education institutions to inform students that school hours count toward meeting the requirement. While new reporting options may assist some enrollees, research shows that any additional reporting or administrative burdens create barriers to eligible people retaining coverage.

Follow-up with enrollees subject to the new requirements will provide additional information about awareness and understanding of the new work and reporting requirements as well as barriers to compliance. Follow-up with enrollees who lost coverage will reveal how many have other health insurance coverage and how many are uninsured; how many are newly working, in what types of jobs, and whether those jobs come with affordable health insurance; and how many remain eligible for Medicaid but lost coverage due to administrative or reporting barriers. Future months of state data may also provide information about how many who were disenrolled in 2018 will reapply for and regain coverage in 2019, and whether they will again lose coverage for failing to meet the work and reporting requirements in 2019. Early implementation findings also cite the potential that coverage losses will result in gaps in care and increased uncompensated care costs. Additional research can examine the longer-term effects of coverage losses and lock-outs for enrollees, providers, and health plans.

Medicaid expansion costs raise new questions about hospital tax

SourceURL: https://www.roanoke.com/news/politics/general_assembly/medicaid-expansion-costs-raise-new-questions-about-hospital-tax/article_f0e7fc2b-2dcc-5448-b639-3e52feef3c35.html

Medicaid expansion costs raise new questions about hospital tax

In this 2018 file photo Sen. Ryan McDougle, R-Hanover, confers with Senate Majority Leader Tommy Norment, R-James City.
BOB BROWN/TIMES-DISPATCH

RICHMOND — A tax on hospital revenue to pay for Virginia's share of the cost of expanding its Medicaid program might not cover the expense of administering a state proposal for a work requirement and other conditions for people who receive health care benefits under the program.

Some members of the Senate Finance Committee were taken aback Tuesday by Gov. Ralph Northam's proposal to use money from the state budget's general fund to pay $13 million in administrative expenses for the state to seek federal approval of a waiver that would allow it to establish the work requirement and other conditions.

Senate Majority Leader Thomas Norment, R-James City, and Senate Republican Caucus Chairman Ryan McDougle, R-Hanover, also expressed surprise at a new estimate that expanding Medicaid coverage to hundreds of thousands of Virginians could cost about $85 million more in the biennium than previously estimated. The additional cost would be covered by the provider assessment created in the budget adopted last year over Norment and McDougle's objections, but they questioned the financial effect on the hospitals that would pay for it.

"Have any of these institutions paying the provider assessments shared with you over what period of time they anticipate recovering these up-front costs they're having to absorb?" Norment asked Finance Committee analyst Mike Tweedy.

Tweedy said a second provider assessment raised the federal reimbursement rate for hospitals to treat Medicaid patients, which will benefit some hospitals more than others, in addition to reducing the cost of uncompensated care under expansion.

The higher projected expansion costs — as well as a proposed use of state money to pay for administering the proposed waiver — touches a politically sensitive nerve in the General Assembly. It was bitterly divided over the Medicaid expansion plan approved in the budget during a special session on April 30 after a protracted battle.

House Appropriations Chairman Chris Jones, R-Suffolk, who helped craft the expansion plan, said he, too, was surprised by the governor's proposed use of state funds to pay the administrative expense of applying for the waiver under Section 1115 of the Social Security Act.

"It was always my expectation that this was going to be part of the provider assessment," Jones said Tuesday.

A spokesman for the Virginia Hospital & Healthcare Association said Tuesday that hospitals remain "willing partners in the effort to increase health care access in the commonwealth."

“The hospital community is fulfilling its commitment as the only health care sector partner that has agreed to make contributions to cover millions in state costs associated with coverage expansion,” spokesman Julian Walker said in a statement.

“We consider the introduced budget proposal to be consistent with the principles of the bipartisan compromise on coverage achieved in 2018, and we pledge our continued support as allies with state leaders in the work to make Medicaid expansion a success.”

Hospitals already have paid about $80 million in state costs for expanding eligibility for the program on Jan. 1 under the Affordable Care Act, officials for the Department of Medical Assistance Services told Norment and members of a finance subcommittee earlier this month. The money represents costs covered in the program’s expansion in this fiscal year.

The department, which runs Virginia’s Medicaid program, estimated in early November that expansion could cost about $80 million more than the $307 million estimated in the budget for the biennium. Tweedy estimated the total cost could exceed $392 million, but he said that because of slowing enrollment, “I would expect that number might come down a little bit.”

Walker said the enrollment of more than 200,000 Virginians in Medicaid since Nov. 1 is “a positive development and a sign that many people who lacked access to needed health care services now have it.”

“While some preliminary estimates suggest second-year coverage costs may exceed projections, an appropriate path forward is working with the commonwealth, the Department of Medical Assistance Services, and elected officials to get more accurate projections of the costs and reimbursements,” Walker said.

“We are prepared to assist the state in updating its forecasting methodology for the existing and expansion Medicaid coverage programs.”

Senate Finance Co-Chairman Emmett Hanger, R-Augusta, who championed Medicaid expansion last year, said after the meeting that the estimates are “subject to adjustment.”

“We’ll track it in the budget, but it’s sum-sufficient,” Hanger said, referring to the open-ended nature of the entitlement program. “So it’s not something we’ll have

to revisit.”

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New proposal would require Medicaid recipients to work for benefits

SourceURL: https://www.wyff4.com/article/new-proposal-would-require-medicaid-recipients-to-work-for-benefits/25927408

New proposal would require Medicaid recipients to work for benefits

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New proposal would require Medicaid recipients to work for benefits

by WYFF US

Hide Transcript Show Transcript

South Carolina health officials are considering changes to the Medicaid system. The Section 1115 Demonstration Waiver would require people on Medicaid to have a job, go to school, or get involved in the community. State officials say the demonstration waiver will help families by improving health overall and reducing health costs.

