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ACA Implications for Eligibility/Exchange Enrollment

Arizona HFMA
February 22, 2013

Goals for our time together today

- Review current status of ACA and exchange implementation with focus on the Eligibility practice
- Examine assumptions about ACA impact
- Discuss thinking and approach to these changes as related to Eligibility practices
- Help create a “watch list” for you of pending clarifications/changes that will impact front-end processes

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While the landscape may change, the objective remains the same

- Find the best, and most appropriate, program to provide insurance coverage for patients who enter the system without a source of payment
  - Patients receive needed care without the burden of heavy debt related to paying for that care
  - Hospitals receive payment for that care enabling them to serve their community and fulfill their mission

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High level time relating to today's discussion

- Final rule on may of these topics will be out in a few weeks: Comments closed 2.13.13
- Application to be available in August
- Exchanges to be up and running 10.1.13 to start enrolling in new programs and plans

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The two primary objectives of ACA represent challenges and opportunities for hospitals

- *Increased coverage,* either through Medicaid expansion or Qualified Health Plans, will increase the number of patients insured and significantly affect eligibility practices

- *Simplification*, and the complexity surrounding it, is a tsunami of change in the short term and will drive a different way of doing "front-end" business

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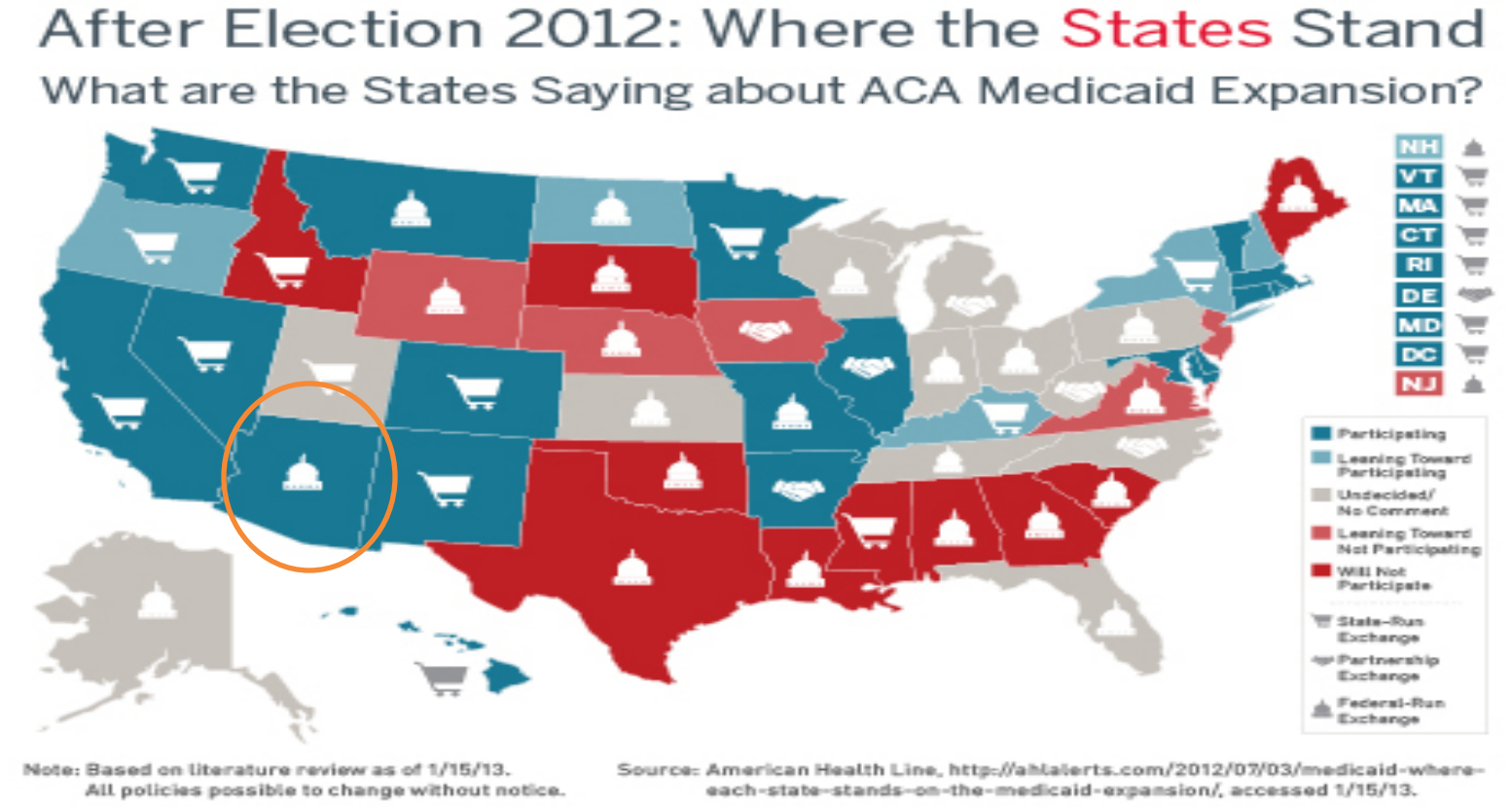
Increased Coverage: Medicaid expansion decisions will require state-by-state planning



