MMMRs- 2019 02 11

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Monday Morning Medicaid Must Reads

Helping you consider differing viewpoints. Before it's illegal.

Feb 11, 2019

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In this issue...

Article 1: *State wrestles with sizable backlog of Medicaid applications*

Clay's summary: Expansion nearly doubled the AK Medicaid rolls. *Doubled*.

Key Excerpts from the Article:

As of Jan. 29, Alaska had a backlog of 15,639 cases of new applicants or renewals on the books. About two-thirds of those, or 10,200 cases, were filed in 2018. The average wait time to be approved is currently 55 days, according to Clinton Bennett, the media relations manager for the Alaska Department of Health and Social Services... That's the average, but not everyone is waiting that long, he wrote in an email..."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," he wrote.
Alaska has a fairly large Medicaid population with about 210,276 people enrolled in the Medicaid and CHIP programs as of October 2018, according to the Centers for Medicare and Medicaid Services.
That's about 24 percent of the state's total population, and up from 123,335 people enrolled at the end of July 2015, just before the Medicaid expansion took effect in the state.
Though it's still a sizable backlog, it's significantly down from the total in May 2018, when the Alaska Ombudsman's Office published a report highlighting the difficulties in the Division of Public Assistance. At the time, the ombudsman noted a backlog of more than 20,000 cases, itself down from 30,000 in July 2017.

Read full article in packet or at links provided

Article 2: *Medicare, Medicaid Enrollment Growing Faster Than Private Coverage*

Clay's summary: New analysis says Care/Caid spending growth is nothing to be concerned about. What do they think we are, idiots? Of course they do. Shut up and pay your taxes. Don't have opinions about how they are spent.

Key Excerpts from the Article:

Over the course of 11 years, annual spending growth averaged 5.2% for Medicare and 6% for Medicaid. This eclipsed the 4.4% spending growth among private insurers.

However, spending per enrollee from 2006 to 2017 was markedly lower for public programs compared to their private counterparts. Medicare spending per enrollee amounted to 2.4% per year, Medicaid registered at even lower 1.6%, while private insurance posted 4.4% annually.
Medicaid and Medicare also achieved positive annual enrollment growth rates over the same period of time, 4.3% and 2.8% respectively, while private insurers finished with a flat enrollment growth rate.
The study's findings conclude that while CMS projects Medicaid and Medicare spending per enrollee to grow sizably over the next decade, both programs have "successfully moderated growth."
The Urban Institute states that the results indicate that neither program require "major restructuring" to reduce national health spending and that the more concerning spending figures lie in the private insurance market.
The study's authors support "modest policy proposals," such as limiting state use of provider taxes in Medicaid or modifications to Medicare cost-sharing.

Read full article in packet or at links provided

Article 3: *Medicaid cost concerns are valid*

Clay's summary: An op-ed considers a litany of examples when the state was left to deal with federal funding changes that made programs cost a lot more than originally promised- AND they connect the dots to Medicaid expansion and the "free federal money." How dare they use logic and past experience???!!? Evil Republicans!

Key Excerpts from the Article:

Even if the state's portion of Medicaid expansion costs doesn't rise, the $150 million price tag is still significant. That $150 million is more than twice the amount required to provide a proposed $1,200 pay raise for every teacher this year. It's more money than what would be saved if roughly 12,400 inmates were released from state prisons, according to one estimate. It's more than four times the amount required to eliminate a backlog of local government reimbursements for emergency responses.
Every dollar spent on Medicaid expansion is a dollar that doesn't go to other needs like schools, roads or public safety. And voter rejection of a 2016 sales tax increase shows limited public appetite for the kind of broad-based tax increases required to avoid such tradeoffs.
The real debate is not simply whether one supports Medicaid expansion, but whether one believes Medicaid expansion should be a higher priority than school funding increases or other causes. And, beyond fiscal considerations, debate should also focus on this question: Does Medicaid expansion improve health outcomes? Much research has found little real improvement.

Read full article in packet or at links provided

State wrestles with sizable backlog of Medicaid applications

SourceURL: https://www.adn.com/alaska-news/2019/02/07/state-wrestles-with-sizable-backlog-of-medicaid-applications/

State wrestles with sizable backlog of Medicaid applications

Alaska is significantly behind on approving Medicaid applications, and in some cases applicants are waiting for months.

As of Jan. 29, Alaska had a backlog of 15,639 cases of new applicants or renewals on the books. About two-thirds of those, or 10,200 cases, were filed in 2018. The average wait time to be approved is currently 55 days, according to Clinton Bennett, the media relations manager for the Alaska Department of Health and Social Services.

