Navigating Out-of-State Medicaid & Getting Paid for Claims

The Essential Guide for Chief Revenue Cycle Officers

Medicaid claims are a significant portion of hospital revenue. According to a recent report[1], Medicaid represented 13.5% of all reimbursement for hospitals, amounting to $141 billion total net revenue in 2021.

Medicaid recipients account for 26.5% of all eligible citizens in the United States. Currently, 80 million individuals are enrolled in Medicaid, with an additional 7 million children enrolled in Children's Health Insurance Programs (CHIP) across the country[2].

When this at-risk portion of the population seeks valuable and necessary care, submitting and processing their claims should be easy. However, Medicaid Managed Care Organizations (Medicaid MCOs) deny 1 of every 8 prior authorization claims (12.5%), which is more than double the rate of Medicare Advantage plans[3] at 5.7%.

With over a quarter of the country enrolled in this assistance program, it's no wonder there are significant challenges in getting claims processed and paid. When those individuals travel across the country, it further complicates the problem.

"Navigating Out-of-State Medicaid & Getting Paid for Claims" explores the history of Medicaid, the impact of Medicaid reimbursement on healthcare organizations, and the challenges healthcare providers and health systems face when managing out-of-state Medicaid claims. Answers to commonly asked questions illustrate why this area of hospital reimbursement is so difficult to master.

This guide also explores the benefit of outsourcing out-of-state Medicaid claims for Chief Revenue Cycle Officers as they work to:

- Simplify out-of-state Medicaid enrollment
- Reduce out-of-state Medicaid authorization denials
- Maximize operational efficiency
- Improve the financial health and well-being of your organization

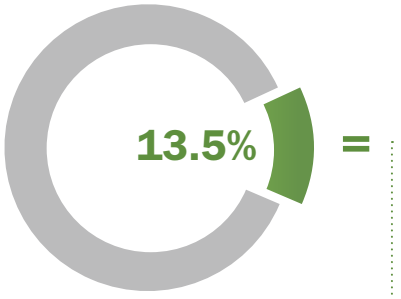
KEY TAKEAWAYS

- **You're not imagining things — out-of-state Medicaid really is that difficult.**
- **Medicaid coverage travels with the patient.**
- **Each state has its own rules for coverage.**
- **Physicians and facilities both need to be enrolled to get paid.**
- **Weigh the pros and cons of trying to work with an out-of-state Medicaid agency.**
- **Know when to outsource your out-of-state Medicaid enrollment and claim management.**

When a person arrives at the emergency room requiring treatment, a hospital is duty bound under the Emergency Medical Treatment and Labor Act (EMTALA)[4] to admit the patient and treat them.

Hospitals do not have the same duty or requirement to enroll with multiple out-of-state Medicaid agencies. Whether the hospital is enrolled with the patient's insurance carrier is a moot point as the patient needs treatment. Only when the hospital discharges the patient does the real investigation begin.

Taking multiple factors into consideration, a hospital must weigh the pros and cons of trying to work with an out-of-state Medicaid agency. A brief look at the history of Medicaid explains why this system is so very difficult to surmount.



$141 Billion

MEDICAID MAKES UP AN AVERAGE OF 13.5%

of a hospital's reimbursement, amounting to $141 billion total net revenue in 2021.

A Brief History of Medicaid

The history of Medicaid starts in 1912 when President Theodore Roosevelt included social insurance for sickness in the platform of his Progressive Party. While the idea had appeal, it fell to the wayside until the Great Depression. In 1935, President Franklin Roosevelt signed the Social Security Act[5], but medical benefits were not included. After World War II, President Truman, reintroduced the idea of national medical care and tried to tie it into his Fair Deal Program. Truman's attempt failed, but the idea of care for a senior population began to take root. In 1960, the Kerr-Mills Act[6], which provided a rough model for Medicaid, created the Medical Assistance for the Aged (MAA), a program that gave states the power to decide which patients needed financial assistance. Some states failed to implement the act or ignored it in its entirety. In 1962, the political attitudes began to shift as the King-Anderson Bill would cover nursing home costs for patients 65 and older. However, it was narrowly defeated in committee.

