MEDICAID IS CHANGING

Are You Prepared?

What takes effect January 1, 2027, what early adopters are teaching us, and how hospitals can preserve coverage before accounts become self-pay.

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Central Pennsylvania HFMA | October 20, 2026

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The headline

January 1 is the effective date. The operational and financial impact will roll through 2027 renewal cycles.

The strategic shift

Move from eligibility verification to Medicaid eligibility preservation.

The hospital goal is not merely to identify inactive coverage. It is to intervene while coverage can still be maintained, restored, or documented.

Before

Eligibility on date of service

Now

Active and stable vs. active and at risk

Next

Coverage preserved, reimbursement protected

How we got here

Federal policy changed the Medicaid eligibility operating model.



Implementation is not a single-day event. It is a renewal-by-renewal operational change.

Three changes converge on the revenue cycle

Each change raises a different point of failure. Together, they compress the hospital response window.

1 Community engagement

Affected expansion adults aged 19-64 must demonstrate qualifying activity or an exclusion/exemption at application or renewal.

2 Six-month renewals

Affected adults move from annual renewal to eligibility review every six months.

3 Shorter retroactive coverage

Pennsylvania: one month for expansion adults and two months for other recipients.

COMBINED EFFECT

More coverage gaps • More self-pay exposure • Less time to rescue eligibility

Pennsylvania is already implementing

PA DHS has moved from policy discussion into systems, outreach, and operational design.

~750,000

Expansion population identified in PA planning

Mail + calls + texts

Beneficiary outreach underway

Next 2027 renewal

Current coverage does not automatically change January 1

After 2027 renewal date

Affected current recipients transition to six-month cycles

Who is excluded from community engagement?

These are exclusions from the Medicaid community-engagement requirement, not exemptions from hospital community-benefit obligations.

Pregnancy / postpartum

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Caregivers

Caregiver of a dependent child age 13 or younger or a disabled individual.

Disability / medical frailty

Medicare enrollment

Tribal status

American Indians, Alaska Natives and other individuals included in the federal exclusion categories.

Other federal categories

Certain former foster youth, people recently released from a public institution, and individuals meeting specified SNAP or TANF work-related criteria.

Separate concept: short-term hardship exceptions

CMS permits defined temporary exceptions in circumstances such as qualifying medical care, certain high-unemployment areas, and qualifying emergencies or disasters. These are time-limited exceptions, not permanent exclusions.

What counts as community engagement?

An affected individual must satisfy the monthly activity, education, or income pathway unless excluded or excepted.

Employment

80 hours per month

Paid work may be combined with other qualifying activities.

Work program / service

80 hours per month

Approved work programs or community service may qualify.

Education

At least half-time

Enrollment in an educational program may independently satisfy the requirement.

Income pathway

$580 per month in 2026

Equal to 80 times the federal hourly minimum wage; seasonal workers use a separate calculation.

Activities may be combined to reach 80 hours. Half-time education is treated as its own pathway under the CMS rule.

The decision is more than an hours test

The state must determine whether activity, an exclusion, or a short-term exception resolves the requirement.

1

Use reliable data

State systems attempt to verify qualifying activities or exclusions.

2

Request information

If available data are insufficient, the beneficiary may need to report or document.

3

Determine status

Compliant, excluded, temporarily excepted, or noncompliant.

