WHO TRANSLATES TO THE PT AND THE STAFF AND COMMUNITY?

MEDICAID RE-ENROLLMENT/RE-DETERMINATION 4-23 THRU 4-24

ENDING OF THE PUBLIC HEALTH EMERGENCY 5-11-23

AR Systems, Inc
Training Library Presents

Impacts of the Medicaid Re-Enrollment Process- The Cliff

Effective 4-1-23 (Yep, April Fool's Day!)

During the PHE, Medicaid patients continued to have health coverage. Federal funds increased to assist the states with the commitment not to disenroll during the PHE.

"

Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? They are scared and sick.

Let me be the Patient Financial Navigator!

Instructor:

Day Egusquiza, President

AND START WITH A LITTLE "PAYER FUN"

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

U usually

N nine

I in

T ten

E experience

D denials…..

C called

I in

G got

N no

A answer

++All time favorite: Singing the"Blues "

Did we mention Medicaid

Redetermination!

Public health emergency "Cliff" – What do your patients know, your staff, and your community know?

The Medicaid Re-enrollment period starts on April 1, 2023 (for most states)– which is the biggest impact to the cash position and workflow for Medicaid patients AND who for **the past three years were not removed from coverage as no monthly eligibility screening was occurring**. (Mdc Protection)

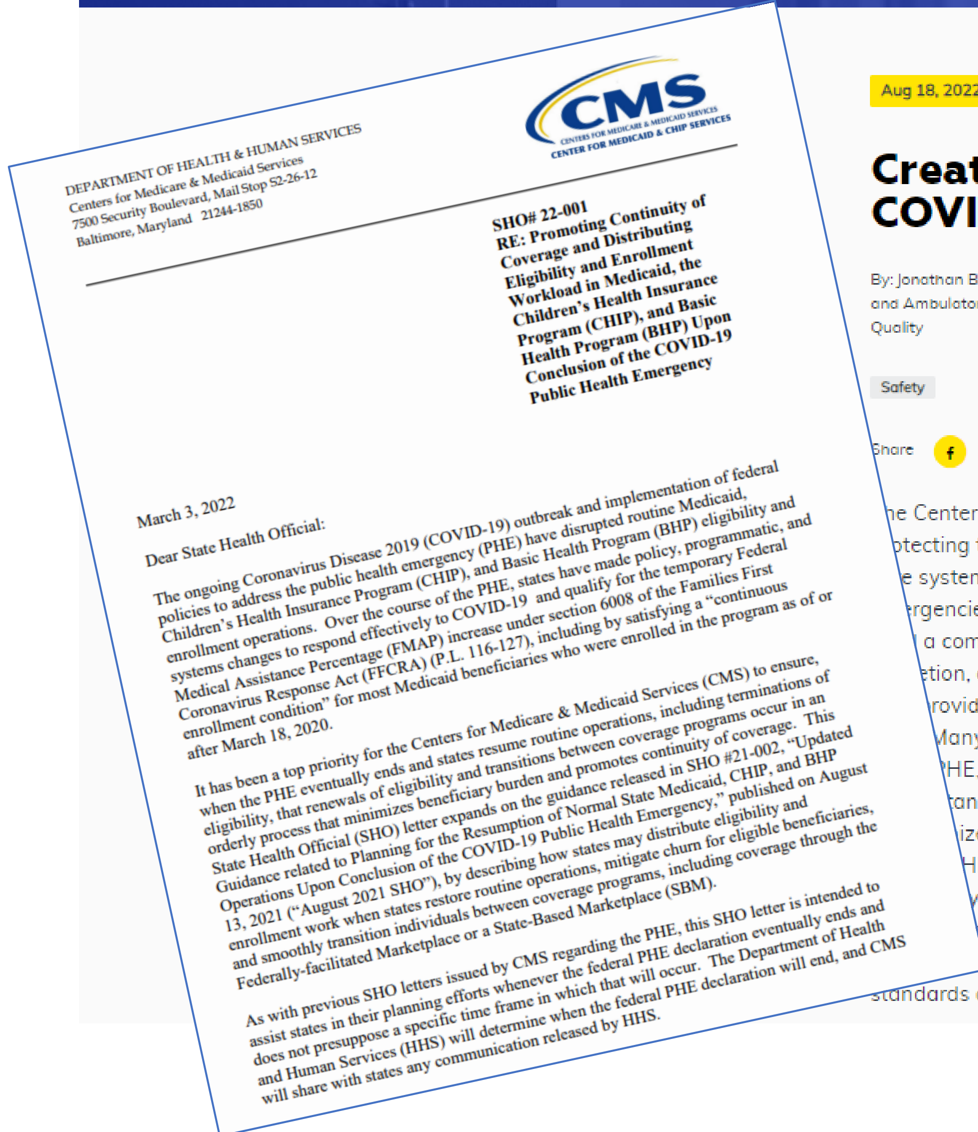
STARTS April 1, 2023 with CMS allowing up to 12 months to be completed
Estimate 18M of the 90M/20% covered by Medicaid- at risk for losing Medicaid: All impacted
The Full PHE ending is May 11, 2023. Yep two different dates.

