Medicaid at the Crossroads:
Hawaii Health Systems Prepare for 2027

HFMA Hawaii Revenue Cycle Seminar

Speaker Introductions



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Welcome & Session Overview

What happens when coverage eligibility becomes more complex for approximately 124,000 expansion

In this session, we will:

- Review the Medicaid policy impact to Hawaii providers
- Identify where revenue cycle risk will rise in 2027
- Explore the opportunity in medically frail exemptions
- Outline readiness strategies leading organizations are adopting
- Apply a leadership readiness framework for 2027

Executive Summary: Medicaid at the Crossroads

OBBBA reshapes eligibility, enrollment, and coverage continuity nationwide, and the June 2026 CMS Interim Final Rule tightens verification further. For Hawaii health systems, the margin for error is narrowing quickly.

17 million
Americans projected to lose coverage as OBBBA provisions and ACA subsidy loss converge

~124,000
Hawaii expansion adults subject to work requirements and six-month renewals

~383,000
Hawaii Med-QUEST (Medicaid and CHIP) enrollees exposed to shorter retroactive windows

26%
Of expansion enrollees CMS projects will qualify for an exemption, if documented correctly

What OBBBA Changes

- Work requirements: 80 hours per month of qualifying activity for expansion adults
- Six-month redeterminations replace annual renewals for expansion adults
- New cost-sharing up to $35 per visit for adults between 100% and 138% FPL
- Retroactive coverage cut from three months to one month for expansion adults, two for all others
- Enhanced ACA premium tax credits eliminated, with premiums projected to rise as much as 75%

Why It Compounds for Hawaii Providers

- Medicaid still covers roughly 28% of Hawaii residents
- Coverage is lost to paperwork, not just to ineligibility, driving procedural terminations
- Status changes mid-episode, increasing PR-22 and coordination-of-benefits denials
- Uncompensated care rises as patients churn between coverage and self-pay
- Hawaii's hospital sustainability fee and state-directed payments face new federal limits and caps

Sources: CMS, Hawaii DHS Med-QUEST Division, Honolulu Star-Advertiser (Oct. 25, 2026), and Kaiser Family Foundation analyses. Hawaii enrollment figures as of October 2026.

Medicaid, ACA & CMS Guidance Timeline: Key Effective Dates, 2025–2027

Federal and CMS milestones reshaping Medicaid and Marketplace eligibility, with the mitigation response for each

MILESTONE	WHAT CHANGES	MITIGATION STRATEGY
Dec. 31, 2025 **ACA Subsidy Elimination**	Enhanced ACA premium tax credits lapse. Marketplace premiums rise sharply and coverage losses push more volume to self-pay.	ElevatePFS' AI screening across 16,000+ diagnosis codes routes patients to Marketplace, disability or Philanthropic funding.
June 1, 2026 **CMS Interim Final Rule**	CMS requires ex parte checks first, limits self-attestation to once, and adds a work-impairment test to "medically frail" (vacated for Hawaii Oct. 29).	ElevatePFS' Automated identification plus disability referral screening flag exempt patients before disenrollment.
Oct. 1, 2026 **Immigrant Eligibility Changes**	Medicaid narrows for non-citizens. Most refugees and asylees other than Cuban and Haitian entrants lose eligibility.	ElevatePFS' comprehensive front-end advocacy model that integrates all coverage leveraging AI-driven screening to ensure accurate eligibility.
Dec. 31, 2026 **Work Requirements & Six-Month Renewals**	Expansion adults must document 80 hours per month of qualifying activity and requalify every six months.	Patient education and pre-renewal alerts keep enrollees ahead of renewal deadlines. ElevatePFS conducting redetermination outreach and enrollment
Jan. 1, 2027 **Retroactive Coverage Limits**	Retroactive coverage drops to 1 month for expansion adults and 2 months for all others, shrinking time to backfill claims.	ElevatePFS' rapid screening and earlier secondary-Medicaid referrals capture applications in the shorter window.

ELEVATE PATIENT FINANCIAL SOLUTIONS®

Jan. 1, 2027: Work Requirements Begin

MEDICAID EXPANSION ADULTS, AGES 19–64

80

hours per month

OR

$580

in monthly income from working

Either one meets the rule

States generally must implement by Jan. 1, 2027. Some began earlier, such as Nebraska on May 1, 2026 and Montana on July 1, 2026.