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Increased Coverage: Structure Simplification

- Coalescence of Medicaid eligibility into 3 primary categories
  - Children
  - Pregnant Women
  - Adults (18-65)
- No more asset tests for Medicaid and none applied to coverage through the Qualified Health Plans (QHPs)
- Modified Adjusted Gross Income (MAGI) will be basis for qualification in each category
  - Patient declaration validated by state payroll and IRS data
  - No coverage for undocumented aliens: Citizenship validated by Social Security database

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…as well as coverage options are primary drivers of products and process

FPL*	Children	Pregnant Women	Adults	Non-participating States: The New "Donut Hole"
400%	Premium Subsidies	Premium Subsidies	Premium Subsidies	Premium Subsidies
250%	CHP+	CHP+	Premium Subsidies/ Cost Sharing	Premium Subsidies/ Cost Sharing
185%		Medicaid		
133%	Medicaid		Medicaid	

*** Does not include the newly standardized across-the-board disregard of 5% FPL**

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Not exactly only 3 categories, *for example*

- The extension of Medicaid coverage to the new group of **former foster care children** up to age 26 (see section 1902(a)(10)(A)(i)(IX)) and to all children age six and older with incomes up to 133 percent of the (FPL) are required by the Affordable Care Act and were not affected by the Supreme Court's decision

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Levels of Coverage for Qualified Health Plans (QHPs)

- Insurers to offer plans that fit within four levels of coverage:
  - Bronze, silver, gold and platinum
  - Insurers don't have to offer plans in all four levels
  - Health insurance exchanges required to offer at least a silver plan and gold plan
  - Four levels of coverage are based on Actuarial values based on percentage of health care costs covered by plan for the average enrollee
    - Bronze 60%, Silver 70%, Gold 80%, Platinum 90%

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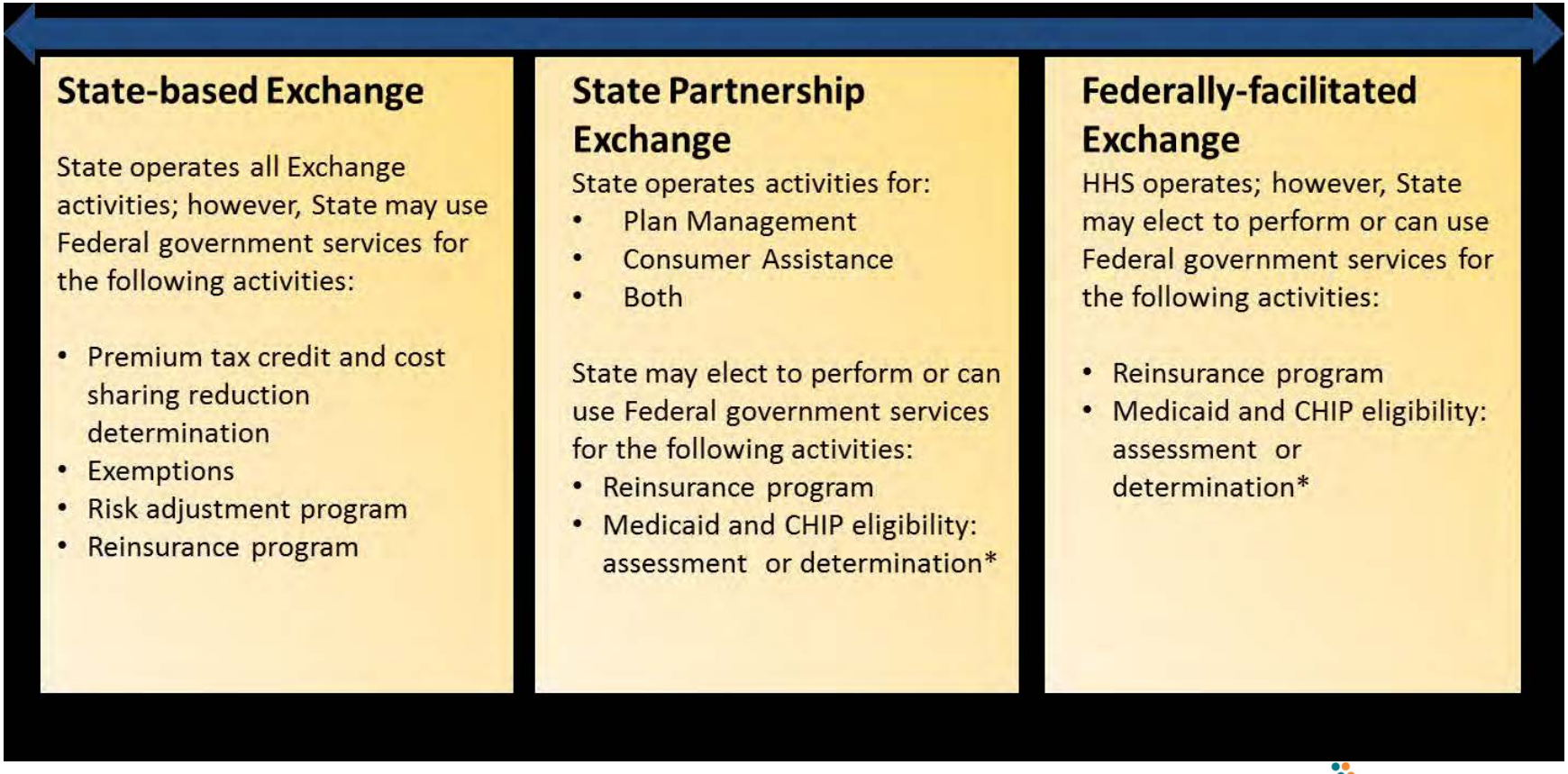
Use of exchange for applications will drive processes