After President Johnson's election in 1964, those who worked on the King-Anderson Bill drafted a new bill providing coverage for seniors, limited hospitalization and nursing home insurance benefits, and Social Security funding. Upon the bill's introduction, the House altered it by adding an increase in taxes to cover the funding. Both chambers passed the modified bill after extensive alterations in conference committee in 1965, and President Johnson signed the Social Security Amendments on July 30, 1965. These amendments added Title XIX, which created the Medicaid program[7]. Under Title XIX, the federal government provided matching funds to states to enable them to provide medical assistance to residents who met certain eligibility criteria. The objective was to help states assist residents whose income and resources were insufficient to pay the costs of traditional commercial health insurance plans. By 1982, all states participated, with Arizona being the last state to do so. Each state administers its own program with the Centers for Medicare & Medicaid Services (CMS) monitoring those programs and the established requirements for service delivery, quality, funding, and eligibility standards.

On March 23rd, 2010, President Obama signed the Affordable Care Act (ACA) into law[8]. This law expanded the eligibility to adults with incomes up to 138% of the federal poverty level. It also allowed states to opt into an enhanced federal matching rate for their expansion populations. This enhanced funding decreased to 90% starting in 2020. Since states have such significant control of this program, states have an opportunity to limit or expand their own programs.

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- **1912:** President Theodore Roosevelt included social insurance for sickness in the platform of his Progressive Party.
- **1935:** President Franklin Roosevelt signed the Social Security Act.
- **1960:** Medical Assistance for the Aged (MAA) was introduced.
- **1965:** President Lyndon B. Johnson signed the Social Security Amendments on July 30, adding Title XIX, creating the Medicaid program.
- **1982:** All states participate in the program.
- **2010:** President Obama signed the Affordable Care Act (ACA), expanding Medicaid eligibility.

Who Qualifies for Medicaid Benefits?

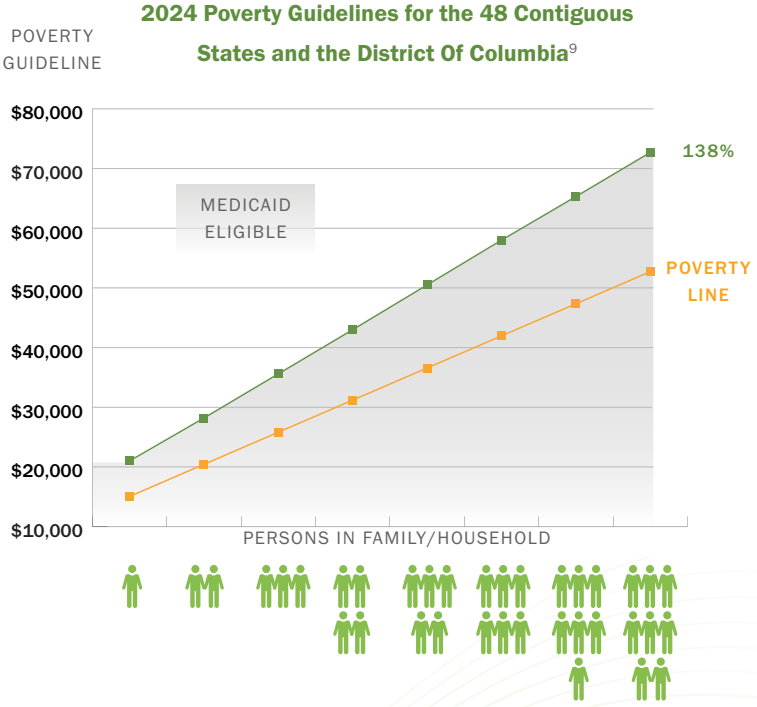
Medicaid exists to assist those whose incomes or resources are insufficient to pay for insurance. But who qualifies and what do they receive when they have Medicaid eligibility?

CMS denotes that Medicaid programs must specifically designate “direct” recipients. For a state to receive federal funding, individuals who fall into specific categories must receive coverage. They are:

- **Children through age 18 in families with an income below 138% of the federal poverty level**
- **Women who are pregnant and have an income below 138% of the federal poverty level**
- **Certain parents or caretakers with very low income**
- **Most seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program**

States retain the power to expand their coverages to other categories as “optional” populations.

2024 Poverty Guidelines for the 48 Contiguous States and the District Of Columbia[9]



*Separate poverty level guidelines for Alaska and Hawaii

What Does Medicaid Cover?

