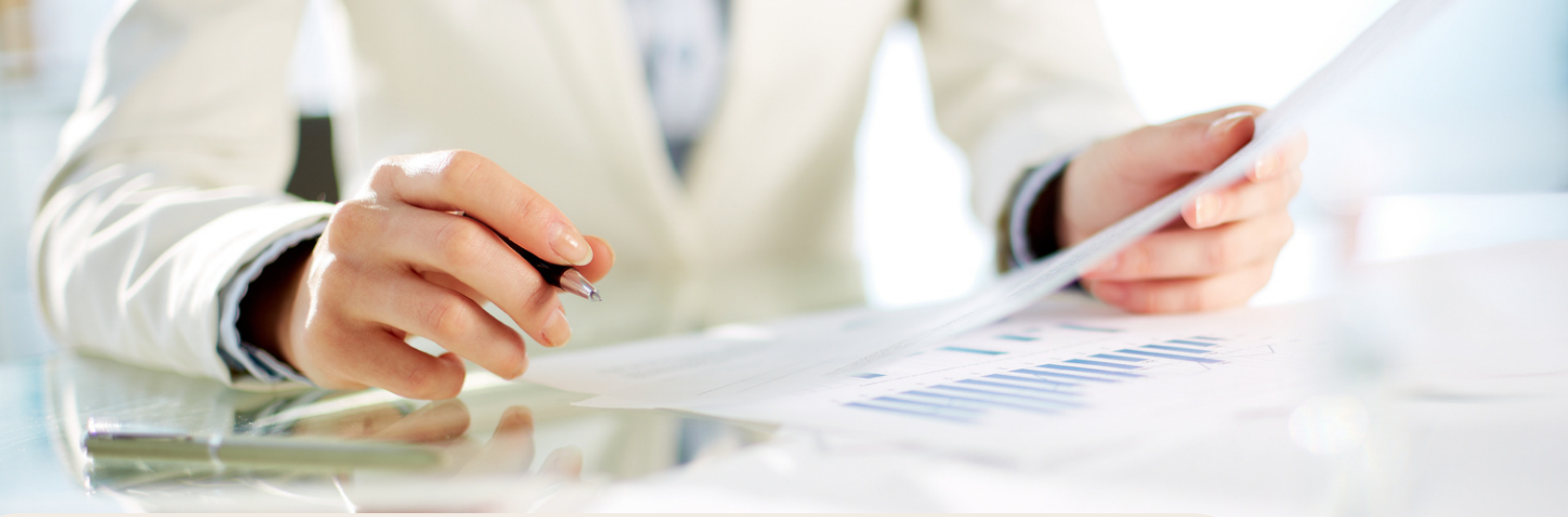
Acentra HEALTH

Reinstating Medicaid Redeterminations

Questions & Considerations in Finalizing State Strategies



REINSTATING MEDICAID REDETERMINATIONS

Ready or not, the time is nearly here when Medicaid agencies will begin the Medicaid eligibility redeterminations process, with new clarity from Congress and the Centers for Medicare & Medicaid Services (CMS).

In December 2022, Congress passed an omnibus spending bill, which decoupled the end of the public health emergency from the resumption of the Medicaid eligibility redetermination process, as well as from the end of the enhanced federal matching dollars states are receiving from CMS. While the PHE continues, states can start the process of redeterminations as early as February 1, 2023, and are required to begin by April 1, 2023.

Before officially starting the redetermination process, states are required to submit their planning documents to CMS and have CMS and Consolidated Appropriations Act reporting capabilities in place. **Following passage of the omnibus spending bill, CMS reiterated earlier guidance that states will have up to 12 months to initiate redeterminations and 14 months to complete the process.**

Managing the three-year backlog is a monumental task that is riddled with numerous potential opportunities for administrative missteps that have consequences on healthcare access for the current Medicaid population. Further, states' actions will have significant oversight from multiple entities – including governors, CMS, federal and state auditors, state legislatures, Congress, enrolled members (and families), advocates, and the public.

ESTABLISHING A REDETERMINATIONS STRATEGY

The date on which states are expected to begin redetermining their enrolled population is now certain, and the time has come to move forward on final planning and ramp up operational activities. **States are aggressively finalizing formal redetermination strategies to hit the ground running by April 1st.**

Here are some questions to ask and items to consider as your agency finalizes its redeterminations strategy:

HOW WILL YOU PRIORITIZE BENEFICIARIES?

Tackling your backlog of redeterminations will require a systematic approach. Some states will start by prioritizing beneficiaries based on risk (e.g., identify those currently receiving healthcare or special needs populations); others may elect to prioritize based on renewal month; or a hybrid approach may be preferable. Managing the challenge of households with multiple coverage scenarios, where some could now be ineligible, will be particularly vexing. For example, the 16-year-old children enrolled in Medicaid in March 2020 could now be 19 years old and subject to different categorical grouping and to a different financial limit. Identifying how your agency will prioritize the redeterminations process is the first step in setting your strategy.