WYFF News 4 attended one of six public hearings the South Carolina Department of Health and Human Services put on for people to hear about the proposed

changes. Everyone who attended stood staunchly opposed to the recommendation.

“There are people out there who, for whatever reason, cannot work,” one man said. “The focus of this program seems to be you’re only entitled to help if you’re deserving.”

“The threat of losing healthcare is frankly immoral and cruel,” another woman at the hearing said.

Mary McGee is an Upstate nurse. She says people of all backgrounds tend to have similar health problems; however, she says Medicaid usually makes the difference in affording care. She and others feel the new rule would restrict access to healthcare.

"There needs to be better access, but to take away Medicaid from people from single mothers or people who have children and disabilities is unconscionable,” McGee said. “It's wrong. The emergency department, which is often the safety net for these people, is not the appropriate place for that, because we can’t do good follow up.”

Anyone who fails to meet the requirements could have their Medicaid eligibility suspended. The state claims it can save more than $6 million if the demonstration waiver is implemented. The public comment period will continue through January 22. After that, health officials said the waiver application will be sent to Center for Medicare and Medicaid Services for review.

Repeal and replace bill for voter-approved Medicaid expansion revised

SourceURL: https://www.deseretnews.com/article/900051214/repeal-and-replace-bill-for-voter-approved-medicaid-expansion-revised.html

Repeal and replace bill for voter-approved Medicaid expansion revised

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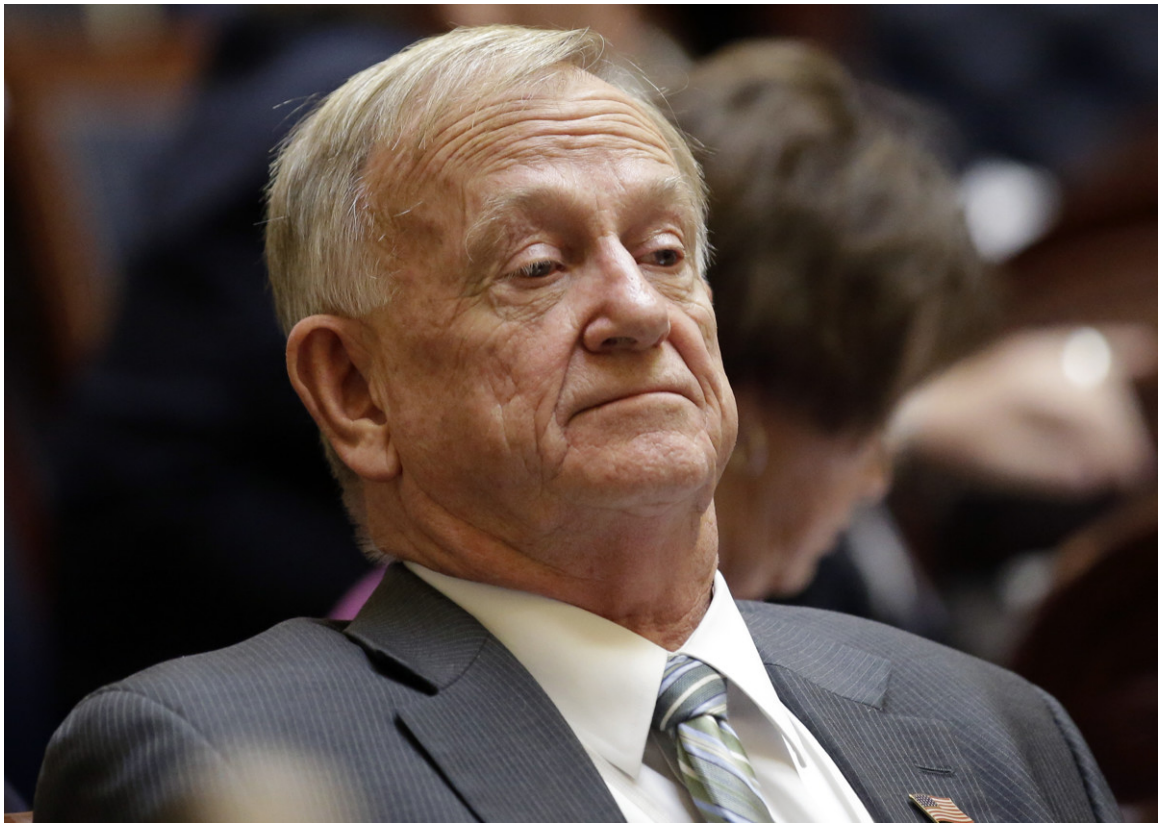
Comments



Rick Bowmer, Associated Press
FILE - This Feb. 22, 2016, file photo, Sen. Allen Christensen, R-Ogden, looks on during a debate on the Senate floor at the state Capitol in Salt Lake City. A bill to repeal and replace the Medicaid expansion ballot initiative approved by voters is

being revised to make sure some low-income Utahns will still get health coverage starting April 1. Christensen is a sponsor of the bill.

SALT LAKE CITY — A bill to repeal and replace the Medicaid expansion ballot initiative approved by voters is now being revised to reverse a possible delay in getting health coverage for at least some of the low-income Utahns.

"We changed our minds," the bill's sponsor, Sen. Allen Christensen, R-North Ogden, said Thursday. "The people around me — and myself included — felt like we could do something now."

Earlier this week, Christensen told the Deseret News he intended the bill to hold off on additional coverage until the federal government approved a waiver needed for a scaled-back version of Medicaid expansion with a lower cost to the state.

