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PHE END COUNTDOWN SERIES:

REVENUE CYCLE & WAIVERS INSIGHTS

April 27, 2023

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- You must be logged in for a minimum of 50 minutes per every CPE hour in order to receive CPE credit

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Meet the Presenters

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Agenda

- PHE Countdown
- Revenue Cycle Impact & Considerations
- Best Practices Procedures & Workflows
- End of PHE Waivers & Provisions

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Public Health Emergency Countdown

- On December 3, 2020, the Department of Health & Human Services (HHS) offered grants to support broader use of telehealth services including in Medicare, private insurance, & through other federally funded providers – all in response to COVID

- The current Administration has announced its intent to end the COVID public health emergency (PHE) on May 11, 2023

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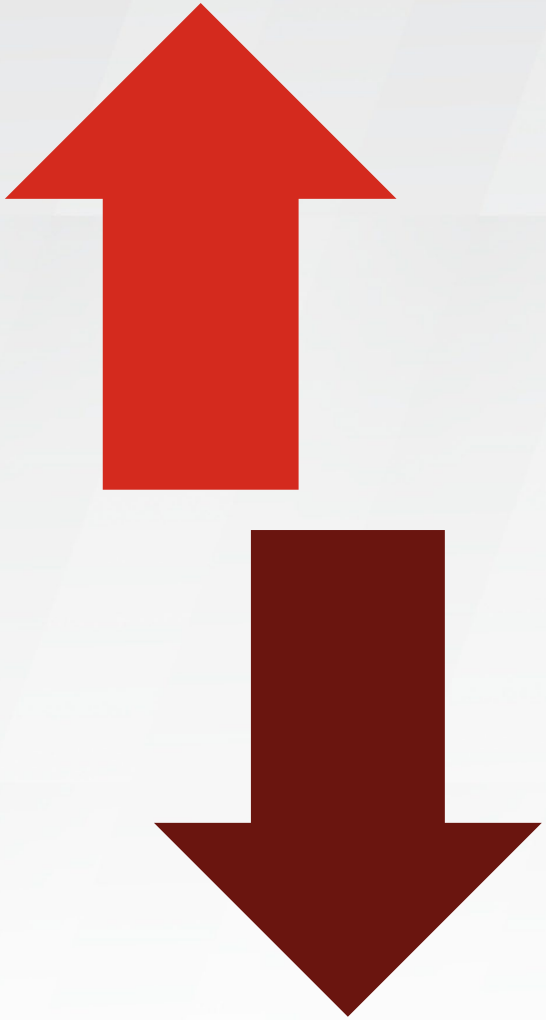

5.2M

Gained Insurance

8%

Uninsured

Background – Continuous Enrollment

- Since the onset of the COVID-19 public health emergency (PHE) in 2020, states have maintained continuous enrollment of individuals with Medicaid

- Consolidated Appropriations Act, 2023 (CCA) contained amendments delinking the Medicaid Continuous Enrollment Requirement from the end of the COVID PHE. As a result, Medicaid continuous enrollment condition ended March 31, 2023

- The department of Health & Human Services projects that 17.4% of enrollees (15 million) will lose coverage at the end of PHE

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Revenue Cycle Impact & Considerations

End of Continuous Enrollment: The “Unwinding”

The 14-month process of redetermining the eligibility of all 90 million Americans enrolled in Medicaid

- State had the option to begin the process in February, March, or April
- Starting April 1, 2023, State Medicaid Agencies may begin disenrolling individuals who are no longer eligible for Medicaid
- Ineligible persons may lose their coverage &/or be moved to other forms of coverage, like CHIP or the marketplace

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Preparing Providers

Encourage retention & transition

Educate and prepare workforce

Establish connections with local stakeholders

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Encourage Retention

- Share or develop targeted outreach communications with Medicaid recipients about the unwinding

KEY MESSAGING

- Encourage enrollees to update their contact information with the state
- Spread the news that redetermination will resume
- Remind enrollees to complete & return any re-enrollment forms

