Trends to watch in Medicaid post COVID-19

Plan, provider, and healthtech opportunities during the ‘unwinding’ transition

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Medicaid is on the cusp of significant change, including resumption of the eligibility redetermination process once the national COVID-19 public health emergency (PHE) ends. The Centers for Medicare & Medicaid Services (CMS) agency is also encouraging state Medicaid programs to expand postpartum coverage and to focus on social determinants of health. These changes present opportunities for Medicaid plans to improve engagement, customer loyalty, and, most importantly, members' health outcomes.

Medicaid Redeterminations on the Horizon

After more than two years on hold, Medicaid programs will need to restart the redetermination process for eligibility when the PHE ends, and the resulting churn is expected to have a ripple effect across the entire health care system — particularly at community health centers.[1]

States have 12 months after the national COVID-19 public health emergency declaration expires to initiate the Medicaid eligibility redetermination process, and they are required to "maximize uninterrupted coverage," prevent inappropriate terminations, and transfer eligible applicants to health plans sold on Affordable Care Act (ACA) exchanges.[2]

Many people who lose coverage are expected to be eligible for ACA tax credits and subsidies, but at least one study suggests "these account transfers do not always work as intended."[3]

The Medicaid and CHIP Payment and Access Commission found that:

Medicaid or the Children's Health Insurance Program enrolled within a year in an ACA marketplace plan, and coverage gaps were longest for Black, Hispanic, and Alaska Native beneficiaries.

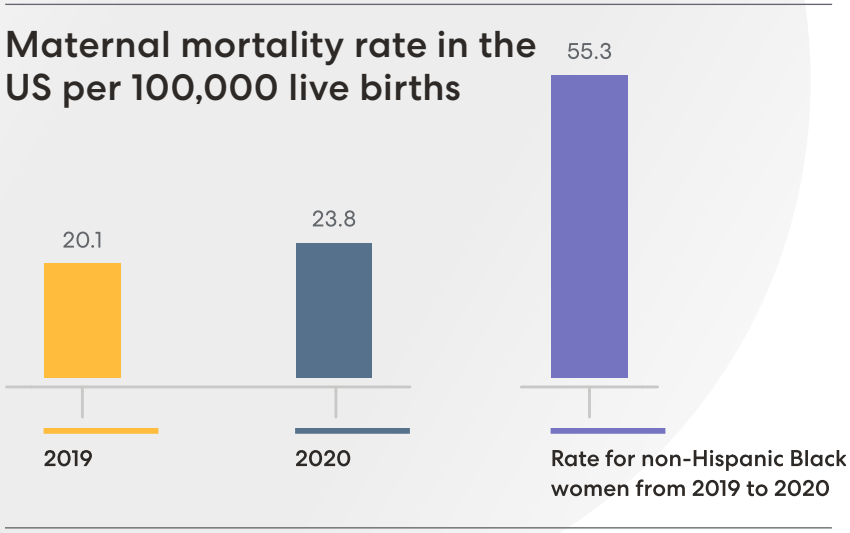
Moreover, a large number of states are not ready for the end of the PHE. A Kaiser Family Foundation survey of state Medicaid and CHIP officials in March found that:

CMS has proposed rules that would establish a clear process to prevent unwarranted termination of coverage and set specific eligibility determination timelines for states, but the rules might not be effective before the PHE ends.[5]

Medicaid managed care plans should not simply wait for states to terminate coverage for newly ineligible beneficiaries. Instead, they should be communicating with their members and verifying addresses and beneficiary circumstances to prevent inadvertent disenrollment. In addition, they should be either sending that information to state Medicaid agencies or helping members do it themselves.[6] This contact must be made in accordance with CMS rules, which ban states from requesting eligibility documentation from beneficiaries during the unwinding period after the PHE ends.[2]

Once the redetermination process resumes, plans should seek termination files from state agencies and direct Medicaid-ineligible members to ACA exchanges and navigators before they lose coverage. Managed care organizations (MCOs) can also work with Federal Qualified Health Centers (FQHCs) as provider partners to ensure care is not disrupted.

Reaching out to beneficiaries to confirm eligibility also presents an opportunity to let members know about new benefits they might qualify for, including extended postpartum care and assistance with social determinants of health (SDOH).



The Postpartum Care and Connection Opportunities

According to the CDC, the maternal mortality rate in the U.S. rose from 20.1 deaths per 100,000 live births in 2019 to 23.8 deaths per 100,000 live births in 2020.[7] The rate for non-Hispanic white women was stable, but rose significantly for non-Hispanic Black and Hispanic mothers, with the rate for non-Hispanic Black women rising to 55.3 deaths per 100,000 live births.