Now, the bill will create what the senator called a "bridge plan," partially expanding Medicaid to Utahns earning below 100 percent of the federal poverty level using money raised by the 0.15 percent sales tax rate increase in the ballot initiative.

Christensen's new approach comes the day after Lt. Gov. Spencer Cox said he and Gov. Gary Herbert are not anticipating any delay in implementing expanded Medicaid coverage.

Proposition 3 puts in place the full Medicaid expansion available under the Affordable Care Act that provides coverage to those earning below 138 percent of the federal poverty level, starting April 1, the same time the tax increase takes effect.

Christensen said under his bill, both the sales tax increase and the partial plan would also start April 1. He said about 100,000 Utahns would be covered under his proposal, compared to 150,000 under full expansion.

The plan would stay in place, he said, while Utah officials try to negotiate the same 90-10 federal funding match offered for full Medicaid expansion. A similar effort last year failed.

He said the state would have to pay the traditional 30 percent share of Medicaid for the partial plan and there may only be enough money available to keep the program going for six months.

The sales tax increase is anticipated to collect some $88 million annually, money that's supposed to cover the state's share under a 90-10 match while bringing in more than $800 million in federal funding.

Under a 70-30 match, the additional revenue would not last as long or result in as much federal funding.

Just how the state would continue to pay for the bridge plan if the federal government doesn't agree to cover a bigger share of the costs is yet to be determined, Christensen said.

"We don't have the details worked out but it'll stay," he said. "We're not going to kick them off."

The governor's deputy chief of staff, Paul Edwards, said in a statement that given the impact of Medicaid on the budget, it's not surprising lawmakers "would want to examine the fiscal soundness" of expanding the program.

"Any modifications would need to be done in a compassionate and responsible way," Edwards said. He said the governor's office will be watching closely for "reasonable efforts to improve and sustain" the voter-approved expansion.

"We trust that all involved in this review understand the importance of honoring the voters' desire to see coverage expanded to those previously excluded from federal support," he said.

Cox said Wednesday the administration doesn't "think there's going to be a delay in implementation on Medicaid expansion. I could be wrong. (In a) 45-day legislative session, anything can happen."

But the lieutenant governor said the administration is "moving forward as if it's going to be implemented under the original timeline as expected." Cox said, however, money is an issue with full expansion.

"It's very clear that tax increase is not going to cover the entire amount of the expansion," he said, adding the governor's office and lawmakers are grappling with "how are we going to pay for this."

Christensen said that legislative analysts have calculated that it would take $105 million to pay for full expansion next year, not the $88 million expected from the sales tax increase and that by 2023, the program would fall $45 million short.

Legislative leaders have expressed concerns about the price tag for the Medicaid expansion approved by voters, but promised any alternative plan would be similar to what Proposition 3 provided.

Under Christensen's original proposal, the full expansion passed by voters would have in effect been repealed and his more limited plan would not have been put in place until the 90-10 funding match was approved.

The 2018 Legislature approved a partial Medicaid expansion plan but was unable to get the Trump administration to approve the waiver needed for the additional federal match.

"I don't understand why people in any way think this would be different," said Rep. Ray Ward, R-Bountiful, a medical doctor and longtime supporter of expanding Medicaid coverage.

He said if the state wants to pursue a waiver for a more limited plan, it makes more sense financially to let Proposition 3 take effect and then replace it should the federal government OK the 90-10 match.

"I just cannot understand, in the name of trying to save the state's budget, why we would choose a plan that would force us to pay 30 percent instead of 10 percent," Ward said.

Christensen has said it would be difficult on the 50,000 Utahns who earn between 100 percent and 138 percent of the federal poverty level to first be eligible for Medicaid expansion and then have the program taken away.

But Ward said if there is finally federal approval for the higher match for a more limited program, those same Utahns are still able to purchase heavily subsidized insurance through the Affordable Care Act.

"To me, it seems pretty simple," he said, acknowledging that the proposed bridge plan would be better than a delay. "Honestly, I'm glad people are talking about this in the context of making sure people have coverage."

Contributing: Katie McKellar

Medicaid block grant waiver reports revive hospitals' funding worries

SourceURL: https://www.modernhealthcare.com/article/20190116/TRANSFORMATION04/190119930

Medicaid block grant waiver reports revive hospitals' funding worries

By Robert King | January 16, 2019

Hospitals are furious that the Trump administration is reportedly exploring allowing states to convert their Medicaid programs into block grants, a policy the industry fervently fought when Congress tried to repeal the Affordable Care Act.

If states take advantage of the block-grant flexibility, first reported in Politico, it would cap federal spending for Medicaid in those states and could leave them on the hook for any expenditures over that limit. States would either have to cut their Medicaid rolls or payments to disproportionate-share hospitals and nursing homes to curb spending, some experts said.

Chip Kahn, CEO of the Federation of American Hospitals, told Modern Healthcare that he is concerned about how block grants will affect access to coverage and questioned whether the CMS can legally allow these waivers.

Other hospital industry groups also were worried about the impact of the grants.

"We have long voiced concerns about how block granting Medicaid could ultimately result in losses of coverage and negatively impact access to quality care," said Ashley Thompson, senior vice president of public policy analysis at the American Hospital Association.

Both groups said that states have flexibility under federal waivers to make changes to Medicaid and questioned the need to install a block-grant program. Kahn also questioned why a state would willingly sign up for a block-grant waiver if it meant possibly lower federal Medicaid funding if the state goes over the cap.