Ways to meet it	Either 80 hours per month of qualifying activity or $580 in monthly income from working. Activities include employment, community service, a work program, or school at least half time, and hours can be combined.
Who is exempt	Includes pregnant and postpartum individuals, American Indians and Alaska Natives (Native Hawaiians are not exempt), medically frail individuals, certain caregivers, and people already meeting SNAP or TANF work rules.
How it is verified	States verify at application and at renewal, using available data first. Members may be asked to document an activity or an exemption.

Sources: CMS Interim Final Rule CMS-2454-IFC (June 1, 2026); CMS Informational Bulletin (Dec. 8, 2025); Public Law 119-21, Section 71119. Based on currently available guidance; subject to change.

Medically Frail Ruling: What It Means for Hawaii

HAWAII IS A PLAINTIFF STATE

25

states and D.C. sued CMS

RESULT

6

month stay on frailty rulings

Ruling covers plaintiff states, including Hawaii. A federal appeal is likely.

What the court decided

A federal judge in Boston struck CMS's added test that a condition must "significantly impair" ability to work, so a qualifying diagnosis can support an exemption.

What stays in place

Work requirements still start Jan. 1, 2027. The court upheld the 12-month look-back on claims data and the limit of one self-attestation per enrollment period.

What it means for Hawaii

Med-QUEST has six months, roughly through April 2027, to rebuild frailty verification around the statute without penalty for related errors or delays.

Sources: Massachusetts et al. v. Oz (D. Mass., Oct. 29, 2026); CMS-2454-IFC; AP, CNN, NACo (Oct. 2026). Subject to appeal and change.

The Hidden Opportunity in Medically Frail Exemptions

Many potentially exempt Hawaii patients interact with hospitals before renewal events, and the 12-month look-back means recent documentation counts.

Who may qualify

- Blind or disabled individuals
- Substance use disorders
- Disabling mental disorders
- Disabilities that significantly limit daily activities
- Serious or complex medical conditions

Hospitals already hold the proof: diagnoses, encounters, and claims from the past 12 months can support an exemption.

Next steps for Hawaii hospitals

1. **Document:** Capture qualifying diagnoses and encounters in the record. Evidence older than 12 months will not count.
2. **Flag:** Screen for likely-exempt patients at registration and financial counseling, before renewal.
3. **Route:** Connect patients and Med-QUEST early. Self-attestation is limited to once, so keep documentation ready.
4. **Watch:** Track the expected appeal and Med-QUEST guidance during the six-month stay.

Clinical documentation and financial counseling can become powerful coverage-preservation tools.

Sources: Public Law 119-21, Section 71119; Massachusetts et al. v. Oz (D. Mass., Oct. 29, 2026); CNN and NACo (Oct. 2026). Based on currently available guidance; subject to change.