- Unwinding the continuous coverage requirement – includes large numbers who are still eligible for Medicaid- could lose their coverage and become uninsured or experience gaps in coverage.
- Ending continuous coverage and reinstating renewals for Medicaid enrollees raises challenges for enrollees too. They need to re-enroll. Who is helping them? Think internal Patient Financial Navigator + state assistance.
- States will have to conduct renewals on their ENTIRE caseloads, and they may not be able to keep to the required timeline for paperwork. If denied, they can re-apply per the outlined process. States will return to their normal redetermination (mostly every 12 months but Idaho 'periodically")

hfma

Public Health Emergency (PHE) wind down

"As discussed in prior guidance, **states will need to develop a comprehensive "unwinding operational plan"** to restore routine operations in their Medicaid, CHIP, and BHP programs. This unwinding operational plan is intended to reflect how states will complete outstanding work and **maximize uninterrupted coverage for eligible individuals**…"



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 22-001
RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency

March 3, 2022

Dear State Health Official:

The ongoing Coronavirus Disease 2019 (COVID-19) outbreak and implementation of federal policies to address the public health emergency (PHE) have disrupted routine Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) eligibility and enrollment operations. Over the course of the PHE, states have made policy, programmatic, and systems changes to respond effectively to COVID-19 and qualify for the temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA) (P.L. 116-127), including by satisfying a "continuous enrollment condition" for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

It has been a top priority for the Centers for Medicare & Medicaid Services (CMS) to ensure, when the PHE eventually ends and states resume routine operations, including terminations of eligibility, that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. This State Health Official (SHO) letter expands on the guidance released in SHO #21-002, "Updated Guidance related to Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency," published on August 13, 2021 ("August 2021 SHO"), by describing how states may distribute eligibility and enrollment work when states restore routine operations, mitigate churn for eligible beneficiaries, and smoothly transition individuals between coverage programs, including coverage through the Federally-facilitated Marketplace or a State-Based Marketplace (SBM).

As with previous SHO letters issued by CMS regarding the PHE, this SHO letter is intended to assist states in their planning efforts whenever the federal PHE declaration eventually ends and does not presuppose a specific time frame in which that will occur. The Department of Health and Human Services (HHS) will determine when the federal PHE declaration will end, and CMS will share with states any communication released by HHS.

Aug 18, 2022

Creating a Roadmap for the End of the COVID-19 Public Health Emergency

By: Jonathan Blum, Chief Operating Officer and Principal Deputy Administrator; Carol Blackford, Director Hospital and Ambulatory Policy Group; and Jean Moody-Williams, Deputy Director of the Center for Clinical Standards and Quality

Safety

Share

he Centers for Medicare & Medicaid Services (CMS) plays an important role in
otecting the health and safety of all Americans as they journey through the health
e system. This is especially true during a pandemic, natural disaster, or other
rgencies. Throughout the COVID-19 public health emergency (PHE), CMS has
a combination of emergency authority waivers, regulations, enforcement
etion, and sub-regulatory guidance to ensure access to care and give health
roviders the flexibilities needed to respond to COVID-19 and help keep people
Many of these waivers and broad flexibilities will terminate at the eventual end
HE, as they were intended to address the acute and extraordinary
tances of a rapidly evolving pandemic and not replace existing requirements.
ize any disruptions, including potential coverage losses, following the end of
HHS Secretary Becerra has committed to giving states and the health care
y writ large 60 days' notice before ending the PHE. In the meantime, CMS
s health care providers to prepare for the end of these flexibilities as soon
and to begin moving forward to reestablishing previous health and safety
standards and billing practices.