There are mandatory benefits and optional benefits. Every state must offer the mandatory benefits to maintain compliance with CMS. States have discretion over whether to offer and cover optional benefits.[10]

MANDATORY

- Transportation to medical services
- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Nursing facility services
- Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT)
- Family planning services
- Tobacco cessation counseling for pregnant women
- Physician services
- Home health services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services licensed or otherwise recognized by the state
- Medication-assisted treatment (MAT)
- Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials

OPTIONAL

- Other licensed practitioner services
- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Prescription drugs
- Other diagnostic, screening, preventive, and rehabilitative services
- Inpatient psychiatric services for individuals under 21
- Hospice
- Case management
- Personal care
- Primary care case management
- State plan home and community based services
- Self-directed personal assistance services
- Community First Choice Option
- Alternative Benefit Plan
- Health homes for enrollees with chronic conditions

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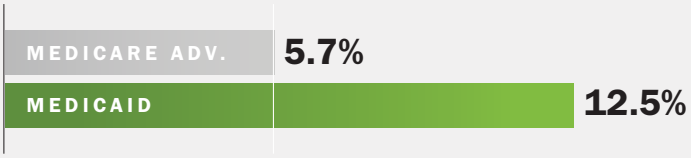
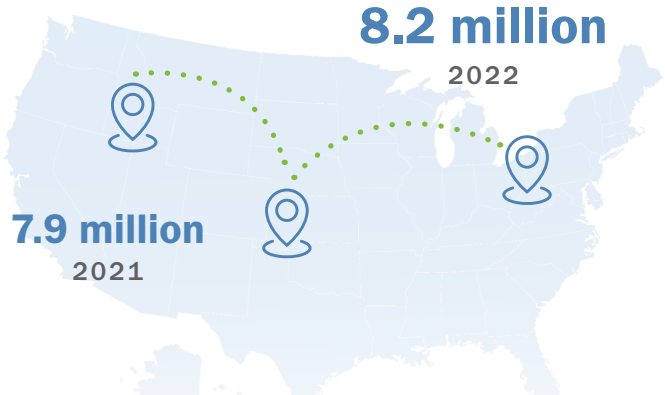


Out-of-State Medicaid

Now that we've established the origins of Medicaid, whom Medicaid is meant to cover, and what Medicaid must cover, let's add the wrinkle of interstate travel. Specifically, what happens when a Medicaid recipient travels from one state to any of the other 49 states.

Just like all other forms of insurance (commercial, Medicare, workers' compensation, Veterans Administration, motor vehicle insurance), the coverage travels with the patient. Unlike with most other forms of insurance, the hospital and the provider might not have enrolled with the patient's home-state Medicaid agency. This issue significantly hampers and complicates successful billing for these claims. Consider the following questions when examining the complicated puzzle that is out-of-state Medicaid.



ACCORDING TO RECENT U.S. CENSUS BUREAU ESTIMATES, the number of people in the U.S. who moved between states rose from nearly 7.9 million people in 2021 to approximately 8.2 million people in 2022. More movement from state to state means more out-of-state Medicaid claims for hospitals.

COMMONLY ASKED QUESTIONS

Does out-of-state Medicaid reimbursement matter?

Medicaid constitutes an average of 13.5% of a hospital's annual reimbursement, amounting to $141 billion. While the largest portion of that reimbursement originates from in-state Medicaid, a small portion comes from out-of-state Medicaid payers. In 2013, at the beginning of the ACA, out-of-state Medicaid comprised 2% of hospital stays.[11] After the COVID pandemic, we saw a spike of 3% of a hospital's inventory comprising out-of-state Medicaid payers. That number already has declined as states begin to reduce their Medicaid enrollments, but that reimbursement still matters as operating margins still have not returned to their pre-pandemic levels.

Should our hospital enroll with an out-of-state Medicaid agency?

When looking at whether your organization should enroll in a specific out-of-state agency, you need to review your inventory patterns. Specifically, are we seeing an increased volume from one state or is it a one-admission scenario? Taking the time to dive into your data will eliminate the outliers and allow your organization an opportunity to concentrate on the states that make the most sense.

Is the Medicaid application only for the hospital, only for the physician, or for both?