HOW WILL YOU CONNECT WITH HARD-TO-REACH POPULATIONS?

Experts estimate that 20 to 30 percent of Medicaid beneficiaries in any given state will be unreachable, making it difficult to inform and educate individuals on the redeterminations process. Oftentimes, engaging community health workers (CHW) to locate and contact these hard-to-reach populations (both virtually and face-to-face) can prove beneficial. Using data to drive the strategy, CHWs can build relationships in communities by geographically targeting school systems, religious organizations, and other outlets to educate individuals on the redetermination process.

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HOW WILL YOU ENGAGE AND SUPPORT NEWLY INELIGIBLE POPULATIONS?

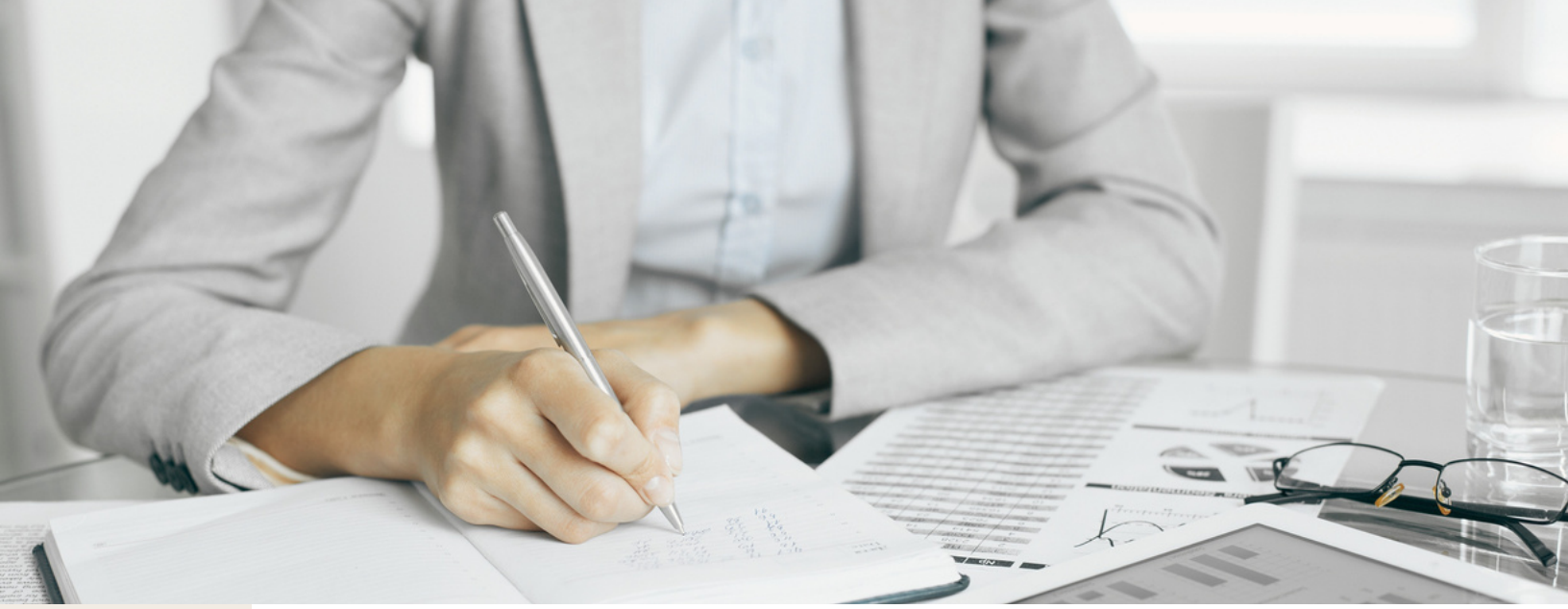
Losing Medicaid coverage can be an overwhelming time for many beneficiaries – particularly for those who are receiving ongoing care. To avoid disruptions in care, many states agencies will offer assistance to individuals and families facing disenrollment. By educating individuals on alternative health plans, identifying social determinants of health and/or gaps in services, connecting them with community services, and providing transitional care management, state agencies can support individuals who may be losing coverage, while also mitigating appeals, litigation, and negative publicity.

HOW WILL YOU HANDLE THE INCREASE IN VOLUME OF CLINICAL ASSESSMENTS FOR WAIVER PROGRAM ELIGIBILITY?

Many states already have a backlog of clinical assessments that were delayed during the PHE. Partnering with a team of clinical assessors who are experienced in performing conflict-free assessments [including intellectual or developmental disability (IDD), Katie Beckett, disability, etc.] can help states augment their workforce to allow for timely initial assessments and reassessments. Completion of the backlog of assessments will be crucial to the state's efforts to ensure appropriate coverage for its members while also retaining the enhanced federal matching funds.