Patricia Boozang, senior managing director at the consulting firm Manatt Health, said it is too soon to determine how popular block grants would be, adding that the "devil is in the details."

"Are we talking about a guidance that would have stringent caps on Medicaid spending or are we talking about something that would foster spending targets, which is what states do for waivers now in setting budget neutrality caps," she said.

So far the CMS hasn't put out guidance on what flexibility states could receive from block grants.

The agency did not confirm it was looking at a block-grant waiver program, but a spokesperson said that the CMS is open to giving states the option to adopt a block grant.

"As the administrator (Seema Verma) has stated publicly, we believe strongly in the important role that states play in fostering innovation in program design and financing," the spokesperson said. "We also believe that only when states are held accountable to a defined budget can the federal government finally end our practice of micromanaging every administrative process."

The exact guidance will be critical to determine whether a state actually signs up.

"I haven't met the state yet that would volunteer for a cut in its federal Medicaid funding," tweeted Drew Altman, CEO of the Kaiser Family Foundation. "A few might negotiate a cap on some or all of its program in return for some more flexibility—maybe. Not clear what these new 'block grant waivers' will amount to."

Block grants are not a new fight for hospital groups. In fall 2017, a bill to repeal the Affordable Care Act sponsored by Sens. Lindsey Graham (R-S.C.) and Bill Cassidy (R-La.) would have converted Medicaid into a block-grant program.

The lawmakers said that the block grants are key to reining in an out-of-control entitlement program and that it gives more power to states to develop a Medicaid program that meets their needs.

"Instead of a Washington-knows-best approach like Obamacare, our legislation empowers those closest to the healthcare needs of their communities to provide solutions," Graham said in a statement in September 2017 when the bill was introduced. "Our bill takes money and power out of Washington and gives it back to patients and states."

Hospital groups vehemently opposed the bill. The AHA wrote to congressional leaders in September 2017 that Medicaid funding cuts could have "serious negative consequences for communities across America" unless the lawmakers made sure alternative coverage is available.

A September 2017 analysis from the consulting firm Avalere Health estimated that Graham-Cassidy's block-grant program would have cut federal Medicaid funding by $205 billion through 2026 and more than $4 trillion over the next two decades.

GOP Senate leadership eventually scuttled the bill because of insufficient support from Republican senators.

The Latest: Kelly pitch on Medicaid doesn’t move GOP leaders

The Latest: Kelly pitch on Medicaid doesn't move GOP leaders

The Associated Press

January 16, 2019 09:26 PM,

Updated January 16, 2019 09:27 PM
TOPEKA, Kan.
The Latest on Kansas Gov. Laura Kelly's State of the State address (all times local):

8:25 p.m.

Democratic Gov. Laura Kelly's pitch to expand Medicaid in Kansas to cover up to 150,000 more people has not moved Republican leaders opposed to the idea.

Kelly spent nearly six minutes of her 37-minute State of the State address Wednesday night attempting to make a case that expanding Medicaid will help Kansas families and rural hospitals and communities. She promised to have a plan drafted before the end of January.

But top Republican lawmakers said nothing in her speech made them rethink their opposition. They continue to view Medicaid expansion as too costly to the state, even after the federal government covers the bulk of the expense.

Past GOP governors opposed expansion.

About three dozen pro-expansion demonstrators stood outside the House chamber before Kelly's speech, waving signs.

—

8:05 p.m.

Top Republicans in the Kansas Legislature are suggesting that Democratic Gov. Laura Kelly will break a campaign promise not to raise taxes if she doesn't buy into a GOP tax relief plan.

GOP legislative leaders said Wednesday night after Kelly's State of the State address that they want to hold Kelly to her promise not to raise taxes.

But they also said that includes adjusting state income tax laws so that Kansas residents aren't forced to pay more to the state because of federal tax changes at the end of 2017.

House Speaker Ron Ryckman Jr. said inaction means some Kansans will pay more.

Kelly didn't mention the issue in her address. She said afterward that she wouldn't say whether she'd veto a tax bill until she saw the legislation.

___

7 p.m.

Kansas Senate President Susan Wagle contends Democratic Gov. Laura Kelly is setting a course for the state that will "squander our fiscal recovery."

The conservative Wichita Republican gave the official GOP response Wednesday to Kelly's first State of the State address.

Kelly's priorities include boosting spending on public schools and expanding the state's Medicaid health coverage for the needy. She is on a collision course with top Republicans because they want to cut state income taxes.

Wagle said the GOP wants to cut taxes so that some Kansas residents don't pay more to the state because of federal income tax changes at the end of 2017.

She also said Kelly wants to merely "surrender to the edicts" of the Kansas Supreme Court in an education funding lawsuit.

____

6:30 p.m.

New Democratic Gov. Laura Kelly is telling Kansas legislators that the state faces an emergency in its child welfare system and is "completely unprepared" for the next national economic downturn.

Kelly outlined an agenda Wednesday evening for the Republican-dominated Legislature that includes increased spending on public schools and expanding the state's Medicaid health coverage for the needy.

She also told lawmakers that she will honor her pledge to balance the budget without raising taxes.

Her first State of the State address sets up a clash with top Republicans. She did not mention their top priority, an income tax cut.

Kelly's tough tone was the most notable element of her address to a joint session of the House and Senate. She declared, "I was elected to rebuild our state."

—

6 a.m.

New Democratic Gov. Laura Kelly is expected to make a pitch to the Republican-dominated Kansas Legislature for boosting spending on public schools and expanding Medicaid.

Kelly was scheduled to deliver her first State of the State address Wednesday evening to a joint session of the Legislature. She took office Monday.

The governor and fellow Democrats want to move quickly to boost education funding.