To qualify for payment from an out-of-state agency, both parties must be enrolled. Therefore, both parties must go through the same enrollment process, fill out their respective applications, go through the same background checksand qualify. Only then can the appropriate agency process your claims for payment.

Since both parties must be enrolled, it is imperative that your checklist include the physician. If any paperwork is missing, those agencies can suspend or reject your application, causing delays in processing of your claims as your organization must go through the process again.

How difficult is the enrollment process?

After the ACA, the enrollment process with any out-of-state Medicaid agency is going to be tedious. How much of an appetite does your organization have for filing multiple applications? An enormous amount of work goes into this process. Here is a generic sample application checklist as an example.

1. National provider identifier
2. Basic business office data (address, phone, fax, email address, etc.)
3. Specific office data (CLIA certification, name and SSN of employees / personnel, etc.)
4. Specific Provider Data (CLIA certification, SSN, licensure information, etc.)
5. IRS tax identification data
6. Banking information
7. Group identification data (Name, NPI, and Medicaid ID),
8. Rural health clinic cost report
9. DEA number registration
10. Specialty information
11. Background checks (fingerprints, ID information, signatures, etc.)[12]

The last component is normally the most difficult to acquire as a background check is mandated regarding your participation in the applicable programs.

How do we know what benefits a particular state covers?

Medicaid benefits fall under two categories: mandatory and optional. Every state must cover the mandatory offerings. When it comes to the optional offerings, you must refer to each individual state to determine if it covers the optional offerings.

Being mindful of what your in-state Medicaid agency requires versus what outside states will cover is an enormous undertaking. Keeping in mind that your organization must adhere to EMTALA, your state Medicaid requirements, and the requirements of an out-of-state agency, the challenges of coverage and enrollment become much more difficult as you enroll in additional states. Making sure you understand coverage requirements and how some outlier states work will help as you decide whether to enroll.

What's the status of Medicaid eligibility across the country?

Since the ACA expanded coverage and the national COVID pandemic increased enrollment numbers, we're beginning to see some states shrink their enrollment numbers. Other states, realizing that the economic effects were longstanding, opted to allow their enrollment numbers to remain higher than in previous years. Each state administers its own program and can legislate differently.

As an example, Texas dropped more than 500,000 from its rolls as it mandated those enrollees go through the re-enrollment process. On the other hand, North Carolina chose to expand its Medicaid population, which allowed nearly 600,000 individuals to qualify for Medicaid benefits. It bears repeating that Medicaid is a state-run program for entitlements, which magnifies the problem as each state has its own goal.

Are there any uniform reimbursement rates for Medicaid?

Unfortunately, the answer is no. Since each state oversees its own Medicaid program, each state can set its reimbursement rates as it sees fit. States generally pay out-of-state hospitals less than in-state providers. Most states pay for inpatient hospital services using diagnosis-related groups (DRGs), and many of these use the same underlying methodology for in-state and out-of-state providers even if the payment rate is different.

For example, Colorado pays out-of-state hospitals a DRG base rate that is 10% lower than the rate paid to in-state hospitals, and Michigan does not apply the same DRG wage adjustment to out-of-state hospitals that it applies to in-state hospitals. Some states base payments to out-of-state hospitals using the payment rates for the state in which the hospital is located. Some states pay out-of-state hospitals the lower of their state rate or the Medicaid payment rate for the state in which the hospital is located for both inpatient and outpatient hospital services.

Do bordering states have special considerations?

In limited circumstances, some state laws allow bordering states to receive special consideration in their reimbursement for out-of-state Medicaid recipients. If a state has limited hospital coverage at the border with most of its medical options in concentrated urban populations, patients in rural areas may not be able to access care in a timely fashion. If a hospital is across the state line, a state can make an exception and allow its participants to seek care across the state line. In those instances, states have exceptions to pay out-of-state providers at a higher reimbursement as they are taking care of a patient population with limited access to healthcare.

For example, Louisiana Medicaid allows hospitals to contract or plan outside the state, including with another provider, such as an independent laboratory, for performance of medically necessary services for their patients.[13] Louisiana Medicaid also allows acute out-of-state providers in its designated "trade area" to be treated as in-state providers. Louisiana lists multiple counties in Arkansas, Mississippi, and Texas as located in its trade area. States can get creative with their administrative handbooks to allow additional areas to serve their sparsely served areas of concern.