HOW IS YOUR PROCESS BEING DOCUMENTED?

With so many eyes on state Medicaid agencies as this process unfolds, documentation is critical – yet this important step often gets overlooked amid the sheer volume of administrative work to be done. By maintaining detailed documentation, states can more easily meet the mandatory reporting requirements and be prepared when and if questions arise as to how the redeterminations process was handled.



HOW PREPARED ARE YOU TO HANDLE CLINICAL APPEALS?

CMS has raised the importance of leveraging contracted resources around increased fair hearing volumes and the expected increase of fair hearings and appeals. Engaging a partner with specialty experience in the Medicaid appeals processes can help states manage the anticipated increase in appeals that are likely to come with redeterminations.

HOW CAN TECHNOLOGY HELP?

Many states are working with antiquated technology systems, with limited access to sophisticated analytical tools. Advanced analytics can help states lighten the administrative load – whether it is by helping sequence the redeterminations process based on risk, or in helping locate and contact hard-to-reach beneficiaries. States may want to consider finding a partner that can provide access to proprietary tools that can facilitate a systematic, data-driven redeterminations process.

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MAKING THE CASE FOR GETTING IT RIGHT

State Medicaid agencies are clearly faced with numerous challenges as they prepare to reinstate Medicaid redeterminations. Medicaid eligibility is incredibly nuanced; finding Medicaid beneficiaries can be labor intensive, and antiquated systems make the entire process challenging from start to finish. Yet, there are significant risks associated with not effectively managing the process, including public scrutiny, inappropriate allocation of state and social resources, and increased provider abrasion.

PUBLIC SCRUTINY

News outlets across the country are reporting that more than 15 million Medicaid participants risk losing coverage when the unwinding begins. Some are calling it our nation's "next big health crisis." It is safe to say that stakeholders – to include individuals whose lives stand to be impacted, community organizations, and news outlets alike – are all watching. State agencies will be under incredible pressure to ensure the redeterminations process is handled properly, or litigation and/or bad publicity are likely to ensue.

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INAPPROPRIATE ALLOCATION OF STATE AND SOCIAL RESOURCES

States have a responsibility to ensure that their social services are being used as intended. Medicaid was established to provide healthcare coverage for those who need it most. Yet, state budgets are limited, which makes it critical to ensure that everyone who is receiving Medicaid benefits meets the eligibility criteria. An effective redeterminations strategy will focus on helping eligible beneficiaries maintain coverage while helping connect those who are not eligible to other community resources or transitioning them to other plans as needed.

INCREASED PROVIDER ABRASION

States will be challenged with questions regarding removal of Medicaid beneficiaries when eligibility is unclear, as well as the impact this could have on the provider community. Simply put, most physicians are not obligated to accept Medicaid – and in a post-pandemic era, the number of those who do is dwindling. States that do a better job of managing their redeterminations process can limit provider abrasion and can maintain a sufficient roster of physicians who are willing to care for Medicaid beneficiaries in their respective communities.

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THE VALUE OF ENGAGING A TRUSTED PARTNER

In conclusion, while the upcoming redeterminations process presents a unique set of challenges, finding a trusted partner to assist with the development and execution of a systematic strategy can position your state Medicaid agency for success. Acentra Health stands ready to serve as a trusted partner by providing an array of clinical and operational experts to support your redeterminations process.

BENEFITS OF ENGAGING AN EXPERIENCED PARTNER INCLUDE:

- Scalable support with ability to address new issues as they arise
- Laser-focus on one or multiple elements of the redeterminations process
- Access to proprietary technology solutions including advanced analytics
- Deep clinical and operational expertise

ABOUT ACENTRA HEALTH

Acentra Health, formed in 2023 by the merger of industry leaders CNSI and Kepro, combines public sector knowledge, clinical expertise, and technological ingenuity to modernize the healthcare experience for state and federal partners and their priority populations. From designing and developing advanced systems that drive efficiency and cost savings, to delivering clinically focused service models for care management and quality oversight, Acentra Health is accelerating better outcomes.

With an expansive reach, Acentra Health provides services in all 50 states, partnering with 45 state Medicaid agencies and five federal agencies. This kind of impact requires the hard work and dedication of our 3,000 employees, 4,500+ credentialed clinicians, and 450 physicians serving on the company's Advisory and Review panel. Acentra Health serves 140 million beneficiaries and enhances payment and service delivery to millions of medical and social services providers, hospitals, pharmacies, equipment, and nursing homes. More specifically, the company manages over a billion and a half claims and disburses over $26 billion in payments annually.

For information on Acentra Health, visit acentra.com.

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