hfma

Public Health Emergency (PHE) Wind Down: 4-1-23

CMS Guidance On Unwinding The Continuous Enrollment Requirement

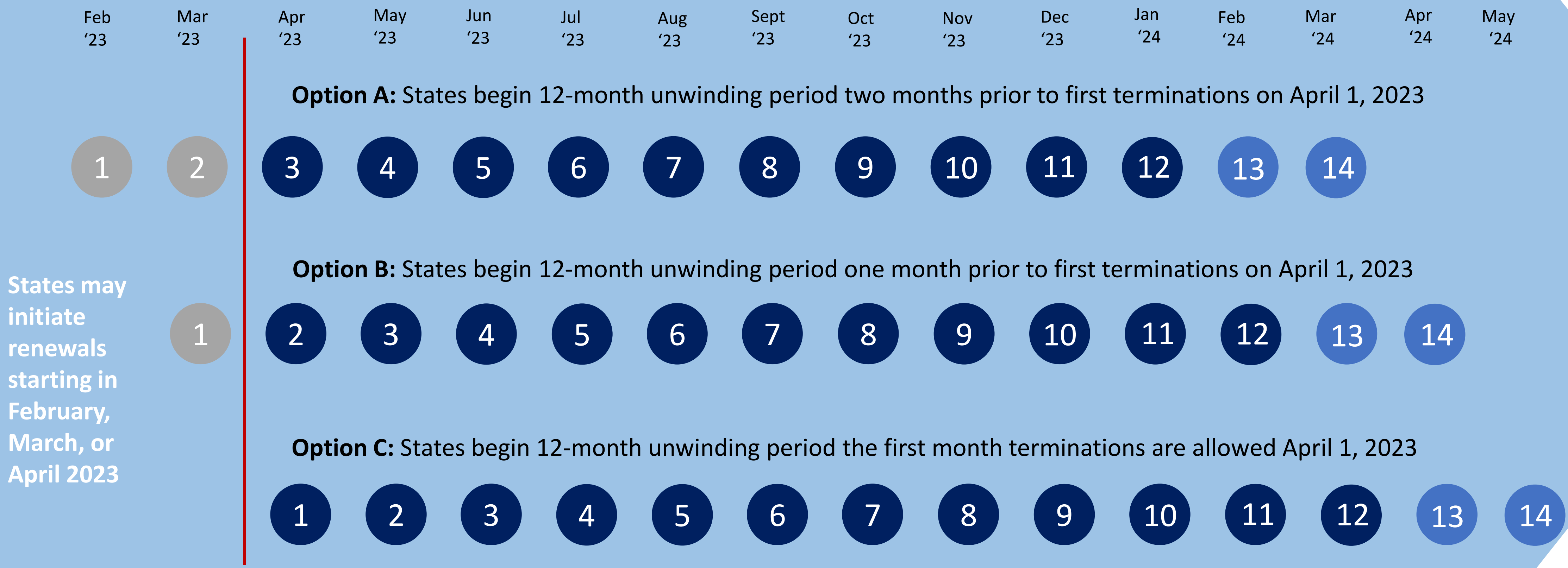
Components of State Unwinding Plans	Requirements
Operational Plan	Plan must specify how states will complete redeterminations in a way that maintains coverage for eligible enrollees, ensures even distribution of renewals, and ensures timely processing of applications.
Timelines	States must be current in processing new applications within four months after the end of the PHE. States must also initiate renewals within 12 months and complete all pending actions within 14 months. To retain the enhanced federal matching funding, they must begin the unwinding period no later than the 1st day of the month after the PHE ends, but can initiate redeterminations up to two months before PHE ends (although they cannot disenroll anyone until after PHE ends).
Risk-Based Approach to Prioritizing Work	States must specify how they will prioritize pending actions: population-based (prioritize populations that are likely to no longer be eligible); time-based (conduct renewals based on renewal month or prioritizes older pending actions); hybrid (combine population and time-base approaches); state-developed (other approach that meets goals).
Distribution of Pending Actions	States are encouraged to initiate no more than 1/9 of total caseload each month.
Facilitating Transitions to the Marketplace	States must transfer accounts of individuals determined ineligible for Medicaid or CHIP to the Marketplace, including all account and eligibility information.
Monitoring State Progress	States will be required to submit monthly data for 14 months using a template under development by CMS; data elements have not been defined.

SOURCE: Centers for Medicare and Medicaid Services (CMS), SHO #22-001, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency" last updated March 3, 2022.

KFF

March 31, 2023 = End of the Medicaid Continuous Coverage Provision

Terminations may begin April 1, 2023



- Initiate Renewals Only
- Initiate Renewals & Process
- Process Renewals Only

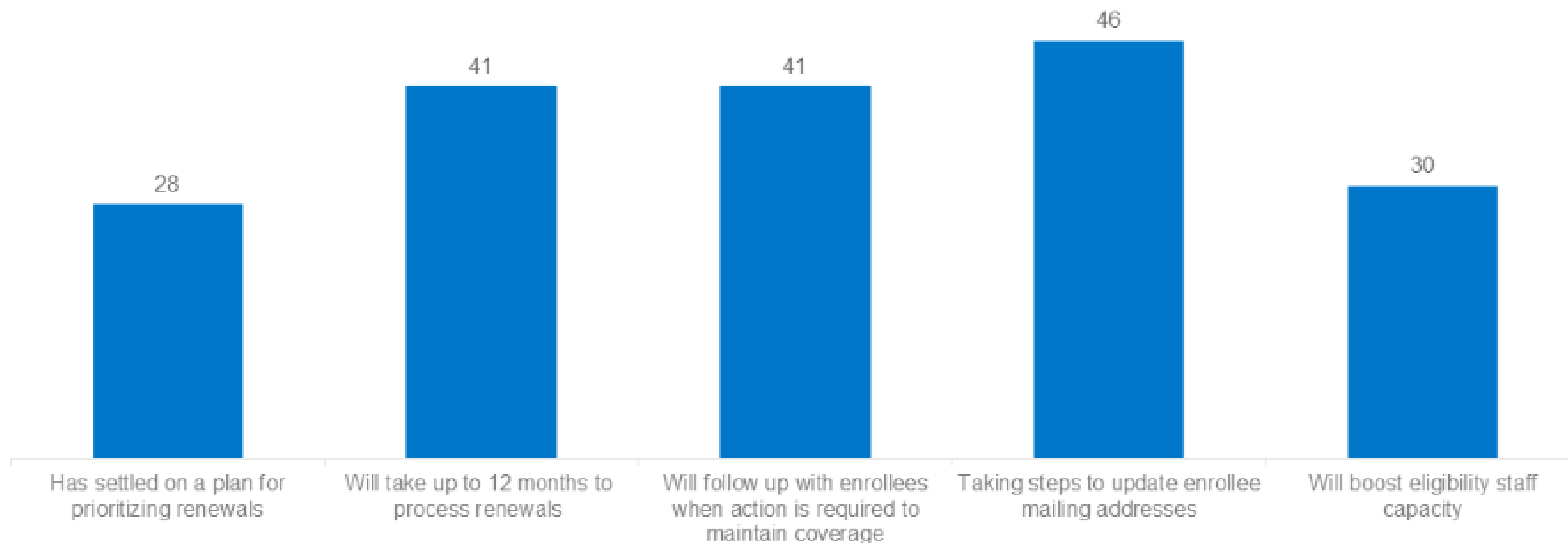
Month 1: *Begin initiating unwinding-related renewals*