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Encourage Transition to Alternate Coverage

Support patients who lose coverage in understanding the options for re-enrolling or transitioning

- Reenrollment: 90-day Medicaid reinstatement periods for those who miss redetermination periods
- Transitioning: ineligible persons will qualify for Marketplace/Healthcare.gov Special Enrollment Period
    - Estimated 1/3 of those who lose eligibility are projected to be qualified for a tax credit

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Educate Staff and Prepare Workforce

- Train direct service staff (social workers, case managers)to be champions of messaging
  - Checking state eligibility systems for redetermination dates
  - Understanding redetermination process & timelines
- Train POS staff to provide information to patient during clinic visits
- Design EMR build for renewal dates alerts

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Establish Connections With Stakeholders

- Connect with state Medicaid agencies to learn about state-specific communication, redetermination timelines, impacted populations
- Partner with providers, pharmacies, & community partners to ensure support in messaging to members
- Work with managed care organizations in your state to verify & update contact information
- Identify local application assistance agencies to refer patient to (state call centers & eligibility offices; navigators; certified application counselors; enrollment counselors in community health centers)

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State-Specific Resources

State-specific “unwinding” flyers: https://www.aap.org/medicaidunwinding

- https://ccf.georgetown.edu/2023/04/01/state-unwinding-tracker/

Georgetown University's Center for Children & Families 50-State Unwinding Tracker

- https://docs.google.com/spreadsheets/d/1tOxmngYs7jDPTGltp-diD1SGvHvZVJOm3G2YuUq0btg/edit#gid=0

List of CMS-approved waivers to support the unwinding period

- https://www.medicaid.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html

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Impact on Patient Financial Services

Denials Management

Best Practices Procedures & Workflow

Patient Financial Clearance

SCHEDULING

- **Verify eligibility** systems for redetermination dates during scheduling functions
- **Establish financial counselors to support uninsured patients to complete assistance applications**
- Develop process to ensure physician order is available at the time of scheduling or process in place to obtain ahead of service date
- Provide verbal & written explanation of hospital policies to the patient
- Provide reminder calls to patients & include discussion regarding patient balances & point-of-service (POS) collection policies, **confirm third-party coverage**, & restate proper clinical preparation for the service
- **Educate patients about their insurance benefits** to include the amount of copayments, deductibles, & coinsurance for which they would be responsible for paying at the time of service
- **Conduct financial screening** to identify patients early that may need financial assistance or charity care to afford services. Offer sliding fee scale options when appropriate

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Patient Financial Clearance

PRE-REGISTRATION

- **Obtain & enter patient demographic information** such as the patient's name, date of birth, address, telephone number, gender, & race
- The reason for the patient's visit or pre-ordered service
- **Insurance carrier information** such as the subscriber number, group number, subscriber demographic information, employer information, & preferred pharmacy
- **Pre-authorization requirements** of the patient's insurance carrier
- A review of the patient's financial responsibility for the scheduled service & any outstanding balances
- **Verify eligibility** systems for redetermination dates during pre-reg functions

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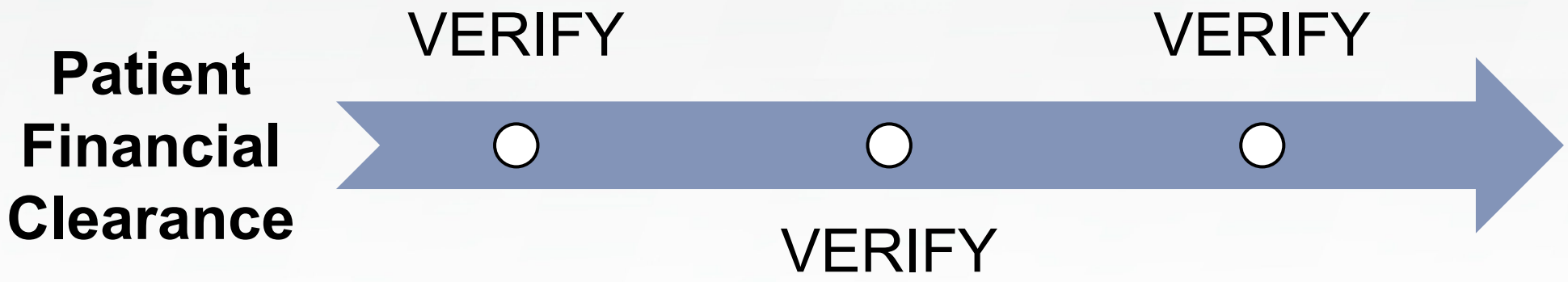
Patient Financial Clearance

