Medicaid Redeterminations:

How Provider Organizations Can Prepare

Medicaid redeterminations are resuming, with states allowed to begin terminations on April 1, 2023. Health systems need to be prepared for the potential impact to both the organization and their patients.

What Is the Concern About Medicaid Redeterminations This Year?

- Medicaid enrollees are required to requalify for coverage every 6 to 12 months. The Centers for Medicare and Medicaid Services (CMS) paused this requirement during the COVID-19 public health emergency and allowed members to stay continuously enrolled.
- Under the Consolidated Appropriations Act, 2023, states are allowed to begin terminations on April 1, 2023.
- Medicaid enrollment grew by roughly 25% during the pandemic, resulting in an unprecedented number who need to go through redetermination.
- The Department of Health and Human Services (HHS) expects 8.2 million Medicaid enrollees to lose their eligibility, and 6.8 million eligible enrollees to lose coverage during the paperwork process.[i]

What This Means for Providers

- Organizations need to be prepared for **potential loss in reimbursement** as patients shift from Medicaid to self-pay responsibility or a product with lower reimbursement.
- Providers may need to manage an **increase in denials or out-of-network patients** as patients who are no longer eligible for Medicaid lose or change coverage.
- Many patients will be confused about the process or concerned about retaining their coverage. There may be **loss of productivity** for staff who need to shift their focus to assisting patients with questions or next steps regarding coverage and payment options. You may see increases in needs for financial counseling, self-pay estimates, additional self-pay follow-up activities, and customer service.

What Provider Organizations Needs to Do Now

- Analyze the increase in your Medicaid payer mix since the onset of the public health emergency to understand the financial impact and future implications to your organization.
- Align hospital and physician policies and procedures. Processes for determining or confirming eligibility, identifying when patients are out of network, and referring patients to resources to assist with finding coverage or resolving financial obligations will be critical.
- Understand your state's processes and timelines for how they will approach the unwinding process. Recognize that if you serve patients across multiple states, those approaches and timelines may differ.

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- Engage with patients currently enrolled in Medicaid. Ensure patients and their families are aware of the state timeline(s) and what they need to do to complete the redetermination process.
  - Provide the understanding to patients that they can be proactive. They should confirm their contact information is up to date and that they have any necessary paperwork needed to comply with eligibility determinations.
- Collaborate with other organizations and agencies to provide resources to patients:
  - **Eligibility vendors.** If you employ these vendors, ensure you are coordinating efforts both on assisting patients with redetermination and on any next steps to assist patients and their families if they no longer qualify for Medicaid.
  - **State Medicaid agencies.** Be aware of all resources available to enrollees through the state and document all applicable contact information.
  - **Local assister programs.** Partner with other local resources to identify how you can work together to assist your patients both with redeterminations and potential shifts to other coverage sources.
  - **Medicaid managed care organizations (MCOs).** Understand their strategies and how you can work together on patient outreach efforts.
  - **Other entities.** Explore additional partnerships that may help your patients manage their liabilities (e.g., patient financing tools).
- Think through how to leverage technology, which may include eligibility and coverage discovery tools, work queues for patient follow-up, or presumptive eligibility tools.
- Identify plans for how to operationalize this review moving forward, as redetermination will become the standard every 6-12 months.

Are You Ready?

We can help. Contact us to learn more about how you can build on the redetermination process to develop a multi-pronged strategy for patient liability management (PLM) and mitigate potential financial exposure. Drawing on our deep expertise, we can guide your organization through the considerations, decisions, and actions to build a robust PLM program to advance your organization and further elevate the patient experience.

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i. "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," Issue Brief HP-2022-20, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.

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