4

Notice + response

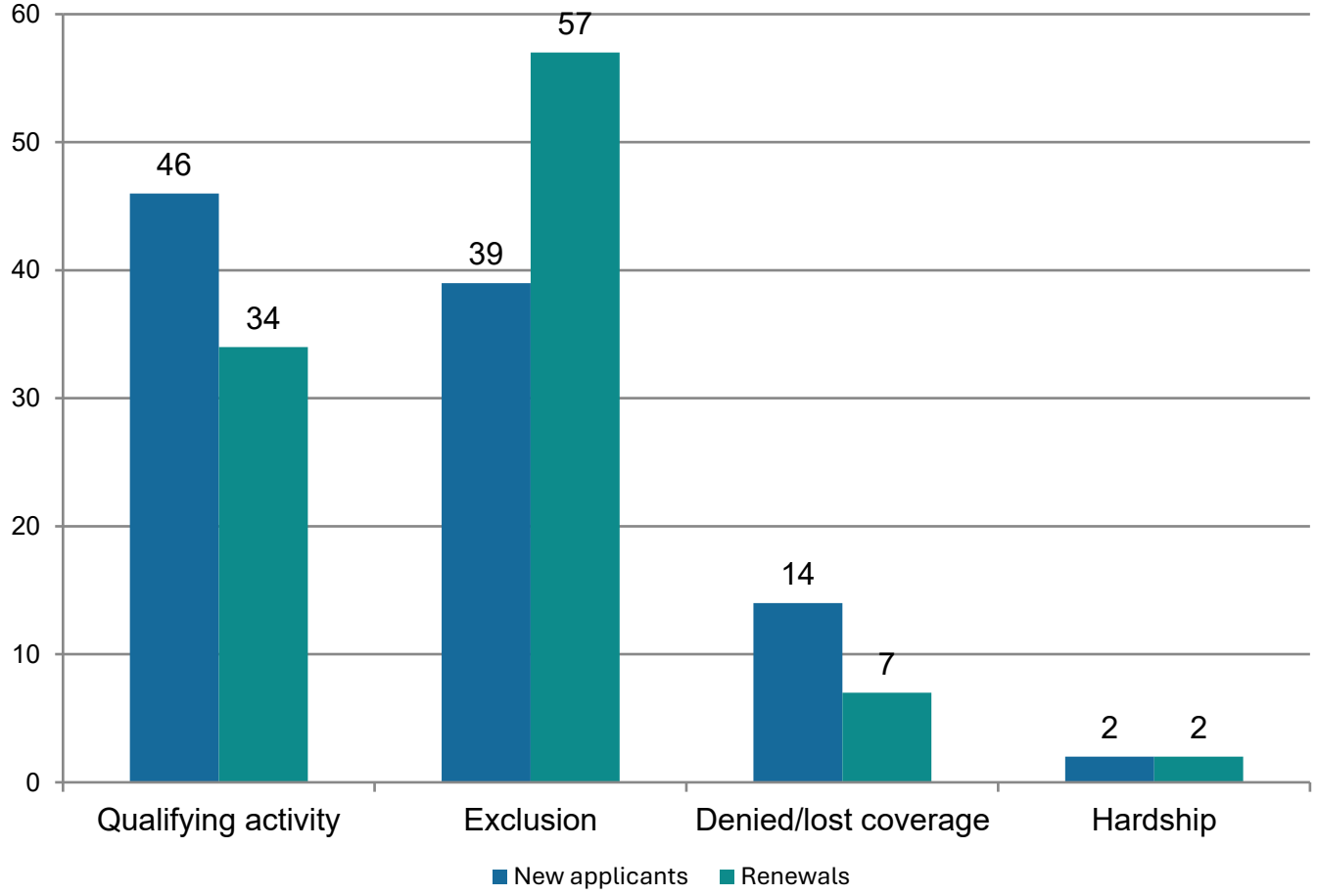
Adverse action requires notice and access to applicable review or appeal rights.

Hospital intervention point

When the state cannot verify the answer automatically, the hospital may be able to help the patient recognize the request, identify a potential exclusion, and assemble existing documentation.

Nebraska: the 2026 test case

Early state data show that exclusions are central to implementation, not peripheral.



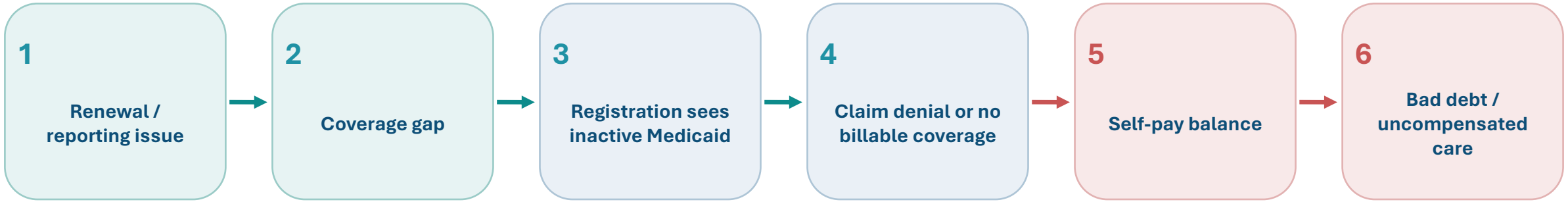
57%

of affected renewals qualified through an exclusion

The risk is not only whether a patient works. It is whether the system can verify activity, identify exclusions, and obtain missing information before coverage ends.

The hospital exposure is a cascade

A missed renewal or unresolved verification issue can travel quickly from registration to bad debt.



Shorter retroactive eligibility means less time to reverse the cascade after care is delivered.

Medical frailty: diagnosis is not the whole test

CMS applies a functional-impairment requirement across the medical-frailty categories.

Qualifying condition + **Significant impairment** = **Medical frailty exclusion**

Tier 1

Existing data sufficient

Tier 2

Possible frailty; more severity or functional evidence needed

Tier 3

Individualized review and additional documentation

Hospital implication: relevant evidence may already exist in the chart, case-management record, or claims history.

Redefine “active Medicaid”

Eligibility is no longer binary when renewal and verification risk are visible.

ACTIVE + STABLE

Coverage verified

No near-term action identified

ACTIVE + AT RISK

Renewal approaching

Missing verification or exemption evidence

INACTIVE + RESOLVABLE

Recent termination

Reenrollment / retroactive path still open

Suggested EHR / patient-account field: Medicaid renewal date + coverage-risk status

Build a Medicaid coverage rescue team

Put the right functions around the patient before the account becomes self-pay.



- Is coverage active?
- Is renewal approaching?
- Does community engagement apply?
- Is an exclusion or hardship available?
- Is verification missing?
- **Can coverage be preserved or restored?**

Start with high-risk touchpoints: ED, oncology, behavioral health/SUD, dialysis, scheduled surgery, discharge planning.