Jan. 1, 2027: Retroactive Coverage Shortens

Example: an application submitted in April

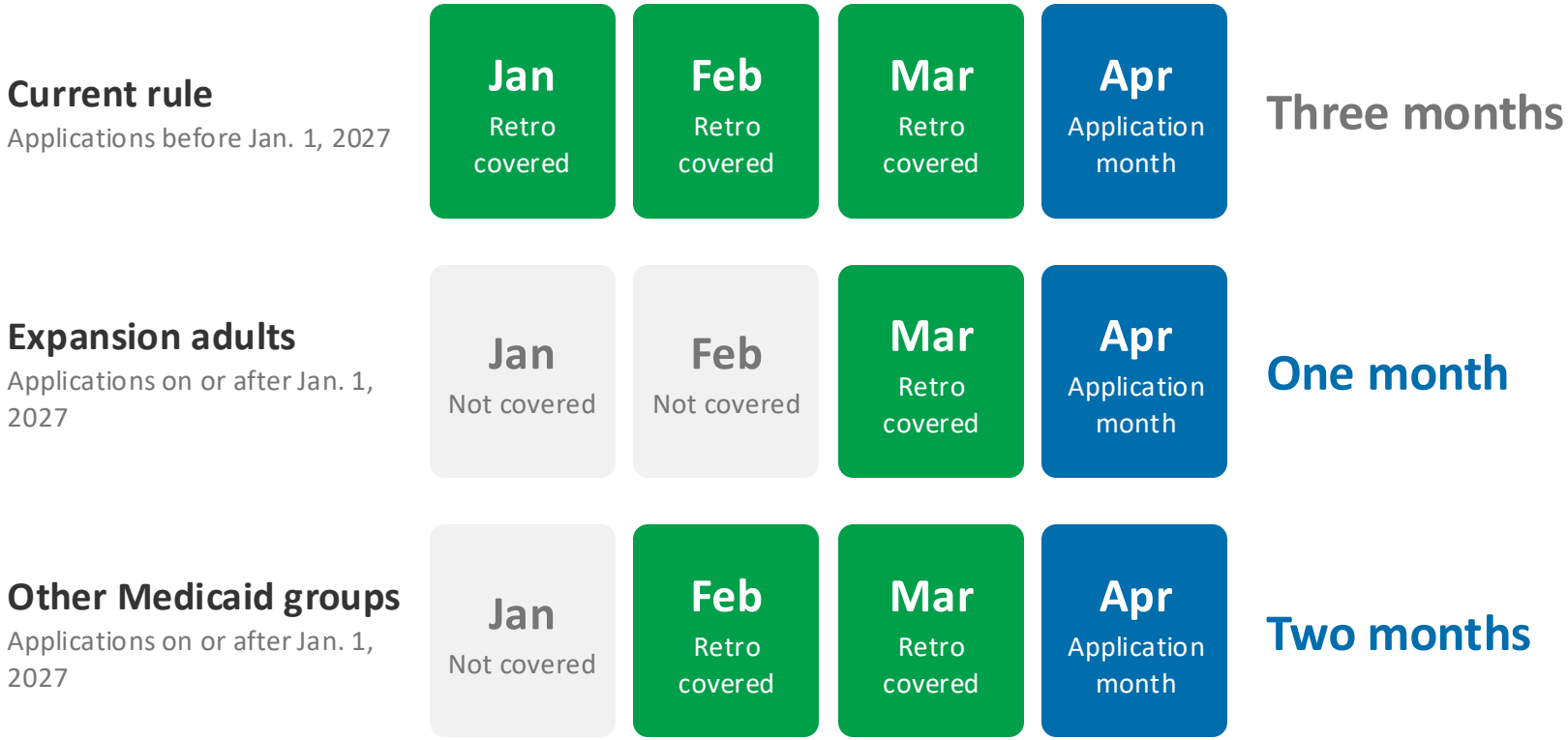


Illustration only. Eligibility must be met in each retroactive month, and the application month sets the look-back.

The application date sets the rule

The new limits apply to applications filed on or after Jan. 1, 2027, not to the date of service. Earlier applications follow the current rule.

What it means for patient access

Timely applications help protect coverage for dates of service. Patients who apply later may have earlier dates that Medicaid does not cover.

Sources: CMS State Medicaid Director Letter #26-001 (Mar. 6, 2026); CMS Medicaid provisions overview (Nov. 2025); Public Law 119-21, Section 71112. Based on currently available guidance; subject to change.

What We Learned from the Unwinding

Hawaii gained roughly 141,000 members during continuous coverage, then saw enrollment decline by more than 83,000 following unwinding.

Lessons for providers:

- Patients often lose coverage for procedural reasons
- Communication breakdowns drive avoidable coverage losses
- Eligibility teams remain stretched
- Coverage transitions quickly impact A/R and collections

2027 may bring another disruption, but organizations that act now are better positioned.



Where Revenue Cycle Risk Will Rise in 2027



Patient Access

- Increased verification requirements
- More renewal-related questions



Financial Counseling

- Growing need for proactive screening
- Medicaid renewal support



Revenue Integrity

- More retroactive eligibility activity
- Greater coordination across departments



Self-Pay Management

- Risk of previously covered patients becoming self-pay

Three Readiness Strategies

What leading organizations are implementing



Improve Demographic Accuracy: Address, phone, email, and preferred communication channel