Once enrollment is completed, do we have to revalidate or re-enroll?

Unfortunately, your organization must re-enroll annually with an out-of-state agency. Staying on top of all Medicaid credentialing is imperative, not only to prevent expirations and deactivations, but also to ensure compliance with each program. Provider enrollment is more than just a one-time application process. It must be maintained following initial requirements and then periodic revalidation requirements, both of which vary by state. For each Medicaid program provider's bill, the hospital/organization must maintain its qualifications according to the program's requirements. Providers must complete periodic revalidation with the program(s). Failure to do so will result in deactivation of the Medicaid program and denied claims. If a provider is un-enrolled, re-enrollment is a very tedious task, and most likely will experience a gap in eligibility for reimbursement.

Since citizens are free to move throughout the United States, their Medicaid coverage should move with them, right?

Since each state has its own criteria for qualification, there is no national qualification for Medicaid benefits. Each state built its own program, so individuals who move to another state are required to enroll in that state's program.

The good news is that individuals are allowed to apply for Medicaid in their new state immediately after relocating, and doing so can help them avoid a lapse in benefits. It generally takes 15 to 90 days to receive a letter of approval once they apply for Medicaid, and patients can usually submit the application online. Federal rules require states to take no more than 90 days to process a Medicaid application based on disability, and no more than 45 days for all other Medicaid applications. But states sometimes fall behind on their application processing.

Additionally, a person can't be covered by Medicaid in two states at the same time. Therefore, they will need to first terminate their original Medicaid coverage and then apply in the new state once they've relocated.

Most states offer retroactive Medicaid coverage, which allows a person to receive coverage for up to three months prior to the date of their application's approval. However, they may be forced to pay for healthcare services out of pocket until that retroactive coverage kicks in and renders them eligible for reimbursement.

Our hospital has been seeing more out-of-state Medicaid claims. Is that possible?

Yes, it is. According to recent U.S. Census Bureau estimates, the number of people in the U.S. who moved between states rose from nearly 7.9 million people in 2021 to approximately 8.2 million people in 2022[14]. More movement from state to state means more out-of-state Medicaid claims for hospitals.

We are also continuing to see a gradual increase in the use of out-of-state care because of the Advancing Care for Exceptional Kids Act (ACE Kids Act, P.L. 116-16), which includes provisions intended to facilitate out-of-state care for children with disabilities.

Outsourcing Out-of-State Medicaid Claim Management

For Chief Revenue Cycle Officers, the list of challenges with out-of-state Medicaid claim management is long. With all of the rules governing Medicaid that vary from state to state, it takes a significant amount of time and expertise to keep track of all the changes. Teams that work these claims internally typically experience low success rates. Many choose to write them off.

If you find that you're dealing with operational inefficiencies and lost revenue, it may be worth outsourcing your out-of-state Medicaid claims.

With over 20 years in complex claims, EnableComp has in-depth knowledge of the intricacies of this niche reimbursement class. We successfully enroll, validate, check eligibility, bill, and obtain reimbursement for providers in all 50 states. Our experts and specialists partner with your business office — providing you with resources, detailed knowledge, and experience to help you get you paid for your out-of-state Medicaid claims. We know how challenging the process can be. We take care of it, so you don't have to.

Outsourcing with EnableComp helps RCM leaders:

- **Simplify out-of-state Medicaid enrollment**
- **Reduce out-of-state Medicaid authorization denials**
- **Maximize operational efficiency**
- **Improve the financial health and well-being of your organization**

WITH AN AVERAGE

3:1 ROI,

our clients often see an increase of over 50% in out-of-state Medicaid payments once we take on the work.

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CONCLUSION

Knowing the history of Medicaid and understanding the nuances of out-of-state Medicaid guidelines helps providers proactively navigate the challenges associated with getting paid for out-of-state Medicaid claims. Getting ahead of the billing process and staying on top of the continuous state-by-state changes not only reduces the number of providers who choose not to participate in out-of-state care, but significantly lowers the amount of debt that is written off for out-of-state Medicaid services — and ultimately contributes to a more efficient and financially healthy healthcare organization.

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