CRF-CPEST – ACA Implementation Frequently Asked Questions

5/21/2014

Attachment 6

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| **Issue/Question** | **Resolution/Notes** |
| What is our role in the Open Enrollment for coverage under ACA? Since most of our clients don't have insurance, are we supposed to refer them to the Navigators to determine what coverage they are eligible for before scheduling recall appointments? | There most likely is not a single process that will fit every local program. There are some important things to keep in mind while determining what works best for your program:   Yes, you should refer individuals to resources to seek/obtain health care coverage through Medicaid Expansion or the Maryland Health Benefit Exchange.   You want to ensure that CRF-CPEST remains a payor of last resort and does not pay for services, diagnosis and/or treatment that are covered by other funding.   You want to ensure that clients get their next services when due and are not delayed due to pending coverage.  What procedure you implement to meet those objectives depends on characteristics of your local program, such as at what point in the recall process you will be scheduling the appointment, how far in advance you need to schedule appointments with your providers, how long it takes to determine coverage for an applicant, etc.  For example, one option is to refer the client first to the Navigator and then follow-up with the client to determine if he/she obtains full coverage at which point he/she would be discharged from your program (if he/she obtained full coverage) or recalled (if he/she did not obtain coverage).  Another option is refer the client to the Navigator but at the same time complete the recall paperwork and follow your recall process while waiting to determine if he/she obtains full coverage. This could include actually covering the screening if he/ she do not obtain coverage by another source before his/her services are due. |
| If an individual calls our program seeking cancer screening services, should we refer her to a Navigator to determine if she is eligible for coverage before we enroll her in CRF-CPEST? | As a general rule, the individual should be directed to resources for seeking/obtaining health care coverage through Medicare Expansion or the Health Benefit Exchange. In the event that the  individual is symptomatic and experiences a delay in obtaining insurance, the program may enroll the individual and begin the scheduling process, including paying for services if he/she does not have coverage at the time of his/her date of service. If the individual does not have insurance coverage and is otherwise eligible for the CRF-CPEST, he/she may enroll in the CRF/CPEST program for services. |
| What if an individual with health insurance has an abnormal screening exam and needs diagnostic and/or treatment services but has not met his/her deductible or can’t afford his/her co-insurance? | If the individual meets the CRF-CPEST eligibility requirements, he/she can be enrolled as a diagnostic and/or treatment only client. Insure grant application includes approval for this level of service. If not, speak with DHMH CRF-CPEST staff and provide additional information as requested. The client will need to receive services from a contracted CRF-CPEST provider.  The provider should submit an EOB from the client’s primary insurer along with the provider’s bill to the local CRF-CPEST Program; the program may pay for the uncovered portion of the bill up to the allowable Medicaid reimbursement rate. |
| Local Programs have learned that Electronic Verification System (EVS) may not be up to date. Individuals who have Medical Assistance (MA), still show up as not having MA for months after “approval”. | **Information from Medicaid:**  The EVS issue is a problem with the Exchange.  Many people are showing as approved when they apply, but they are not coming into our MMIS system (which is how Medicaid knows to pay for them).  If local program staff see these, they should report them and get help from a LHD or DSS office to process them.  If EVS is not showing active, there was a problem with their eligibility. |
| Managed Care Organizations (MCOs) not providing covered screening procedure (colonoscopy) within a reasonable distance for individuals in particular service area, especially the Upper Eastern Shore. Local program staff asked for guidance regarding an acceptable travel distance for clients to get covered services. | **Information from Medicaid:**  MCOs are required to have a Gastroenterologist within certain specialty regions- there is no distance requirement. Talbot county is in a specialty region with Caroline, Kent, Queen Anne, Cecil. Amerigroup has contracts with providers in Cecil County.   That does not mean that someone living in Talbot has to go to Cecil.  They can go to lower shore or across the bridge- Anne Arundel and Howard comprise another specialty region.  We have learned that there is a procedure via the MCO for Medical Assistance patients to get transportation to medical appointments if the procedure they need cannot be done in their county of residence.  A referral form and other additional forms may be required. |
| Local program staff have expressed that some MCOs may incorrectly be listing providers that accept their coverage (Example: Amerigroup- gastroenterologists (GIs) listed on their website, within a 50 mile radius of Talbot County and east of the Bay Bridge, who are accepting new clients do NOT in fact accept their coverage.) | We will be asking Medicaid about this concern. |
| Medicare patients, like other insured patients including Medicaid, should have no co-pays or co-insurance for colorectal cancer screenings as it is one of the mandated services to be provided by the ACA. When a patient has a biopsy (s), there may be co-pays or co-insurance as the colonoscopy may be considered a diagnostic procedure by the provider. | We have seen that this continues to vary. During site visits and in review of invoices; we have seen patient invoices for colonoscopies with biopsies that do not cover all costs. Although, on other occasions, the clients’ explanation of benefits note no co-pays or co-insurance when biopsies have been taken. On occasion, local program staff enroll clients only later to find out that all colonoscopy services were covered by the client’s insurance. Local program staff are reminded that when the program does not pay for any part of the colonoscopy, the client’s colonoscopy will not be included in the program’s Performance Measures. |