The Kansas Supreme Court ruled last year that a new law increasing aid to public schools wasn't enough because it didn't account for years of inflation. The state school board has proposed phasing in a $364 million increase over four years.

Kelly also wants to expand the state's Medicaid health coverage for the needy.

Republican leaders have been skeptical that the state can afford the two initiatives.

Georgia Gov. Kemp pitches Medicaid waiver in State of State

SourceURL: https://www.thestate.com/news/article224674790.html

Georgia Gov. Kemp pitches Medicaid waiver in State of State

By BEN NADLER The Associated Press

January 17, 2019 06:18 PM,

Updated 11 hours 23 minutes ago

Atlanta Journal-Constitution via AP Bob Andres

ATLANTA
Georgia's newly elected Republican governor announced during his State of the State speech Thursday that he was setting aside $1 million to create a waiver plan that would give the state more flexibility in using federal Medicaid funding.

Gov. Brian Kemp, who has frequently assailed Medicaid expansion — a keystone of his defeated Democratic rival Stacey Abrams' platform during their 2018 gubernatorial race — said the waiver would "expand access without expanding a broken system that fails to deliver for patients."

Kemp did not elaborate about what the waiver might include and questions emailed to his office were not answered.

His office instead sent a statement saying that the funding was for a consultant to assist in reviewing options and developing a plan and that the "ultimate goals are lowering costs, increasing choice, and improving quality and access."

Medicaid strategies that some Republican-led states have talked about include partially expanding the program to cover only residents below the poverty line, a less generous option than provided by the 2010 Affordable Care Act, which extended eligibility to many people just above poverty as well.

Partial expansion would be less costly for states, but it's unclear whether the federal government has the legal authority to grant such a waiver. It would almost certainly draw a court challenge, as have some Medicaid work requirements approved under the Trump administration.

Georgia is one of just 14 states that have not yet expanded Medicaid as prescribed under the ACA, also known as "Obamacare."

The expansion of Medicaid was initially intended to be national, but a 2012 ruling by the Supreme Court made it optional for states. Most of the states that have not taken up expansion are Republican controlled.

Georgia's previous Republican Gov. Nathan Deal opposed Medicaid expansion on the grounds that if federal funding ceased, the state would be left to fully pay the costs.

Kemp said the state of health care in rural Georgia was particularly concerning.

"Seventy-nine counties have no OB/GYN. Sixty-four counties have no pediatrician. Nine counties have no doctor," Kemp said.

Some Republicans in Georgia have become more receptive to the idea of expanding Medicaid access by seeking a waiver in recent years but have also called for restrictions like a work requirement.

Democratic lawmakers say they are pushing for wholesale expansion of Medicaid.

Democratic state Sen. Harold Jones said in response to Kemp that Medicaid expansion, not a waiver, was the right path forward for Georgia, according to a

transcript of his remarks published by the Atlanta Journal-Constitution. Jones said expansion was the only way to help struggling families and struggling hospitals.

Kemp also touched on previously unveiled plans to increase teacher pay, funding for school safety and resources for combatting gang activity in his speech.

Kemp laid out a proposal to permanently increase teacher salaries by $3,000 for all certified Georgia teachers, which he said was a "sizeable down payment" on his campaign promise to raise pay by $5,000.

Kemp touted plans to allocate money to each Georgia public school for safety measures and an anti-gang task force within the Georgia Bureau of Investigation. He's seeking $30,000 for each public school in the state — a total cost of $69 million — to enact safety measures determined at the local level. Kemp also said he plans to address mental health within schools and provide extra resources.

Kemp said he wants to put $500,000 in initial funding toward the new GBI anti-gang task force.

Kemp's address avoided some of the more controversial conservative pitches of his primary campaign, including pledges to sign tough abortion restrictions, sign a "religious freedom" bill that critics says allows discrimination against gays and lesbians, and to "track and deport criminal illegal aliens."

The last pitch morphed into "track and deport drug cartel kingpins" in his State of the State address, while the other issues went unaddressed.

Clinics Struggle To Resolve Fears Over Medicaid Sign-Ups And Green Cards

SourceURL: https://www.npr.org/sections/health-shots/2019/01/15/685191126/clinics-struggle-to-resolve-fears-over-medicaid-sign-ups-and-green-cards

Clinics Struggle To Resolve Fears Over Medicaid Sign-Ups And Green Cards

January 15, 20195:00 AM ET

Ana B. Ibarra

From

A migrant worker in a Connecticut apple orchard gets a medical checkup in 2017. A proposed rule by the Trump administration that would prohibit some immigrants who get Medicaid from working legally has already led to a lot of fear and reluctance to sign up for medical care, doctors say. **Spencer Platt/Getty Images hide caption**

toggle caption
Spencer Platt/Getty Images

Last September, the Trump administration unveiled a controversial proposal — a policy that, if implemented, could jeopardize the legal status of manyimmigrants

who sign up for some government-funded programs, including Medicaid.

The Trump proposal is still working its way through the public comment and evaluation process, and could go into effect as early as this year, though some state attorneys general say they would challenge any such policy in the courts.

In the meantime, some doctors and clinics are torn: They want to keep patients informed about the risks that may be coming, but don't want to scare them into dropping health benefits or avoiding medical care right now.

"We are walking a fine line," says Tara McCollum Plese, chief external affairs officer at the Arizona Alliance for Community Health Centers, which represents 176 clinics in the state. "Until there is confirmation this indeed is going to be the policy, we don't want to add to the angst and the concern," she says.

However, if immigrants do come to a clinic asking whether using Medicaid now might affect their legal status down the road, trained staff members are ready to answer their questions, McCollum Plese says. (According to legal specialists, the rule would not be retroactive — meaning it wouldn't take into account a family's past reliance on Medicaid.)