Month 12: *Last month to initiate unwinding-related renewals*

Month 14: *Last month to complete all unwinding-related E&E actions*

https://ccf.georgetown.edu/2022/11/16/no-60-day-notice-on-the-unwinding-phe-expected-to-be-extended-until-april-2023/

Public Health Emergency (PHE) Wind Down



SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2022.

hfma

When each state will begin terminating Medicaid Coverage? PS What about the border states?

- **Continuous coverage** with Medicaid since PHE.
- Since early 2020, increase of 28%, 20.2M.
- On April 1, most states will resume who is and is not eligible for Medicaid – leaving up to 18 M people nationwide without health coverage.
- Each state dates, per CMS, will begin to remove from coverage:
  - April: AZ, Ark, ID, NH, SD.
  - May: CT, FL, IN, IA, KS, NE, NM, OH, OK, PA, UT, VA, WVA, WY
  - June: AL,AK, CO, GA, HI, KY, ME, MA, MS, MT, NV, NJ, ND, RI, SC, TN, TX, VT, WA, WS
  - July: CA, DE, IL, LA, MI, MN, MO, NY, NC
  - Oct: OR
  - Each state has their own rollout plan: as rapidly as possible/all out push in the month they start or re-enroll them in their normal renewal month or??

hfma

Anticipated Impact of Redetermination-Start w/90M Expectations at the beginning…

AHIP-funded study: NORC at Univ of Chicago

- 54% of Medicaid Benes who lose coverage during the redetermination process will likely transition to employer sponsored coverage. *48M
- 21% will lose coverage entirely *18M
- 15% will transition to Children's health Insurance Program/CHIP *13M
- Remainder will either join non-group coverage or thru a different public program. (Exchange/Marketplace) 10% *9M

Overall, more than 1 in 5 who lose Medicaid will become uninsured. Using data analysis, 7 states had a 23% or higher expected uninsured rate. (TX, FL, AZ, SC, NM, ME, NC)

- States with largest growth during the PHE, will see the largest loss of coverage. (Urban Institute)

- Medicaid Managed Care payers have benefited by having Continuous Coverage and growth in Medicaid.
- Elevance (was Anthem, Inc) has benefited from relaxed eligibility and ended with 47.5M members.
- Health insurers' growth is expected to slide due to sluggish or loss of Medicaid benes= Mgd Medicaid.

Issues to note:

1. Benes have had 3 years with no out of pocket. (in most states)
2. Benes have not had deductibles to pay and then co-insurance that Commercial plans will have.
3. Benes have not had to learn how to read EOBs, understand prior auth, coverage limitation (different than Medicaid), payment plans

How has it gone with the first states rolling out? Hint: Huge procedural problems- failed to report information to the state or could not be reached-May.

- With redeterminations under way, health policy experts say too many people in some states are losing health coverage for the WRONG Reasons.
- "Too many people are falling thru the cracks.This should be of grave concern to all those charged with protecting the health of our residents." Executive Dir of FL Health Justice Project, May 19th
- FLORIDA: Nearly 250,000 individuals have been disenrollment from the state Medicaid's program over the last month/May **but 82% of those disenrolled was due to their information not updated with the state**. About 43,000 made too much to be eligible and were referred to other resources.(Marketplace/Exchange.)
- "This is very troubling and is similar to the scary numbers we saw in ARKANSAS last week, where approximately 80% of **terminations were due to procedural reasons**/Client did not update or return redetermination paperwork." Ms Alker Georgetown Ctr of Children and Families. May 16. 73,000/VOX

- INDIANA: Began terminating coverage in May, nearly 53,000 people have been disenrolled with 88% of the terminations due to procedural reasons.
- Pennsylvania: Reports fewer terminations due to procedural reasons. More than 77,000 people have been reviewed, about 8000 have lost coverage and 45% lost coverage due to procedural reasons.
- ARIZONA: 40,000 dropped due to procedural reasons

"When governors see such large numbers of terminations of coverage due to procedural reasons, they should pause the process and see what is going on." Ms Alker

She noted that it is difficult to compare states' redetermination processes because each Medicaid program is prioritizing different groups and reporting data differently. HUGE!