REGISTRATION/ADMISSIONS

- **Complete patient insurance verification for all visits**
- Pre-determine if services will meet medical necessity
- Provide the Advanced Beneficiary Notice of Non-Coverage (ABN) to all patients when Medicare may not cover a provided service. Utilize electronic tools such as to clinical decision support for evaluating patient placement



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Denial Management Committee

Front (Patient Access)

COMMUNICATION

- Identify tracking mechanism for denials
- Establish governance committee with representation from key areas of revenue cycle (patient access, HIM, UR/Case Mg, vendor partners supporting AR activity, & PFS) responsible for review, tracking, trending
- Assign review for denial prevention planning
- Document & repeat

Back (PFS)

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End of PHE Waivers & Provisions

Unwinding Waiver Approvals

Two months after the end of the month in which the PHE ends

- States should complete eligibility determinations for all pending modified adjusted gross income (MAGI) & other non-disability-related applications, *e.g.*, individuals determined on the basis of being age 65 or older, received during the PHE

Three months after the end of the month in which the PHE ends

- States should complete eligibility determinations for all pending disability-related applications received during the PHE

Four months after the end of the month in which the PHE ends

- States should resume timely processing of all applications

Timelines to Complete Eligibility & Enrollment Actions After the PHE Ends

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Strategies to Support Unwinding Period

- Enroll &/or Renew Individuals Based on Supplemental Nutritional Assistance Program (SNAP) Eligibility (Targeted SNAP Strategy)
- Enroll &/or Renew Individuals Based on Temporary Assistance for Needy Families (TANF) Eligibility (Targeted TANF Strategy)
- *Ex Parte* Renewal for Individuals With No Income & No Data Returned (Beneficiaries With No Income Renewal)
- Facilitating Renewal for Individuals With No Asset Verification System (AVS) Data Returned Within a Reasonable Timeframe (Streamlined Asset Verification)
- Partnering With Managed Care Plans to Update Beneficiary Contact Information (MCO Beneficiary Contact Updates)
- Use of the National Change of Address Database (NCOA) & United States Postal Service (USPS) Returned Mail to Update Beneficiary Contact Information (NCOA &/or USPS Contact Updates)
- Partnering With Enrollment Brokers to Update Beneficiary Contact Information (Enrollment Broker Contact Updates)
- Partnering With Program of All-Inclusive Care for the Elderly (PACE) Organizations to Update Beneficiary Contact Information (PACE Contact Updates)
- Extending Automatic Re-Enrollment Into Medicaid Managed Care Plans up to 120 Days (MCO Plan Auto-Re-Enrollment)
- Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests (Fair Hearing Timeframe Extension)
- Delaying the Resumption of Premiums Until a Full Redetermination Is Completed (Premium Resumption Delay)

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PHE Provisions Ending May 11

- Medicare's 20% add on payments diagnosed with COVID-19 will end on May 11
- Health Plan requirements to reimburse out-of-network providers for COVID–19 vaccines & testing
- Patient cost sharing kicks in for COVID-19 at-home test, testing services, & therapeutics for Medicare beneficiaries
- Reduction in post-acute care service access
- Flexibility of provider-based departments
- Expiration of EMTALA waiver
- Critical access hospital (CAH) allowances
- Controlled substance prescribing allowances

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Q&A

Connect With the Presenters

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PHE End Countdown Series

Thursdays • 3–4 p.m. ET

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