ISSUE BRIEF

Meeting the Medicaid Redetermination Challenge

Opportunities to add to your existing strategy and identify ineligible enrollees, prioritize outreach and coordinate benefits

Medicaid Programs Face Unprecedented Challenges

Administrative complexity and budget uncertainty combined with enrollment increases have created a perfect storm.

Now that the national COVID-19 Public Health Emergency (PHE) has lifted, state Medicaid programs and their partners face daunting administrative and member coordination challenges. Chief among them is determining which enrollees may remain on the program and which are ineligible due to income or other health coverage.

During the pandemic, states saw Medicaid enrollment climb faster than at any time in the last 15 years. Currently, Medicaid enrollment nationally is estimated to be approximately 85 million people, creating two massive on-going challenges for state leaders.[1]

- **Continuous coverage requirements during the PHE have created complex Medicaid coverage scenarios, communication needs and budget pressures.** Continuous coverage requirements have created a complex scenario in which many enrollees who otherwise would have been ineligible remain on state rosters and covered under state and federal budgets. This often occurs without the state being informed of changes in contact information or access to other coverage. Now that the PHE has been lifted, Medicaid leaders are working tirelessly to address these challenges, in part by focusing on how to conduct ex parte eligibility redeterminations. They are also developing communication strategies to coordinate any necessary coverage transitions with enrollees and health plans.
- **Managing Medicaid enrollment, eligibility and other benefits coordination through a state staffing shortage.** For many months, states have been processing huge enrollment increases while simultaneously facing unprecedented staffing shortages. Resignations, early retirements and labor competition have strained Medicaid staff capacity, with some states reporting they have lost up to 20% of their eligibility workforce.[2]

Redeterminations and Member Coordination Present a Complex Situation

Resuming processes after a PHE-driven hiatus have created new administrative challenges

Perhaps no challenge is as complex for Medicaid programs as resuming eligibility redeterminations. During the PHE, states ceased disenrolling Medicaid members, except those who died or notified the state that they moved out of state. This contributed to a nearly 19% increase in Medicaid rosters since 2020.[3]

Some of those on state Medicaid rosters have likely become ineligible or are eligible for other programs for a variety of reasons, such as increasing income or having other coverage. Although it is not fully known what share of Medicaid enrollees might have otherwise been determined ineligible during the pandemic, this figure may be as high as 15-20%+.[4]

Now that the PHE has ended, continuous coverage requirements will disappear and Medicaid leaders will be required to perform eligibility redetermination for nearly 85 million people over a 14-month period. Addressing the backlog has been exceptionally difficult given the short window and staffing shortages. Some Medicaid leaders and stakeholders have voiced concerns that the situation may result in inaccurate redeterminations, including instances in which eligible members may lose coverage. Others fear they will not have enough time to manage complex member coordination issues, such as connecting Medicaid members to other coverage options and programs.

Finally, Medicaid leaders are under intense scrutiny to ensure that the redetermination process is equitable for everyone. If third parties identify what they perceive as biases, overwhelmed programs could face legal and reputational risk.

Accurate Member Coverage Data Is Part of the Solution

Member coverage data can significantly improve redetermination management

In June 2022, CMS released a list of ten actions to support the unwinding of the PHE. Among the recommendations were the following six strategies to help drive redetermination accuracy, reduce administrative cost and waste and support members across coverage transitions:

- Implement and strengthen automated ex parte processes
- Engage system vendors to identify changes, start planning and perform robust testing
- Establish a renewal redistribution plan
- Engage community partners, health plans and the provider community
- Obtain updated contact information
- Launch effective communication strategies

To execute on these strategies, states need to communicate with enrollees and determine whether they have access to other coverage. During the pandemic, Americans moved throughout the country, reconstituted their families and living situations and changed jobs (and health coverage) at a faster pace than ever before. As a result, states have reported that the contact information they have for enrollees is often inaccurate.

Additionally, Medicaid leaders do not have access to information about other health insurance coverage that a member might have acquired during the PHE. This limits the ability of state Medicaid programs to conduct ex parte eligibility redeterminations, direct ineligible members to other programs and coordinate coverage transitions with health plans.