That's the average, but not everyone is waiting that long, he wrote in an email.

"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," he wrote.

Alaska has a fairly large Medicaid population with about 210,276 people enrolled in the Medicaid and CHIP programs as of October 2018, according to the Centers for Medicare and Medicaid Services.

That's about 24 percent of the state's total population, and up from 123,335 people enrolled at the end of July 2015, just before the Medicaid expansion took effect in the state.

Though it's still a sizable backlog, it's significantly down from the total in May 2018, when the Alaska Ombudsman's Office published a report highlighting the difficulties in the Division of Public Assistance. At the time, the ombudsman noted a backlog of more than 20,000 cases, itself down from 30,000 in July 2017.

The eligibility staff couldn't keep up, in part because of the increasing number of cases per worker — up 24 percent since the expansion in 2015 — and other types of applications for public assistance, such as food stamps, which began increasing during the height of the economic recession in July 2017.

The state practices pre-enrollment eligibility verification, Bennett said, meaning that eligibility systems or workers must verify income before approving someone to enter the program. The state cooperates with the federally facilitated marketplace, Healthcare.gov, to verify eligibility for low-income individuals. If Healthcare.gov is unable to determine eligibility, the state will take over from there.

The Legislature also passed a bill reforming the state's Medicaid program in 2016. One of those requirements was to implement a new technology system. Changing over systems amid the increased volume after the expansion may have led to the backlog boom, said Tricia Brooks, a senior fellow at Georgetown University's Center for Children and Families.

"I think that in Alaska, it was sort of a perfect storm," she said. "... You have this new system coming in, (the state was) a late adopter of the Medicaid expansion, so you have this volume going on. The combination of those two going on is really tough, particularly when you're in an environment where you're changing the business rules."

Alaska is one of a handful of states that have an extensive delay for processing applications, Brooks said. The federal standard is 45 days for non-disability Medicaid applications, and 90 days for disability Medicaid applications. That delay can mean that some go without coverage, and it makes things complicated for the administrators when some are renewals as opposed to new 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."

The Republican Senate Majority, which backed the original 2016 Medicaid redesign legislation, is concerned about the eligibility backlog as well. Senate

President Cathy Giessel, R-Anchorage, said the current process is weighing the state down and allowing some people who do not qualify to obtain coverage.

Other states dealing with a similar problem have hired third-party qualified contractors to screen applicants. Giessel said that's a step Alaska should take, too.

The backlog can be frustrating for providers as well as for recipients, she said.

"I think it's the frustration that any compassionate Alaskan has," she said. "When they're on waiting lists so long, it's not compassionate. It's not compassionate. We want to fix that. In addition, we know there are folks on the rolls that are not eligible, that shouldn't be."

The reform was a big request of the department, but it is making some progress and reporting savings, Giessel said.

There are still changes that could make things better such as moving regulations through that allow expanded coverage of services via telehealth and possibly breaking up the Department of Health and Social Services into smaller departments, allowing for more efficient management, she said.

Two bills prefiled for the 2019 session propose adding work requirements for certain eligible adults. Giessel said that's one other item the Senate is considering in the wake of Medicaid expansion, to encourage able-bodied adults on Medicaid to work.

"Am I personally happy with the way Mediciad reform is going? It's slow," she said. "It's very much like the glaciers in Alaska. They're there, but moving very slowly."

To reduce the backlog in Alaska, Brooks pointed to a number of steps other states have taken, including the step Giessel mentioned to hire a third-party contractor to verify eligibility. Another way, which has been encouraged by CMS, is to use eligibility data from the SNAP program to determine eligibility for Medicaid. Most people who qualify for SNAP also qualify for Medicaid, Brooks said.

Another logjam in the system can be as simple as people calling the Division of Public Health to check the status of their application. That takes staff time to answer the phones. One way to address that problem is to launch online account that allow people to check the status of their applications online, Brooks said.

The majority of states have now done that, she said.

“Online accounts really improve the efficiency of the eligibility operations,” she said. “I think there’s been less trouble with the online accounts than there have with the underlying eligibility rules engine. It is a way to offload some of the work volume.”

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Medicare, Medicaid Enrollment Growing Faster Than Private Coverage | HealthLeaders Media

SourceURL: https://www.healthleadersmedia.com/finance/medicare-medicaid-enrollment-growing-faster-private-coverage

Medicare, Medicaid Enrollment Growing Faster Than Private Coverage

By Jack O'Brien | February 11, 2019

From 2006 to 2017, spending per enrollee for public programs has been lower than private coverage options even as enrollment grew substantially for both Medicaid and Medicare.