State's Varying approaches complicate effort to determine impact of Medicaid Redeterminations.

Each state is focusing on different groups, getting different % of disenrollment – either to commercial insurance/thru employer; moved to Marketplace with tax credits/subsidies to help with premiums/other financial aide or now uninsured. (July 2023, Healthcare Dive)

- States are taking different approaches to redetermination – making it difficult to do apples to apples comparison.
- Apples to Oranges/state specific- adding to the complexity of determining how the unwinding is affecting the Medicaid population.
- EX) Focusing on Expansion pts. Focusing on CHIP patients.
- Only 29 states have an automated system for processing renewals

- Just 18 states are completing ½ or more of their renewals thru the ex-parte process, where states confirm eligibility using available data without action from enrollees, according to KFF.
- Other vulnerable groups may struggle with confirming eligibility due to : ltd English, older adults, people with disabilities, aren't comfortable with technology or no reliable internet.

What are some States doing about reducing the potential for denials of coverage? Kaiser did survey in April, 63% questioned did not know about redetermination. Community Awareness??

National Assoc of Medicaid Directors:

- The state-submitted plans include public education components, with the focus on ensuring the benes are aware of the process. Mid-year address changes.
- Recent Federal Comm Commission decision could make contacting benes easier. The FCC said Federal and State government –as well as their health partners(hospitals, health centers,etc)- can make enrollment calls and text messages without violating robocall and robotext prohibitions.

Montana H&W:

- Using historical addresses from processed claims to find best address.
- Expect many to be re-enrolled due to low income. Yearly renewal.

Ohio group:

- A safety net system in Cleveland, meets weekly with representatives from Dept of Job and Family services.
- There is a 'so called Fall Out Files" compromised of Medicaid benes who will not automatically be re-enrolled. The health system then sends out text msgs, phone calls and letters to help get the process completed.

Michigan HHS:

- Eligibility timeline: a) Individual renewal month, b) awareness letter sent –tells renewal packet is coming, c)packets mailed or electronic with due date, d) monthly renewal packet is processed, e) last date of coverage/month end if no longer coverage.
- *"Some individuals will not receive a renewal packet. Auto or passive renewals are completed with MDHHS have enough current, don't need more. Bene will receive a HealthCare Coverage letter." MI Bridges Account*

July update: Over 3M disenrolled across 29 states & DC since April/Kaiser Family Foundation ¾ of all lost coverage due to procedural reasons.

- **What are some examples of procedural reasons related to renewal process?**
  - Did not have updated address – no way to contact by mail. Unaware it was occurring.
  - Did not return required information – bank statements, tax returns, or other important information related to income or other criteria.
  - Some may return all required information but still denied. EX) Lost information or misinterpreted by the person reviewing the application.
  - Overall – they may still be eligible but they didn't complete the renewal process.
  - Each state has internal processes unique to the state regarding auto re-enrollment as H&W already has their income from another source. (EX: living in NH or on LTC assistance in-home – have SS info)
  - Each state was to do public education with avenues for updating information.

- **What to do if the patient is denied –for any purpose? Appeal, but timelines apply**
  - Must be an American citizen to qualify for Medicaid. Medicaid is income based.
  - CHIP= Children's Health Insurance Program provides medical coverage for individuals age 18 and younger whose parents earn too much income to qualify for Medicaid, but not enough to pay private insurance. (started 1997)
  - If the patient appeals within the first 15 days from the termination date, he/she can keep their Medicaid benefits during the appeal process.
  - If 90 days have passed since termination, the patient can reapply for Medicaid.
  - If the Medicaid patient does not complete the redetermination process in time, Medicaid benefits will cease and there will be lack in coverage.
  - Some electronic data matching failed which prevented enrollees from auto reenrollment.

July data: Precent of Medicaid patients who have been denied due to procedural reasons, by state. 75% /KFF (Each state can report separately/Ltd standards) CMS is overseeing all compliance issues ensuring each state is following the rules for redetermination.

New Mexico	99%
South Carolina	93%
Georgia	93%
Kansas	87%
Connecticut	87%
Indiana	85%
Oklahoma	80%
Mississippi	80%
Montana	80%
New Hampshire	80%
Arkansas	79%
Arizona	79%
Washington	75%
Idaho	76%*

Ohio	75%
Kentucky	72%
Nevada	70%
Vermont	68%
Rhode Island	65%
Maryland	65%
South Dakota	66%
Florida	65%
West Virginia	59%
Pennsylvania	44%
Michigan	42%
Colorado	33%
Iowa	30%

What does the Redetermination Process look like to a patient , a family? (Kaiser Family Foundation June 15)