Other providers prefer to take steps that are more proactive to prepare their patients, in case the proposal is adopted. At Asian Health Services, a clinic group that serves Alameda County, Calif., staff members pass out fact sheets about the proposed changes, provide updates via a newsletter aimed at patients, and host workshops where anyone with questions can speak to legal experts in several Asian languages.

"We can't just sit back and watch," says CEO Sherry Hirota. "We allocate resources to this, because that's part of our job as a community health center — to be there not only when they're covered," she says, "but to be there always" — even when that coverage is in jeopardy.

Currently, people are considered "public charges" if they rely on cash assistance (Temporary Assistance for Needy Families or Supplemental Security Income) or need federal help paying for long-term care.

Trump's proposed change to that rule, which is awaiting final action by the U.S. Department of Homeland Security, would allow the federal government to consider immigrants' use of an expanded list of public benefit programs, including Medicaid, food stamps and Section 8 housing as a reason to deny

lawful permanent residency — also known as green card status. Medicaid is the state-federal health insurance program for low-income people.

If the proposed rule change goes into effect, it could force patients to choose between health care and their chance at a green card, McCollum Plese says. "And most people will probably not take the services."

Already, some immigrant patients are skipping medical appointments out of fear stoked by the proposed rule, according to providers and advocates.

"For now, our focus has been on correcting misinformation, not necessarily raising awareness among those who haven't heard about the potential changes," says Erin Pak, CEO of KHEIR Center, a clinic group with three locations in Los Angeles. "This is a proposal that thrives on fear and misunderstanding," she says, "so we wanted to be thoughtful about how and when to engage patients on the issue, given that nothing has passed into law."

The Department of Homeland Security is reviewing more than 200,000 comments from the public before it issues a final rule. And it's still possible the department won't adopt the rule at all, legal experts say.

At KHEIR Center, most patients are immigrants from Korea. Many are highly aware of the proposed rule because of the coverage it has received in Korean-language media, according to Kirby Van Amburgh, the center's director of external affairs.

Other groups served by the clinic, such as Latino and Bengali immigrants, have tended to ask few questions, Van Amburgh says.

Trained staff address patients' questions one-on-one, she says, and hand out a fact sheet when needed.

Last month, L.A. Care health plan, which covers more than 2 million Medicaid enrollees in Los Angeles County, hosted a webinar on the topic for about 180 providers. David Kane, an attorney at Neighborhood Legal Services of Los Angeles, led the webinar and urged doctors to tell concerned patients that nothing has changed yet — and that most immigrants would not be affected.

If the federal government adopts the rule, it would not be effective immediately, he notes; there would likely be a 60-day grace period before the changes take effect. After that, implementation could be further delayed or stopped in court.

John Baackes, CEO of L.A. Care, has been critical of the Trump administration's proposal, and says his organization offered the webinar because of the estimated 170,000 clients — legal immigrants — who could potentially be affected.

"I think we've got to let people know what could come, and try to give them more accurate information so that they don't act imprudently," Baackes says. To do that, "we have to stay current."

This story was produced by Kaiser Health News, which publishes California Healthline, an editorially independent service of the California Health Care Foundation. KHN is not affiliated with Kaiser Permanente.

Reports That Trump Administration May Allow States To Block Grant Medicaid Infuriates Hospitals

SourceURL: https://khn.org/morning-breakout/reports-that-trump-administration-may-allow-states-to-block-grant-medicaid-infuriates-hospitals/

Reports That Trump Administration May Allow States To Block Grant Medicaid Infuriates Hospitals

Hospital groups say that states already have flexibility under federal waivers to make changes to Medicaid so there isn't a need to install a block-grant program. CMS has not confirmed it is looking at a block-grant waiver program, but a

spokesperson said that the CMS is open to giving states the option to adopt a block grant.

Modern Healthcare: Medicaid Block Grant Waiver Reports Revive Hospitals' Funding Worries

Hospitals are furious that the Trump administration is reportedly exploring allowing states to convert their Medicaid programs into block grants, a policy the industry fervently fought when Congress tried to repeal the Affordable Care Act. If states take advantage of the block-grant flexibility, first reported in Politico, it would cap federal spending for Medicaid in those states and could leave them on the hook for any expenditures over that limit. States would either have to cut their Medicaid rolls or payments to disproportionate-share hospitals and nursing homes to curb spending, some experts said. (King, 1/16)

In other hospital news —

The Associated Press: Need Hospital Care Or Tests? Some Ways To Get Cost Estimates

Want to know how much your hospital is going to charge for that knee surgery? U.S. hospitals are now required to post list prices for medical services online, under federal rules meant to help patients find affordable care and avoid hefty surprise bills. The spreadsheets, often thousands of lines long, will leave many patients overwhelmed. Procedures are described in medical jargon and abbreviations. That's if you can find the lists. (Johnson, 1/16)

The Star Tribune: Minnesota Hospitals See Spike In Unpaid Bills

Unpaid hospital debt in Minnesota surged 25 percent in 2017, another sign that even patients with health insurance are struggling to pay high deductibles and co-payments for medical care. The increase is the biggest jump since the Affordable Care Act (ACA) took effect in 2013, according to a report released Wednesday by the Minnesota Hospital Association. (Howatt, 1/16)

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Passport says state cuts threaten future, new Louisville

headquarters

SourceURL: https://www.courier-journal.com/story/money/companies/2019/01/15/passport-says-state-medicaid-cuts-threaten-companys-future/2523800002/

Passport says state cuts threaten future, new Louisville headquarters

Deborah Yetter, Louisville Courier Journal Published 7:15 p.m. ET Jan. 15, 2019
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Buy Photo
Passport Health's new headquarters is under construction in western Louisville. Jan. 10, 2019 (Photo: Michael Clevenger/Courier Journal)

Passport Health Plan is appealing state cuts to its Medicaid business that it says threaten the future of the 21-year-old nonprofit, as well as its new headquarters under construction in western Louisville.