Early research shows that the ban on involuntary disenrollment during the PHE has led to "substantial reductions in postpartum Medicaid loss" and "Medicaid-uninsured churn decreased by 6.6 percentage points" in 2021.[8]

To combat rising maternal mortality, CMS has approved the extension of Medicaid and CHIP coverage for **12 months** after pregnancy in **18 states** and is reviewing applications from an additional **9 states.**[9]

Medicaid-uninsured churn decreased by 6.6 percentage points in 2021.

Additionally, CMS released an action plan in June 2022 to improve health outcomes and reduce inequities for people during pregnancy, childbirth, and the postpartum period.[10] Unsurprisingly, insurance coverage and access to care is a central feature. The plan also includes social needs screening and identifying promising approaches for state Medicaid agencies to connect beneficiaries with organizations that can provide social supports such as housing assistance and nutrition services.

These new policies present opportunities for Medicaid MCOs and providers to connect with customers when notifying them of the extended benefits, recommending screening for risk factors, reminding them to get regular checkups, connecting them with community organizations, and expanding access to peer support providers, including doula birthing assistants.[11]

Medicaid plans and providers should also remind members about postpartum care and help ensure they receive recommended screenings for:

- Physical, social, and psychological well-being
- Infant care and feeding
- Sexuality, contraception, and birth spacing
- Chronic disease management
- Diabetes, among other related concerns

This extended coverage gives health plans and provider partners an opportunity to lay the foundation for a lifetime of good health for parents and babies.

Where the Customer Experience and SDOH Intersect

While high-quality health care is an important factor in health, factors such as a safe living environment, access to transportation and nutritious food, and adequate housing influence health even more, and these SDOH factors can be modified to drive health improvements.

- **Safe living environment**
- **Access to transportation**
- **Nutritious food**
- **Adequate housing**

Addressing social determinants of health is one key to improving not only maternal health but also population health.[12] Improving SDOH before a person becomes pregnant may reduce risks for complications and lead to better outcomes for both the pregnant person and later, the infant.[13] But pregnant people and infants aren't the only beneficiaries of SDOH improvement initiatives.

States increasingly encourage or require MCOs to screen enrollees for unmet SDOH, refer them to community organizations that can help, and ensure care management and marketing are culturally competent.[14] In some states, MCOs can count certain SDOH spending toward their medical loss ratios. Some contracts also require plans to follow up and ensure resources are used, as well as collect and submit performance data.

These initiatives offer MCOs and provider partners a powerful way to connect with members and influence member health. They can mean more touchpoints between plans, providers, and members, but there are also challenges such as language barriers and difficulty reaching some members.

Keeping Customer Service Human While Guided by Technology

A healthcare customer service agent is perceived as the "voice" of both the healthcare plan and the provider. Great customer connections start with expertise, anticipate customer needs, and are simple, empathetic, adaptable, and culturally competent. To be successful, plans and providers need dedicated quality assurance teams, trained agents with a sense of ownership, and design and training delivery specialists focused on building rapport and meeting each customer's specific needs.

It is important to note that a disproportionate share of Medicaid households have families headed by a nonelderly adult with limited English proficiency (LEP), and federal laws require that state Medicaid agencies provide information in a format these individuals can understand.[15] To meet this requirement, customer connection teams must be multilingual.

Medicaid MCOs and providers that lack the resources for intensive member outreach should consider outsourcing to an experienced partner that can develop a custom program. A partner should be able to communicate effectively in the language of Medicaid terminology and in individual members' primary language, through members' preferred media. Bilingual agents can decrease call hold times and deliver a culturally competent customer service experience.

An outsourcing partner should have advanced technology that ultimately improves the member experience while also saving time and money. Such technology may include an artificial intelligence platform that listens to calls, guides efficient resolution options for members and agents, and ensures regulatory compliance.

A skilled partner should also be able to provide analytics and actionable insights. Plans might want to take a population-based approach to communication, such as reaching out to cohorts or at-risk populations likely to be eligible for expanded benefits or different coverage. AI and advanced analytics can help plans categorize cohorts and prioritize outreach. This outreach can be coordinated through joint initiatives of plan and provider with the common goal of improved outcomes.

Finally, the partner's technology must operate with the highest possible security and conform to HIPAA regulations and leading-edge consumer privacy protections.

Medicaid plans, providers, and healthtech firms prepared for the upcoming changes will have significant opportunities to improve member outreach and communications, provide better services, and ensure members have the best possible health and quality of life.

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