- ***ARK:*** *Pt was called by doctor cancelling her appt because her Medicaid was terminated. The reason surprised her even more. She lost her health insurance because she failed to submit paperwork to hep the state collect the child support she was owed. "What's that got to do with me, the kid's dad (not paying child support?) She was in a 90-degree June day inside the unairconditioned community center in Marvell where Legal Aid Attorneys are tying to help people who lost their Medicaid. "If you don't cooperate, you loose everything. How was I suppose to get the paperwork for my ex?"*
- ***ARK****: Anxiety is high in ARK as to the state decides how many of its more than 1M Medicaid recipients should keep their health insurance. Not only is ARK one of the poorest states - more than 1/3 of its residents are enrolled in health insurance programs for low-income people -but the state is rushing to complete its review in 6 months instead of the 12 months as recommended.*
- ***FLORIDA****: In Miami, a community activists was using her Facebook page to alert Medicaid recipients around FL. One follower, who asked not to use her last name as she was fearful it might impact her employment, said she DID NOT get a notice from state officials. She lives in Titusville, near Cape Canaveral, and her children recently lost Medicaid. (CHIP) "We never got anything telling us to re-certify. We never got anything saying we were booted out of the system."*
- **America's Crisis of Poverty and Homelessness Grows:** The number of homelessness people has broadly risen this year, according to the Wall Street Journal analysis of state data. Newsweek reports on a study in the Journal of American Medical Association that the death of 183,000 Americans in 2019 could be attributed to poverty. Meanwhile, scores/millions of Americans are being dropped from Medicaid because of red tape.

Ex of **Marketplace coverage** – private insurance selling to individuals /families who do not have other insurance. Can qualify for financial assistance

- EX of a plan in a rural state.
- Bronze plan
- Monthly premiums: Subsidies to help

1) $638 2) $678 3) $705

- Deductibles

1) $8500 /Ind $9100 out of pocket max
2) $7000/Ind $7300 OOP max
3) $7500/Ind $9100 OOP max.

Doctor Visits

1) $0 primary care copay $120 specialist
2) $0 copay after deductible same for specialist
3) $40 primary care copay $95 specialist

- Internal plan to help patients who are new to insurance.
- Pt Financial Navigator -create a payer/employer dictionary so informed internal specialists to answer questions, help read EOBs,payment plans.
- Same for the new pt moving to the market place. Use the state's webpage to get full coverage for each package.
- Know the Marketplace coverage exceptions:
  - New address
  - Married
  - New child
  - New job
  - Can enroll as special consideration.
  - EX: YourhealthIdaho.org

Hospitals at risk – **300+ rural hospitals at immediate risk of closure** –have lost $ on patient services with public assistance ending (PHE) and are not likely to receive sufficient funds to cover the losses. These hospitals have low reserves and more debt than assets. (Center for HealthCare Quality & Payment Reform 7-23)

Stats from AHA	2023	
Total hospitals in all US	6129	
# of community hospitals	5157	84%
Of these, # of nongovt not-for-profit com hosp	2978	58%
# of owner investor-owned, for profit	1235	20%*
# of State & local govt community hospital	944	15%
Additional: # of Fed Govt hospitals	206	3%
# of nonfed psych hosp	659	11%
Other hospitals 2021	107	2%

By state - sample	# at risk of total # hosp
Kansas	29 Of 169 *34 private
Mississippi	25 of 128 *36 private
Oklahoma	24 of 165 *61 private
Alabama	19 of 133 *62 private
California	9 Of 570 *148 private
Iowa	7 Of 145 *5 private
Idaho	2 of 55 *13 private
Nevada	2 of 76 *37 private
As we carefully watch multiple small rural hospitals close , many are tied to Private for-profit investor owned.	Communities without a hospital – also means providers too.

What should Revenue cycle leaders do now to prepare?

What should CFOs start working on – Current Medicaid market, est. 18M at risk

What now? Some ideas:

- How do you inform your community of this significant change? They need to ensure that Medicaid has their most current address as they will have to re-apply for coverage.
- Determine what the State's plan is as they all have to begin in April, regardless of PHE. Work closely as significant $ hit.
- Think back to pre-2020. We were checking eligibility with each registration. Time to re-educate the registration staff too. But help the pt know the steps to re-apply or move to the Marketplace with potential assistance with premiums. 16M have signed up/Marketplace/Exchange thru Jan 15, 2023.
- Work with **'first touch staff"/registration** – in offices and hospitals – to begin to conduct the automated eligibility screening. Be watching for Medicaid – history, each month can move/or whatever your state requires for re-screening- then 'ALERT" to see loss and have internal plan. Referral, Pt Financial Navigator, etc.

How high is your Medicaid mix?

Did your state expand Medicaid?

Let’s get started to have an internal rollout of Medicaid re-enrollment.

Example of a NY community **safety net** hospital
ADC 160 Rural

- *Payer mix 18-20% Medicaid. State expanded Medicaid*
- *Have hospital-based clinics. Approx 80 in multiple locations*
- *How connected are they with the hospital? A true health system?*
- *Others: Disproportionate Share (ex 10%); Sole Community Hospitals, many rural hospitals/29% (631) of rural hospitals are either at immediate or high risk of closure*
- Outline of action items: **Call to action for all providers!**
  - State Dept of H&W rollout
  - Community awareness rollout
  - Identifying all Medicaid patients – including SNF, duals, children, expanded
  - Internal rollout plan

Re-Determination steps: Getting ready --onward

Work with the state or local Dept of H&W. Don't forget boarder states too!