The company uses the payments from the state to provide managed care for about 310,000 people, 200,000 of them in Louisville.

The appeal filed Jan. 9 follows failed efforts to negotiate a resolution with top state officials, Passport spokesman Michael Rabkin said Tuesday.

"We remain committed to working with the cabinet in good faith to find a solution to this issue," Rabkin said.

The dispute comes at critical juncture for the organization, which is building a new headquarters on a 20-acre site at West Broadway and 18th Street, hailed as an economic boon to western Louisville.

See also: Bevin's new Medicaid plan same as the last one, opponents say in lawsuit

According to copy of Passport's appeal obtained by the Courier Journal, the company said the state's rate cuts were "arbitrary" and violate its contract with the state.

It said it expects to lose $144 million in 2019 under the cuts, which "will jeopardize its fiscal solvency and continued existence."

And despite efforts last year by Passport officials to propose improvements to the state rate cuts, "those suggestions were summarily rejected without clear justification or explanation," the appeal said.

Doug Hogan, a spokesman for the state Cabinet for Health and Family Services, said the new rate structure simplifies an overly complicated system that divided the state into eight regions.

The new plan divides the state into two regions, the Jefferson County area where Passport does most of its business and where rates were cut, and the rest of Kentucky, where rates increased.

Hogan said the new system was developed with guidance from the U.S. Center for Medicare and Medicaid Services and based on an independent actuary using claims data and projection of costs.

Rabkin said the new rate structure "unfairly targeted the Louisville region" and has a "disproportionate impact on Passport."

Hogan acknowledged Passport is "disproportionately impacted" by the changes but said that's because "that impact flows primarily from Passport's own data and historical trends due to their market share within that region."

He said state officials have met with Passport on several occasions and asked for proof that the new rate structure is unsound, which the company has not provided.

Read this: Bill requiring doctors to report abortions induced by medication advances

Rabkin said the cuts began July 1, 2018, and have resulted in significant losses for Passport, which relies almost solely on Medicaid for income. Passport was the first company to take on managed care for state Medicaid patients and has grown to employ about 700 — jobs that could be affected by the cuts, Rabkin said.

"We've been operating at a loss," Rabkin said. "I know we've had to utilize reserves a bit over the last few months."

Meanwhile, Rabkin said the future of the company's new headquarters "is a very good question."

Losing the Passport headquarters would be a terrible blow to western Louisville, said the Rev. Kevin Cosby, pastor of St. Stephen's western Louisville megachurch and an influential leader who was among many officials who spoke at a ceremony in 2017 announcing Passport's planned campus.

"It would be a tragic loss," Cosby said. "It would be devastating. Passport is poised to be a tremendous corporate neighbor and a harbinger of future development that will take place."

Passport, which plans to move next year to the new building from rented office space in southeast Jefferson County, has "made a strong commitment to West Louisville," Cosby said.

See also: Louisville mom aims to help families afford lifesaving service dogs

Buy Photo
Passport Health's new headquarters is under construction in western Louisville. (Photo: Michael Clevenger/Courier Journal)

Hogan, the cabinet spokesman, said the state appreciates Passport's investment in the community but that's not the purpose of Medicaid managed care.

"Rather, the purpose of the managed care contracts is to provide medical coverage to our beneficiaries," he said.

Passport is building a four-story, 355,000-square-foot building that would be part of a complex of several new projects including a YMCA under construction. The YMCA expects to open its $28 million health and fitness complex at the southeast corner of the intersection this year.

The project was greeted with praise by city officials and community leaders, including many western Louisville ministers, after plans for a Walmart superstore fell through for the long-vacant site of the former Philip Morris tobacco plant.

Passport CEO Mark Carter, in the company's 2017 annual report, described the project as a means for his organization to create a new model in health care in Louisville, one that would "help our members flourish in all aspects of their lives."

But Passport's finances took a turn for the worse after the state unexpectedly cut Medicaid payments in the Jefferson County region last year, Rabkin said.

Rabkin said state officials haven't adequately explained why they made the change and why competitors outside the area got a payment increase.

"We are still asking that question," he said. "We're still trying to figure out how that came to be and why."

Hogan said the state has concerns about what it said are Passport's higher reimbursements to providers, higher administrative costs, and state fines imposed for more inaccurate or incomplete claims than those of other managed care organizations, known as MCOs.

"Passport, and not the cabinet, has the means to address these business practices that may be contributing to its financial stress, but which are not present to the same degree with our other MCOs," Hogan said.

More news: In race to overturn Roe v. Wade, Kentucky Republicans want to be first

Passport is unusual in that it was established in 1997 for the sole purpose of providing managed care for Medicaid in the Louisville region to help the state with growing costs. It was organized by hospitals, doctors and other health providers as a nonprofit entity to handle Medicaid claims and promote wellness in Jefferson and 15 surrounding counties.

In its appeal, Passport said the state fails to take into account its unique status.

"As a tax-exempt, nonprofit organization, our profits are dedicated to investing in expanded access, quality of care, innovative programs and our own communities while other (managed care companies) send their profits to shareholders, many of whom are located outside the Commonwealth of Kentucky," it said.