Front-end playbook

Turn registration and discharge into coverage-preservation checkpoints.

Registration

Has your address changed?
Did Medicaid ask for information?
Have you been told coverage is ending?
Has work, school, caregiving, or medical status changed?

Point of care

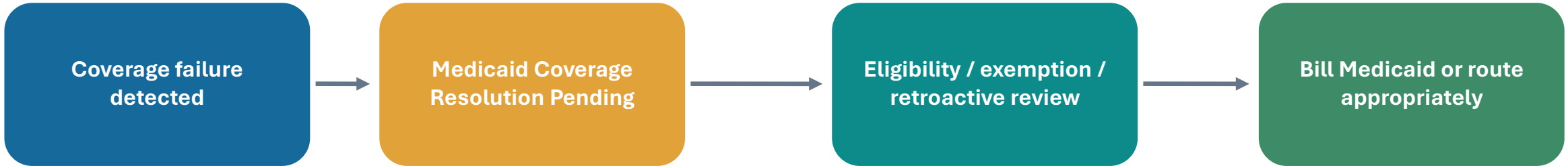
Confirm renewal timing
Identify possible exclusions
Route complex cases to financial counseling
Connect clinical and eligibility workflows

Before discharge

Coverage active
Contact information current
Renewal status understood
Next action clear
Counselor referral completed

Back-end playbook

Create a resolution path before a Medicaid account is permanently treated as self-pay.



Self-pay sweeper
Prior Medicaid history + current self-pay status

Accelerated review
One-month expansion retroactive window

Measure coverage saved, not only denials avoided

A CFO-ready scorecard connects eligibility intervention to reimbursement preserved.

Volume

At-risk cases identified

Conversion

Assistance initiated

Outcome

Coverage maintained / restored

$ impact

Medicaid reimbursement preserved

$ exposure

Self-pay avoided

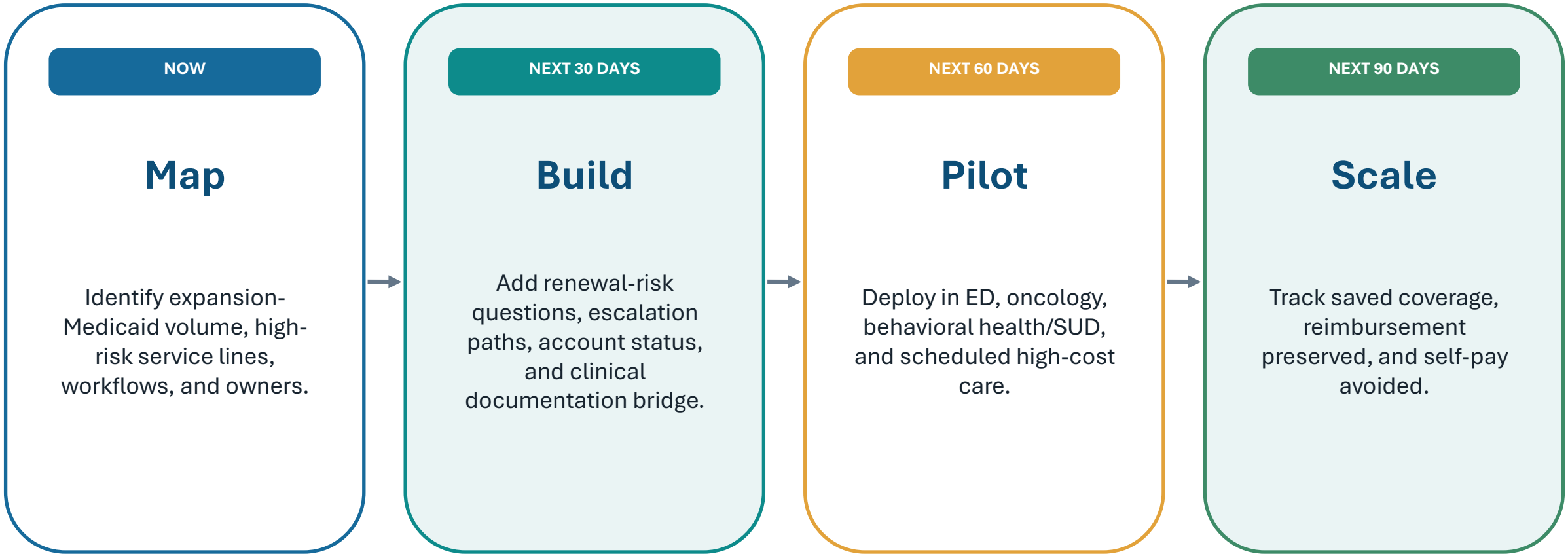
Prevention

Eligibility denials intercepted

HFMA notes self-pay recovery may be only 1%–2% of charges. Preserving Medicaid coverage can therefore be more valuable than downstream collections.

A practical launch sequence

Start with visibility, then intervention, then measurement.



THE TAKEAWAY

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Hospitals have spent years perfecting denial management.

In 2027, the smarter strategy may be preventing the patient from becoming uninsured in the first place.

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