

EXECUTIVE BRIEFING

Medicaid redetermination set to resume after a hiatus of more than 2 Years: How to avoid the chaos

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<https://www.healthscape.com/insights/medicaid-redetermination-set-resume-after-hiatus-more-2-years-how-avoid-chaos>

Medicaid managed care organizations (MCOs) will be busier than usual in the coming months. When the Medicaid redetermination process starts up again, the U.S. Department of Health and Human Services (HHS) expects that more than 15% of current enrollees will lose their coverage.ⁱ Because of the unprecedented increase in enrollment over the past 2 years, this is a significant blow to patients who have come to rely on this coverage. It is also a financial and administrative burden on MCOs that have benefitted from the enrollment increase. However, with the right strategy and planning, MCOs can prevent much of the churn and help patients maintain the coverage they need.

Medicaid enrollees are required to requalify every 6 to 12 months through the process known as redetermination. The Centers for Medicare and Medicaid Services (CMS) paused this requirement during the COVID-19 public health emergency (PHE) and instead allowed members to be continuously enrolled because of the support of federal matching funds, which will be phased out this year. Under the Consolidated Appropriations Act, 2023, states will be allowed to begin terminations on April 1, 2023. This has the potential to cause chaos for the healthcare industry.

Why the chaos? Medicaid enrollment grew by roughly 25% during the pandemic, so the number of enrollees in the system is now higher than ever, resulting in an unprecedented number who need to go through redetermination. HHS expects 8.2 million Medicaid enrollees to lose their eligibility, and 6.8 million eligible enrollees to lose coverage during the paperwork process if historical patterns hold true.ⁱⁱ To compound the issue, many current enrollees who gained coverage since March 2020 have never had to go through the redetermination process before. They may not know to look out for specific forms or even how to fill them out. If they do not participate in the process, the chance of losing coverage is almost certain. In addition, many enrollees will no longer qualify for Medicaid due to income changes. The initial economic downturn during the pandemic made it possible for many to qualify for coverage, but gains in the job market since then means that the coverage some people qualified for 1 to 2 years ago may no longer be an option.

A Wake-Up Call for Medicaid MCOs: Redetermination Now Carries Both Greater Risk and Opportunity

Pre-pandemic, Medicaid enrollment represented a smaller percentage of a health plan's financial landscape, and redetermination was an operational function that focused on ensuring that members completed the process. However, given the increase in Medicaid enrollment over the past 2 years, the redetermination process is elevated to a critical function that will significantly impact payer revenue. The strong performance that many payers have seen in membership, revenue, and margin over the past 2 years is now at risk.

While some decrease in membership and reduction in financial benefits is inevitable, with proper planning and strategy, MCOs have an opportunity to minimize the impact. A comprehensive redetermination strategy including 5 essential elements can enable MCOs to successfully navigate these challenging circumstances.



1. Analyze Member Data to Identify Those at Risk

MCOs can prepare by understanding their existing data and developing expertise in state-specific guidelines for post-PHE redetermination. This way, they can quantify the potential problems and come up with targeted solutions rather than be blindsided by the loss of enrollment.

Several signals will indicate an at-risk member. Members who have had recent changes of address, changes in income, or previously had frequent changes in eligibility should be identified as at-risk for redetermination.

Organizations should establish cross-functional working groups that include operators from their Provider Network and Contracting, Analytics, Finance, Provider Relations, Member Services, and Clinical Operations teams to pool resources and information. Collaborating on available data will enable MCOs to segment at-risk members and prepare unique action plans for each segment.

2. Deploy Targeted Member Engagement Tactics

Once an MCO segments members, it can deploy specific tactics for those segments. For example, first-time Medicaid enrollees need to know that redetermination is an important process for maintaining coverage, and they need to know how to navigate it. Members who will no longer qualify for Medicaid coverage will need information about how to select a non-Medicaid plan. The MCO can educate these members about their options, including enrolling in a Marketplace plan provided by the same payer, to minimize loss of health insurance coverage. MCOs should also take advantage of adjusted outreach rules that will make it easier to reach members, such as outreach via text message.ⁱⁱⁱ

3. Identify Tactics to Improve Member Experience

MCOs will have a better chance of retaining members if their quality score ratings are high and members are satisfied with their experience. MCOs should identify tactics to boost member experience and focus on member retention. A focus on high-touch care management activities that are specifically geared to members with chronic conditions can result in better outcomes and member satisfaction. In addition, taking advantage of data analytics to stay one step ahead of patient procedural needs related to eligibility will help members feel cared for.

4. Collaborate with Providers on the Front Lines with Patients

Reaching members in a meaningful way is a challenge for MCOs. Communication campaigns and individual outreach are important, but the message may not resonate with members through these tactics alone. Providers interact directly with members and are well-positioned to provide them with information about this process and its potential impacts to the member's coverage. By partnering with providers, MCOs have a better chance of making sure important information about redetermination and Medicaid alternatives reach members.

Health plans benefit from having regular strategic and operational reviews with key providers. Providers' foundational interest in these reviews is tactical: to ensure that rosters are correct and that claims are being paid. However, once trust is established by addressing foundational issues, these payer-provider reviews can be elevated, and partnering on initiatives like redetermination is more effective.

5. Work Closely with Regulators

Managed care plans should keep in close contact with state regulators to ensure that updated post-PHE procedural guidance is well understood, especially as it relates to permissible member engagement and available waivers. While some states will be less motivated than others to preserve enrollment, many states are ready to work with MCOs to ensure that members do not lose coverage simply because of a procedural issue and help members who no longer qualify to identify alternatives that will prevent a gap in coverage. However, the extent of state outreach efforts will vary. MCOs in states that have not expanded Medicaid, for instance, should be aware that they may need to make extra investment in reaching out to members.

Make Redetermination a Core Strategy Rather Than a Crisis Response

Once redetermination starts up again, MCOs will inevitably see a decline in overall enrollment, be forced to decline more claims, and need to manage an influx of member and provider support requests. But health plans can minimize the impacts with the right preparation.

In addition, health plans should incorporate the tactics implemented during this special circumstance into their regular operations. They will need to re-evaluate their members every 6 to 12 months going forward. Best practices learned from this crunch time will be valuable for ongoing operations.

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Sources

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