For many years, Passport operated as the only Medicaid managed care organization in Kentucky until the state decided in 2011 to seek other outside,

for-profit companies to provide managed care statewide for most of its Medicaid patients.

Passport now is one of five outside companies that manage health care for most of the 1.4 million Kentuckians covered by Medicaid, a $11.5 billion program that gets most of its money from the federal government. The other four are commercial health insurance companies that operate in multiple states.

Those companies are Aetna Better Health of Kentucky, Humana CareSource, WellCare of Kentucky and Anthem.

Passport is the only company of the five that relies on Kentucky Medicaid as virtually its sole source of income. It's the second largest provider after Wellcare.

Check out: Yelp for hospitals: This website shows you operation costs in Kentucky

Buy Photo
The Passport headquarters under construction near 18th Street and Broadway. Jan 10, 2019 (Photo: Michael Clevenger/Courier Journal)

Asked about the rate changes, Bill Jones, Kentucky market president for WellCare, said in a statement: “Since WellCare entered the Kentucky market, the company has worked within the rates set by the state to provide quality health care to our members.”

The state pays each company a fixed "per member, per month" rate and, in turn, the company reimburses providers, such as doctors, hospitals and clinics, for the care provided to patients.

While the state has the authority to set rates, they generally are established in contracts held by each managed care organization.

Rabkin said Passport was caught by surprise when state Medicaid officials last year announced they were changing rates and making them retroactive to July 1. The changes cut payments in the Jefferson County region by about 4 percent and increased them by about 2 percent for the rest of the state, he said.

Rabkin said Passport will continue to try to negotiate with the state while it pursues its appeal of the rate cuts.

Hogan said cabinet Secretary Adam Meier is "reviewing the appeal filed by Passport and will do so in good faith just as he and his predecessors have reviewed previous issues they have raised."

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Deborah Yetter: 502-582-4228; dyetter@courierjournal.com; Twitter: @d_yetter.
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ForeverCare Drops Out of Medicaid Organized Care Model

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ForeverCare Drops Out of Medicaid Organized Care Model

By:
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Three PASSEs Sign, Move Forward in DHS PASSE Model

LITTLE ROCK, Ark. - A company that offers services to high-needs Medicaid beneficiaries wants to partially stop doing business in Arkansas.

ForeverCare told its members Wednesday in an email that it will pull out of an organized care program operated by the Arkansas Department of Human Services (DHS).

"I apologize some of you may be finding out about our decision not to proceed with Phase II of the PASSE program this morning from anyone but me," wrote Mike McCabe, the plan president. "Over the last two years we have attempted to build a health plan focused on members care and providing the best of everything for those in Arkansas we serve. In the end, the decision we made was based on what is best for the members."

A state law passed in 2017 created Provider-led Arkansas Shared Savings Entities, known as PASSEs, that operate like managed care companies. Four companies are part of the program that serves a total of more than 40,000 Arkansans with significant behavioral health issues or developmental or intellectual disabilities.

Phase I of the program, which began in Feb. 2018, provided care coordination. ForeverCare dropped out of Phase II Wednesday, which would also make the PASSEs responsible for paying for members' Medicaid services.

McCabe continued in his email, "Despite our best efforts we do not have the systems in place to assure members would be cared for in the way they deserve. In addition, the risks posed by the continuing questions around the program are too great for us to move forward at this time."

"I believe we have three PASSEs that didn't have the same thoughts on this," said Paula Stone, the deputy director of the Division of Medical Services for DHS. "We meet with passes weekly, actually daily at this point. We had a really large meeting with the passes to address any outstanding questions or concerns they had."

Stone said ForeverCare's 7,600 beneficiaries will soon get a notice of their reassignment to one of the three remaining PASSEs well before the Phase II start date of March 1.

DHS pushed back the implementation of Phase II from Jan. 1 to March 1 "to allow systems to be tested, ensure that the billing systems are functioning seamlessly to allow timely payments to providers and allow more time for the training and enrolling of even more providers to the PASSE networks."

In an email to the DHS director and others involved in the program explaining his company's withdrawal, McCabe wrote ForeverCare "reached this decision with much reluctance in light of the March 1, 2019 implementation date."

McCabe continued, "As we have discussed, in addition to the fact that ForeverCare's internal requirements dictate that it cannot enter into the Phase II Agreement unless the state date of Phase II is moved to July 1, 2019, we believe there are also program operational issues which need to be resolved before DHS implements Phase II."

McCabe wrote the company could still be involved if DHS pushed back the deadline or delayed ForeverCare's participation in full risk until July 1.

"I think the reason ForeverCare has elected to walk away is because they see what's coming forward on March 1," said Loretta Cochran, a ForeverCare member. "They know the risk of the gaps that are still open, and they're not going to be a willing party to hurting their clients. I appreciate them being honest. The other three, I think, are sticking their heads in the sand."

Cochran, who is the guardian of a ForeverCare beneficiary, worries payments will not work correctly for smaller, more rural providers and beneficiaries will lose

services.

"I won't be here forever," she said. "I have to have a system that I know is going to take care of and close that gap in support and leadership. If ForeverCare leaves and we don't get these problems fixed before we cut over, I don't know if we're going to have that. In fact, I fully doubt that we will have any kind of security like that."

Stone said DHS does not plan on extending the deadline, confident everything will be in place by March 1.

"We feel like we have a good plan in place where we've spent the morning making sure it will go smoothly for all of those beneficiaries," she said.

Once reassigned to one of the three remaining PASSEs, former ForeverCare beneficiaries will have 90 days to switch.

Beneficiaries can find more information by visiting the PASSE website or calling the PASSE ombudsman at 501-320-6006.