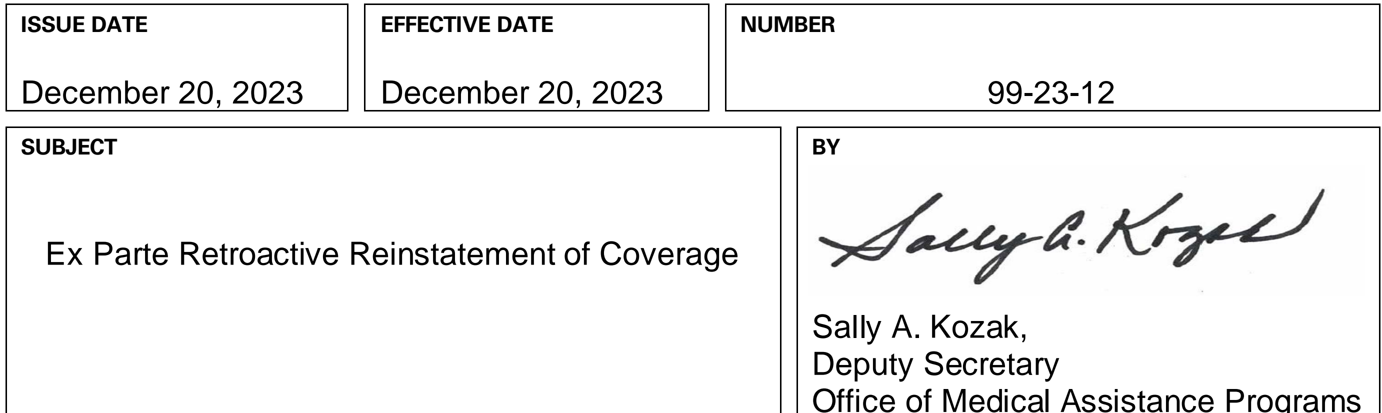
pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN



ISSUE DATE	EFFECTIVE DATE	NUMBER
December 20, 2023	December 20, 2023	99-23-12

SUBJECT	BY
Ex Parte Retroactive Reinstatement of Coverage	Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx.

PURPOSE:

The purpose of this bulletin is to inform Medical Assistance (MA) providers how to submit claims, including claims outside the 180-day claim submission timeframe, for MA beneficiaries whose MA coverage or Medicare cost sharing benefits have been reinstated due to changes in the ex parte renewal process.

SCOPE:

This MA bulletin applies to all providers enrolled in the MA Program.

BACKGROUND/DISCUSSION:

The MA Program must comply with federal renewal regulations, which require states to conduct periodic renewals of eligibility for all Medicaid beneficiaries and to redetermine eligibility between renewals when the state receives information about a change in a beneficiary's circumstances that may affect eligibility. These federal regulations are designed to ensure that states achieve high levels of program integrity and make efficient and appropriate use of federal and state dollars, by ensuring that only individuals who meet the Medicaid eligibility standards remain enrolled.

Under the Families First Coronavirus Response Act, Pub. L. No. 116-127 (2020) (FFCRA) enacted during the federal COVID-19 public health emergency (PHE), states

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at:
https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx.

received increased federal funding if they kept persons who were enrolled in Medicaid as of March 18, 2020, continuously enrolled in Medicaid with the same level of benefits, referred to as the continuous coverage requirement. There were very few exceptions to the Medicaid continuous coverage requirement.

On August 30, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director Letter (SMDL) to remind states of their obligation to conduct Medicaid renewals in accordance with all federal requirements. The SMDL can be found at this link: https://www.medicaid.gov/sites/default/files/2023-08/state-ltr-ensuring-renewal-compliance.pdf. The SMDL focused on the completion of ex parte renewals, which are completed based on reliable information available to the state Medicaid agency without requiring information from the individual. Specifically, CMS explained that consistent with regulations at 42 CFR §435.916(a)(3) and (b) and §457.343, states must provide individuals whose eligibility cannot be renewed based on available information with a renewal form and must inform the individual of any additional information or documentation needed to determine eligibility (e.g., income, resources, residency, immigration status, etc.). In instances where states are unable to renew eligibility for one or more members of a household on an ex parte basis, states must still renew eligibility on an ex parte basis for all other members of the household for whom the state has sufficient information to determine the individual continues to be eligible.

CMS determined that due to incorrect systems programming or other operational issues, some states have been conducting ex parte renewals at the household level, instead of reviewing eligibility for each household member at an individual level. This may have resulted in improper terminations of individuals in multiple circumstances. To ensure compliance with federal regulations, CMS instructed all states to review their renewal processes and make any necessary systems and operational changes.

As a result of CMS' instructions to states, the Department of Human Services (Department) reviewed its ex parte renewal process and restored MA coverage or Medicare cost-sharing benefits to affected individuals who, upon review, were determined to have been eligible for continued MA benefits at the time their renewal was due. The Department restored coverage for each affected individual back to the date their MA benefits were closed and will notify each affected individual of the beginning and end dates of the restored coverage.

PROCEDURE:

Effective with the issuance of this bulletin, Medicaid covered services and benefits, including payment of Medicare Part A & B deductibles and coinsurances for Medicare covered services, that were not covered or paid for on or after April 1, 2023, for affected individuals can be retroactively covered and paid by the MA Program.

Affected individuals will receive notice of their retroactive reinstatement of MA. This notice advises affected individuals to contact their providers to let them know about their reinstatement effective date(s). Providers may also obtain the reinstatement effective dates through the Provider Inquiry Service Center at 1-800-537-8862 Option 2, then Option 6, then

Option 1. Providers can also use the PROMISe™ Provider Portal or the Electronic 270/271 Process to verify the individual's eligibility dates.

Affected individuals can contact providers about any paid or unpaid bills they have for MA covered services, including pharmacy services, they received for dates of service on or after April 1, 2023. Providers are to submit claims for these services to the Department through the PROMISe™ system for payment. These claims will not be subject to timely filing edits in PROMISe™ as system changes were made to allow for claim submission beyond the normal 180-day timeframe.

These claims will also not be subject to prior authorization or require a benefit limit exception. Services or items provided after the issuance of this bulletin will be subject to any benefit limit exception or prior authorization requirements that would otherwise be applicable.

Providers must refund to affected individuals the amount they paid out of pocket for claims paid to the provider for services rendered during the identified timeframe of eligibility.

Providers are reminded that 55 Pa. Code § 1101.63(a) provides that providers must accept as payment in full, the amount paid by the Department for covered services plus any copayment that is required to be paid by the beneficiary. Providers must return any supplementary payment they receive from the beneficiary or other source for a service covered under the MA Program. Providers are prohibited from balance billing MA beneficiaries.

Providers with questions about submitting these claims to the Department through the PROMISe system can call the Provider Inquiry Service Center at 1-800-537-8862 Option 2, then Option 6, then Option 1.