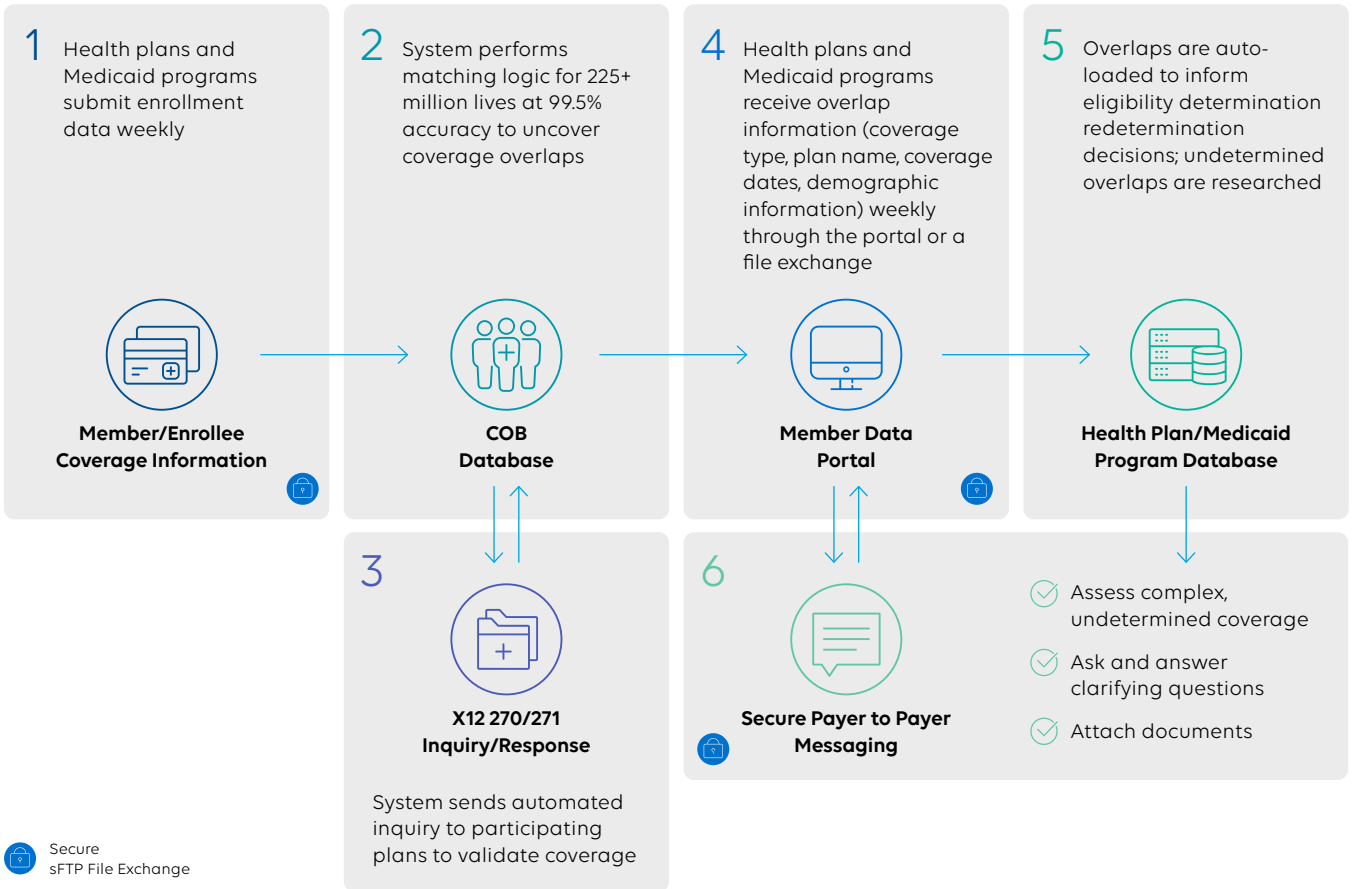
CAQH Fosters Communication Between State Medicaid Programs and Health Plans

CAQH, a non-profit organization focused on reducing healthcare administrative burden, can help states manage member eligibility determination, benefit coordination with health plans and ongoing enrollee communication.

The CAQH Coordination of Benefits (COB) solution is a national registry of coverage information that helps payers coordinate benefits and payment responsibility for more than 236 million people. Member data is submitted by payers weekly and members are matched across payers at 99.5% accuracy to identify overlaps in coverage.

Once member enrollment information is submitted by payers in a standard data format, the COB solution uses a proprietary algorithm that has been developed and tested over the past eight years to identify coverage overlaps across payers. Member coverage is then verified through an automated X12 270/271 eligibility transaction request and response. Every week, payers receive a file reporting the results of the weekly coverage overlap analysis, including member demographic and contact information, coverage types, plan names, dates of coverage and payer payment responsibility. The overlap files can then be used to drive a range of coordination of benefits activities including assisting with eligibility determination, payer payment responsibility and member outreach. For complex or undetermined coverage cases, payers have access to a secure payer-to-payer messaging system to share documents and help resolve any data or coverage issues.

Weekly Coverage Overlap Determination Process



This solution can provide Medicaid leaders robust and timely member coverage data to support:

- **More accurate ex parte eligibility decisions:** By identifying other sources of coverage for their current or potential enrollees, Medicaid programs can easily identify members who may be ineligible or eligible for other programs or coverage assistance.
- **Prioritization of communication with Medicaid members:** States can use the information to prioritize outreach to enrollees during the unwinding of the PHE and communicate effectively with enrollees.
- **More targeted, effective coordination with health plans:** Coverage overlap files and a payer-to-payer communication tool enable Medicaid leaders to engage with health plans to coordinate and transition benefits and support care continuity.
- **Eligibility and payment accuracy after the PHE expiration:** The CAQH COB solution can support ongoing payment accuracy and eligibility determination efforts.

COB by the Numbers

236M+

Lives in the COB Database

100%

National health plan participation

99.5%

Accuracy of validated overlaps

Medicaid leaders interested in learning more about the importance of COB data should visit **caqh.org/medicaidcob**.

About Us

For more than 20 years, CAQH has helped nearly 1,000 health plans, 1.6 million providers, government entities and vendors connect, exchange information and operate more efficiently. CAQH technology-enabled solutions and its Committee on Operating Rules for Information Exchange (CORE) bring the healthcare industry together to make sharing business information more automated, predictable and consistent. CAQH Explorations researches opportunities to reduce the burden of manual processes in healthcare administration. Visit www.caqh.org.

1 https://www.kff.org/medicaid/press-release/states-are-planning-for-the-end-of-the-continuous-enrollment-requirement-in-medicaid-after-the-covid-19-public-health-emergency-expires-but-many-have-not-made-key-decisions/

2 https://www.npr.org/sections/health-shots/2022/04/04/1089753555/medicaid-labor-crisis

3 https://www.kff.org/medicaid/press-release/states-are-planning-for-the-end-of-the-continuous-enrollment-requirement-in-medicaid-after-the-covid-19-public-health-emergency-expires-but-many-have-not-made-key-decisions/

4 https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/03/11/many-medicaid-recipients-could-lose-coverage-as-pandemic-ends

5 https://www.medicaid.gov/resources-for-states/downloads/top-10-fundamental-actions-to-prepare-for-unwinding-and-resources-to-support-state-efforts.pdf