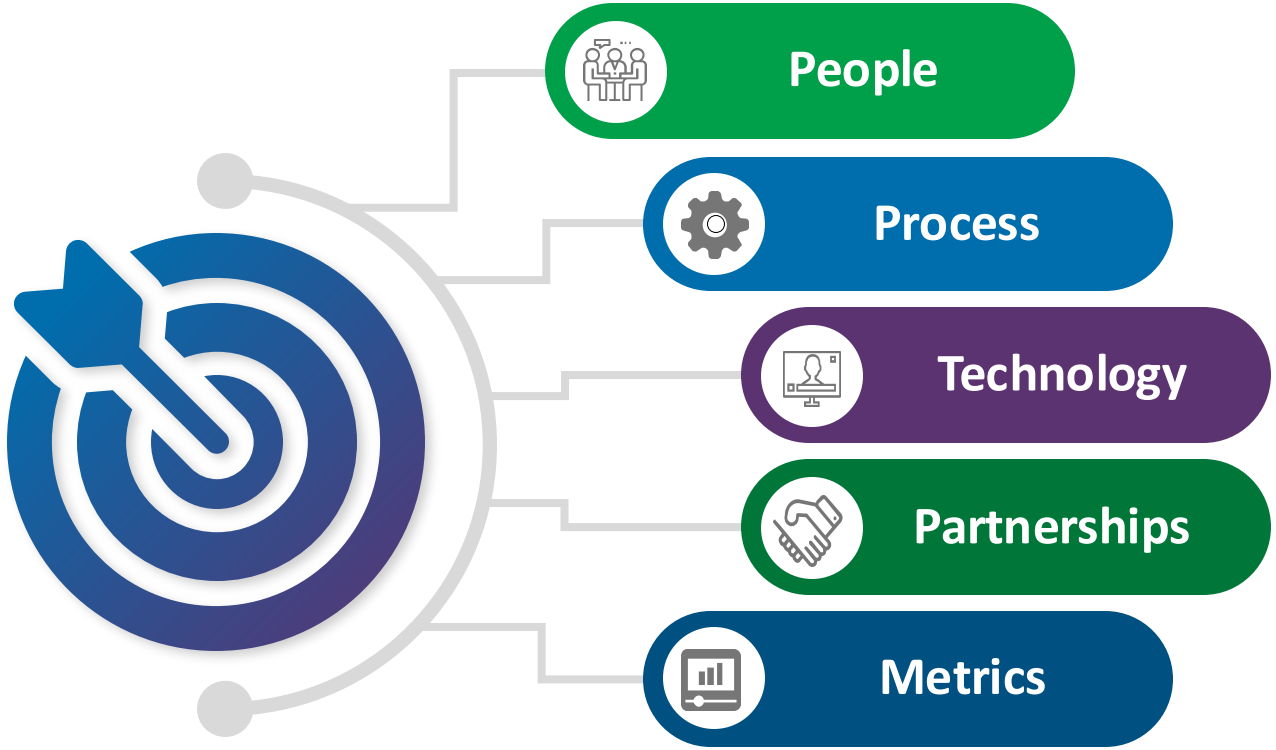


Earlier Medicaid Identification: Preservice outreach, scheduled screening, and real-time eligibility review



Renewal Support Programs: Renewal reminders, financial counselor engagement, and documentation help

2027 Leadership Readiness Framework



- Are teams trained on new requirements?
- Are workflows standardized?
- Can systems identify at-risk patients?
- Are health plans and providers aligned?
- Are coverage loss trends being monitored?

Our Response, Provision by Provision

OBBBA Provision	Patient & Provider Risk	ElevatePFS Response
Work requirements, 80 hrs/mo.	Expansion adults lose coverage when hours cannot be documented	Verification tools built into the platform, The Work Number integration for direct income and employment proof, and referrals to qualifying volunteer, training, and community engagement activities
Medically frail exemptions	Work-impairment test struck down in Hawaii, but 12-month look-back and one-time self-attestation remain	AI screening across more than 16,000 diagnosis codes, structured exemption capture, and routing to clinical and case management staff for validation
Six-month redeterminations	Procedural terminations when deadlines or documents are missed	Optional Redetermination Support: Advocate opens tasks 60 to 90 days pre-renewal, omnichannel pre-renewal campaigns, and coordination with onsite caseworkers and managed care plans on termination lists
Retroactive window cut to 30 and 60 days	Less time to bill for care delivered before enrollment	A sub-7-day average from admission to filing, with secondary Medicaid referrals moved earlier in the admission cycle
Cost-sharing for 100-138% FPL	Collection burden on patients historically unable to pay	Provider alerts when an expansion approval carries cost-sharing, plus PayerSearch cost-sharing detail drawn from real-time eligibility across 114 payers
ACA subsidy elimination	Marketplace premiums out of reach, pushing patients into self-pay	Marketplace enrollment assistance, Elevate-funded premium assistance for qualifying patients, and Philanthropic grants for premiums, copays, and prescriptions

Automated disability referral identification runs across all of the above, increasing the share of patients correctly placed on traditional Medicaid, where a disability-based exemption removes work requirements, six-month renewals, and cost-sharing altogether.

The policy discussion is important, but implementation is where success or failure will occur.

How are Hawaii healthcare organizations preparing today for uncertainty in 2027?

OBBBA and Hawaii's Readiness for 2027

Panelist Introductions



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