Declaration due 2.15.2013 **ARIZONA**



For states that do not seek to operate a State-based Exchange or a Partnership with the Federally-facilitated Exchange, HHS will establish and operate a Federally-facilitated Exchange.

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Many processes should become simpler

- Exchange will serve as the central source for all program applications, including Qualified Health Plan (QHP) coverage
- Requirement for data sharing and use of specific data sources have been established
- Requirement for on-line, in-person, by mail or by phone application options
- *Single application for all programs*****

****THINK ABOUT THIS*

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"Simpler" Application Process

- The online application process will vary depending on each applicant's circumstances, their experience with health insurance applications and online capabilities
- The goal is to solicit sufficient information so that in most cases no further inquiry will be needed
- The online application will administer an *identification proofing process*
  - The tool will have a large bank of questions it will randomly generate based on information from external databases
  - Based on the information an individual provides, the identification proofing system tool will generate three to five challenge questions

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CMS Assumptions on Volume/Cost of Applications 2014-2016

Year	Application Type	# Respondents	Hours/App	Annual Hours	Total Cost
2014	Online Application	3,902,981	0.17	663,507	$17,914,689
2014	Paper Application	433,665	0.5	216,833	$5,854,491
2015	Online Application	1,745,957	0.17	296,813	$8,013,951
2015	Paper Application	193,995	0.5	96,998	$2,618,946
2016	Online Application	2,546,731	0.17	432,944	$11,689,488
2016	Paper Application	282,970	0.5	141,485	$3,820,095

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New roles and requirements will need to be clarified and some certified

- Navigators: *grant funded* community-based organizations to facilitate enrollment on a large scale
- Application Counselors: individuals or groups NOT grant funded
- Agents and Brokers: Similar to current roles
- Authorized Representatives: ability to act on behalf on patient

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Putting it into perspective

“The exchange will be supplemented by a small army of insurance agents, brokers, community-outreach workers and "navigators" who will plunge into neighborhoods, schools, hospitals, day-care centers, unemployment and social-service offices to identify the uninsured and help them sign up online, on paper or through toll-free telephone lines. **The ground game for this monumental undertaking is just now unfolding, awaiting federal rules expected in the next couple of weeks that will allow community groups to compete for government grants and pay for a host of navigators.** *There's just a hell of a lot to do by October.”*

Orlando Sentinel

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New process will require “leaps of faith” to which we are not accustomed

- Increased acceptance of self-attestation
- No requirement for provision of additional documents as long as tax return information, employer pay data and person’s statement are consistent
- “Automatic” reenrollment after one year if tax and pay data validate eligibility

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Presumptive Eligibility for Hospitals: *Medicaid Only*

- Allowed via ACA: **Not** dependent on state decision to grant presumptive eligibility
- State may designate more groups than those specified at §435.1102 and §435.1103 for which hospitals may determine PE (e.g., disabled individuals, 1115)
- May require attestation of citizenship/ immigration status and/or State residency
- May impose performance standards on hospitals electing to determine PE – e.g., based on number of regular applications submitted and/or approved
- May take corrective action for hospitals not following state policies or meeting standards

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Some may be simpler, or maybe not…