- Get a contact who is keenly aware of the state's rollout plan. BE THEIR BEST FRIEND!
- Include questions regarding the process for notification of the patients. MAIL! TEXT!
- What happens if the mail is returned? No forwarding address?
- How will they conduct the re-determination?
- What is the state doing as it relates to community education?
- Anything different for a safety net or disproportionate or sole community providers?
- Any retro issues? How often will the electronic eligibility be updated?
- How are they rolling out the different programs to review? CHIP? SNF patients? Dual coverage? **Likely – on their normal renewal date, but check.**
- Once the redetermination is done, how will the providers be made aware? ESPECIALLY with the many Mgd Care Medicaid plans? (They are also stating they will take a hit $-loss of Dual and Mgd plan volume)
- State to help non-covered new clients to move to the Marketplace/Exchange. How will that be done? Providers notified?
- **Identify the Pt Financial Navigator to be the coordinator with the State as well as internally.**

hfma

Redeterminations – Getting ready internally to lessen the impact of potential significant increase in bad debt & confused pts.

Develop an internal action plan – now! April 1st is here + 12 months

- **Develop an internal Medicaid re-determination team –Health System. OWNERSHIP is key with ongoing updates**

Actions:

- Create a letter to give to every Medicaid patient each time they register. Keep it very simple. Direct them to a) H&W best contact and b) your internal Patient Navigator who can help them understand what is happening, look up their coverage, if denied/reapply monthly, how the marketplace works . BE VERY INFORMED
- Train all front desks/clinic, any decentralized areas/PT, ER, and all central registration areas. Build a script so a consistent message is occurring.
- Run community awareness updates/local TV & webpage
- Develop a financial impact of the current Medicaid payments and conduct multiple analysis – loss of 50%, loss of 25%, etc. Share with all leadership.
- Every registration will need to be verified as still eligible for the April 1, 2023 – April 1, 2024 period. Evaluate an internal communication tool that Pt Access inputs to share confirmation of eligibility to the PFS back end. Not optional!
- The Medicaid team should be dynamic to ensure they are keenly aware of the loss of coverage – run reports, use H&W's contact to 'see', and if moved to Marketplace, they will likely have a deductible even if they help with monthly premiums
- **Pt Financial Navigator is involved in all pt communication – offering Ed on what is happening, how to help with payment plans for new balances.**

hfma

Who are just some of the impacted areas?

The patient loses Medicaid –did not reply, no way to contact, or income too high, but not low enough to get help with Marketplace coverage/deductibles

- At risk high group for Medicaid coverage: Maternity and Newborns
- World health outcomes= US 55th in the industrialized country/maternity mortality and 33rd for infant mortality. *Self & Medicaid
- Public health – no care as no insurance coverage = poor outcomes
- Waits until severe and goes to ER.
- Or ER becomes a quasi-doctor's office again
- All providers have to know most current Medicaid coverage – meds, procedures, etc.
- Social services/Care Mgrs – pts no longer qualify for coverage. May have been in SNF for outpt rehab. Community resources more important than ever!!
- Patients won't seek care as no coverage. (Jon Yost story)
- Utilization /Prior auth –(EX) pts coverage changes. Had 1 month, re-eval, next month no coverage.
- Most Medicaid Mgd care grew in the last 3 years – with no ongoing eligibility occurring. **Duals –lose**. (Community Networks –help)

A few notes on the bigger picture – ending of the PHE on May 11, 2023

Many financial and flexibility issues to address.

More community outreach to understand.

More financial analysis

Lots of internal ed to understand changes.

NOPE, you won't be bored…and it will DEFINITELY take a village …

May 11, 2023 -Public Health Emergency (PHE) Wind Down

Provision	Expiration	Implication
Cost Sharing Waiver for COVID-19 vaccines, testing and treatment	End of PHE	Millions Americans still use these services, and will now have to pay NOTE: Moderna said/still free/uninsured. Pres Biden – looking at stock piles/no cost 2-23
6.2% Federal matching rate (FMAP	Continuous enrollment: last day of month from PHE Other provisions: last day of quarter PHE end	State spending / budgets will increase to cover deficit 13M could lose Medicaid coverage
Telehealth expansion beyond rural All Waivers lifted –including expanded use of Tele. Watch for new allowances –Care and Caid	Consolidated Appropriations Act of 2022 extended for 151 days post PHE Most Medicaid waivers tied to PHE, some have already expired	**Medicare is evaluating permanent coverage provisions** **Most states have Medicaid waivers in place for telehealth coverage – at risk. UPDATES FOR 2023/FinalRule/Budget updates**
Disaster relief State Plan Amendments (SPAs) – Eligibility, enrollment, premium, benefits, other policies	End or PHE (or earlier date at state level)	**All 50 states have used emergency waivers to address challenges from pandemic – access implications to eligibility, coverage and benefits**
Section 1115 (PHE), 1135(SPAs), and 1915(c) Waivers (HHS approved)	1115 – 60 days after end of PHE 1135 – end of PHE 1915(c) – six months after end of PHE	All 50 states have used emergency waivers to address challenges from pandemic – access implications to eligibility, coverage and benefits