KEY TAKEAWAYS

While Medicaid and Medicare grew their enrollment rolls, private coverage growth remained flat.

Even so, both public programs managed to keep their spending per enrollee well below that of private insurers.

The study's authors state that these findings do not support calls for major changes to the structure of federal health programs.

While enrollment in Medicaid and Medicare have grown in recent years, spending per enrollee has been effectively managed, especially compared to spending per enrollee under private coverage, **according to a new Urban Institute study released Monday morning.**

Over the course of 11 years, annual spending growth averaged 5.2% for Medicare and 6% for Medicaid. This eclipsed the 4.4% spending growth among private insurers.

However, spending per enrollee from 2006 to 2017 was markedly lower for public programs compared to their private counterparts. Medicare spending per enrollee amounted to 2.4% per year, Medicaid registered at even lower 1.6%, while private insurance posted 4.4% annually.

Medicaid and Medicare also achieved positive annual enrollment growth rates over the same period of time, 4.3% and 2.8% respectively, while private insurers finished with a flat enrollment growth rate.

The study's findings conclude that while CMS projects Medicaid and Medicare spending per enrollee to grow sizably over the next decade, both programs have "successfully moderated growth."

The Urban Institute states that the results indicate that neither program require "major restructuring" to reduce national health spending and that the more concerning spending figures lie in the private insurance market.

The study's authors support "modest policy proposals," such as limiting state use of provider taxes in Medicaid or modifications to Medicare cost-sharing.

Both Medicare and Medicaid were praised in the report for contolling per capita health costs during a time of slowed national health expenditure growth, especially as questions regarding the fiscal sustainability of federal health programs have been raised.

The study also found discrepencies between spending on prescription drugs, administrative costs, and hospital services in relation to spending among public and private health entities.

Growth among spending for Medicare was primarily due to prescription drug spending, while administrative costs and physician services led the way for Medicaid. For private insurers, hospital services compromised most of the spending growth.

Medicaid cost concerns are valid

SourceURL: https://newsok.com/article/5622428/medicaid-cost-concerns-are-valid

Medicaid cost concerns are valid

by The Oklahoman Editorial Board
Published: Sun, February 10, 2019 1:08 AM Updated: Sun, February 10, 2019 1:37 AM

Gov. Kevin Stitt

Under the Affordable Care Act, states can add able-bodied adults to Medicaid with the federal government covering 90 percent of the cost. States provide 10 percent. But that 10 percent is not insignificant and, as Stitt noted, there's good reason to think the state's share will only grow with time.

"While Medicaid expansion currently stops at a 90 percent federal match, we cannot assume that it will remain this high forever," Stitt said. "The estimated $150 million price tag today for Oklahoma to expand Medicaid could leave us down the road fronting more than $1 billion when the federal government pulls back on its commitment. They've done it before and they'll likely do it again."

Oklahomans need look no further than this year's budget to see examples. To maintain *existing* programs to train doctors and provide health care to children, lawmakers must spend $77 million more. That new spending doesn't provide new benefits. It simply fills holes created by federal funding changes.

Changing federal matching rates and broken federal promises are both routine. Former President Barack Obama championed Medicaid expansion, but also proposed Medicaid cuts in his 2011 and 2012 budget proposals. Former U.S. Sen. Tom Coburn, R-Muskogee, often noted the federal government promised to cover 40 percent of the cost of the Individuals with Disabilities Education Act when it passed; actual payments covered around half that.

Even if the state's portion of Medicaid expansion costs doesn't rise, the $150 million price tag is still significant. That $150 million is more than twice the

amount required to provide a proposed $1,200 pay raise for every teacher this year. It's more money than what would be saved if roughly 12,400 inmates were released from state prisons, according to one estimate. It's more than four times the amount required to eliminate a backlog of local government reimbursements for emergency responses.

Every dollar spent on Medicaid expansion is a dollar that doesn't go to other needs like schools, roads or public safety. And voter rejection of a 2016 sales tax increase shows limited public appetite for the kind of broad-based tax increases required to avoid such tradeoffs.

The real debate is not simply whether one supports Medicaid expansion, but whether one believes Medicaid expansion should be a higher priority than school funding increases or other causes. And, beyond fiscal considerations, debate should also focus on this question: Does Medicaid expansion improve health outcomes? Much research has found little real improvement.

One doesn't have to agree with Stitt's argument, but any response should involve more than whistling past the graveyard.