- State options will drive some processes:
  - Exchange may “automatically” approve based on data OR approval decision can be made through a state-determined department
- If tax or pay data demonstrate change in qualification, Medicaid recipient will be notified and will need to reconcile
  - No clarity yet on reconciliation process or shifting to alternate programs
- *Exchanges plan to “test” data in 2014*

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And some processes will essentially stay as complex as they are today

- SSI/SSDI eligibility process will not change under ACA
  - Elimination of lifetime limits will keep some covered that may have lost coverage before
  - New Medicaid criteria may help bridge the time gap to Social Security coverage
- The need to pursue auto/general liability, workers compensation, “retrospective” COBRA will be important to maximize appropriate hospital revenue
- Expect same or increased focus on clinical authorizations throughout episodes of care

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A working hypothesis

- Hospital eligibility processes in 2014 will be *chaotic*, with complexity increasing as exchanges are implemented
- Volume of applicants will increase and include nearly all without insurance accessing care in the hospital and associated settings
- Patients will require support to complete applications and understand choices, especially with new exchange options
- Over a period of a few years eligibility process will become simpler and more patients will come into the hospital with coverage
- *Need for cost control will drive increase in clinical authorizations, care denials and patient management across care continuum*

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A Proposed Approach

- Prepare to increase on-site staff support, shifting team from follow-up to front-end
- Interviewers need to combine eligibility expertise with new advising skills, similar to those of an insurance broker in the individual market: consider role/certification
- Strong focus on disability will be imperative
- Ensure opportunities for higher payment levels are achieved in areas such as Motor Vehicle Accidents
- Utilize clinical expertise to enhance eligibility services through authorization support and disability support

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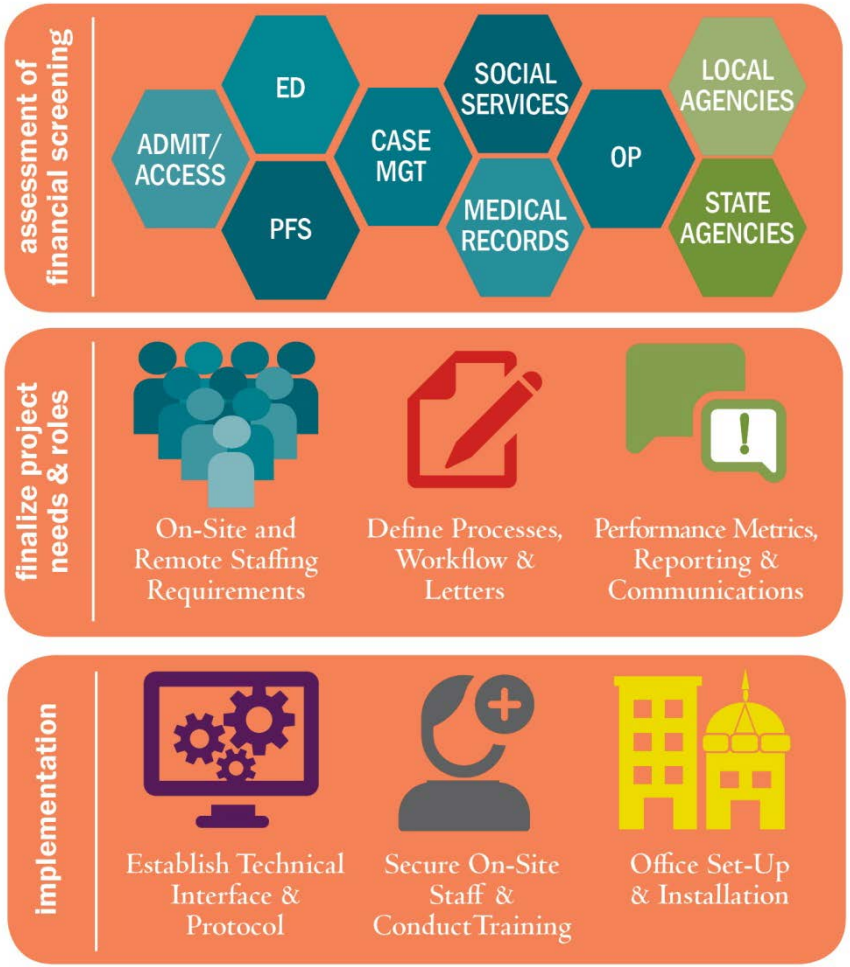
Remainder of the year: Almost like planning a new start-up



- Will require strong collaboration between many in-and-outside the organization
- Closely stay abreast of developments as they occur, especially related to exchange specifics, Medicaid participation decisions and new regulations
- Focus on process definition once things are clearer
- Establish strong quality monitoring programs to ensure adherence with processes and new regulations while looking for opportunities
- Train, train, monitor and train some more

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