Public Health Emergency (PHE) Wind Down

Provision	Expiration	Implication
Medicare Payments = 20% IPPS increase for COVID-19 patients	End of PHE	Approximately 1M beneficiaries treated in 2021, $23.4B ($24K/patient)
3-day IP stay rule for Skilled Nursing Facility (SNF) waiver	End of PHE	Requirement returns which may cause disposition, patient flow issues and other costs
MA Plans required to cover services at OON facilities	30 days after PHE	Higher OOP costs for beneficiaries
Extension of COBRA election and notice guidelines	60 days after end of National Emergency (NE)	Certificate of coverage requirements will be required, and bridge coverage will be disrupted

*This list is not inclusive of all provisions – highlighting relevant impacts to provider coverage and payments. (HFMA Western Symposium, Jon Wiik and Day Egusquiza, General session, Las Vegas 1-23.)

https://www.kff.org/coronavirus-covid-19/issue-brief/what-happens-when-covid-19-emergency-declarations-end-implications-for-coverage-costs-and-access/#coverage-costs-and-payment

More impact issues with the ending of the PHE 5-11-23-----Telehealth

- On May 10th, HHS announced many TELEHEALTH and TELEPRESRIBING flexibilities will remain in place after the end of PHE on May 11th. **Congress extended many flex thru Dec 31, 2024.** Also extended behavioral thru Nov 11, 2023 with some opioid flex thru May 11, 2024. HIPAA flex have expired but will be phased out during a 90-day period/using non-compliant technologies for telehealth. Lots more
- Thru the 2023 Consolidated Appropriation Act, **Congress extended many telehealth flex for Medicare pts including waiving geographic limitations, allowing pts to stay in their home for telehealth rather than traveling to a healthcare facility, and allowing some visits to be done as audio-only if pt is unable to use both audio and video**. These are set to expire 12-31-24.
- Medicare Advantage: Must cover , at a minimum, same as Traditional but can offer more.
- Medicaid & CHIP: Telehealth flex vary by state and states can continue to have great flex in scope.
- Private Insurance: Telehealth flex for private insurance plans varied by plan. The ending of the PHE will not change the variation between payers.

- WOW! The implementation of all these ‘rules’ with potential legislation to expand some but not all –will continue to add confusion to coverage. Stay tuned and stay informed.

LETTERS FROM PAYERS

- Medicare Advantage   4-4-23
- ‘The Federal PHE is ending. MA plan made a number of changes to support our members and administer benefits during the pandemic.
- Now that the PHE is ending, we will be reinstating standard benefits and adjusting or eliminating some of the changes we made for COVID.
- (Remember – telehealth –same as TM)

- 1) COVID-19 testing: Claims for FDA approved or authorized COVID testing claims will be covered at regular plan in-network or out-of-network cost-sharing amounts, if your plan covers diagnostic tests.
- 2) At –home COVID test: at-home rapid tests for COVID will no longer be covered after May 11, 2023
- NOTE: Out of network- encouraged to get pre-service organization determination before you receive the service… PHE = no out of network penalties for MA plans.

SUMMARY – BE THE PATIENT

YAHOO! Here comes the Pt Financial Navigator to the rescue.

- Identify the 'best of the best"
- Best communicator and trainer – internal staff on resources, how to get help to all registration staff , customer service and ER = all points of entry thru the back end and appeals, etc.
- Best communicator to the patients.
- Create handout/other digital tools to answer the Most Common Questions from patients – insurance payment, deductible, copayments, billed charges vs allowables, prior auth means, inpt vs obs, and so forth …with the contact person the Pt Fin Navigator or a super well trained Customer Service Rep working closely together.
- **PFN Role**:
    - How the Rev cycle process will work for them.
    - How their insurance pays visits, outpt services, inpt, etc.
    - How estimates work and how to create a payment plan
    - How to appeal insurance denials or reduced payer payments
    - How to understand and access the ACA Marketplace option
    - How to navigate potential Medicaid or Financial Assistance

MISSION STATEMENT FOR THE REVENUE CYCLE STAFF

Mission statement for the Revenue Cycle staff:

My patient did not ask to be sick…

My patient did not ask to have their life disrupted …

My patient did not ask to have their insurance pay so little or not at all or no insurance….

My patient is scared and doesn't know where to turn to navigate the business of healthcare……

Be the patient. And the answers are easy.

Revenue Cycle Leads the Community Education

Every action = How does this impact the pt?

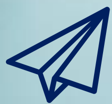
How can the Revenue Cycle help?

AR Systems, Inc
Training Library

Thank You for Joining Us in this Educational Journey

DAY EGUSQUIZA
President, & Founder
AR Systems, Inc. &
Patient Financial Navigator Foundation, Inc.

daylee1@mindspring.com
208 423 9036



http://arsystemsdayegusquiza.com
http//pfnfinc.com