**Interstate Medicaid Billing Problems: Helping Medicaid Beneficiaries Who Get Care Out of State**

**Issue Summary:**

Despite federal requirements that states pay for Medicaid services for beneficiaries who are absent from the state, Medicaid beneficiaries are frequently billed for such out-of-state care. Even when consumer health assistance programs intervene to advocate for patients, out-of-state providers often refuse to accept another state’s Medicaid payments and continue to bill patients.

In May 2002, the Health Assistance Partnership asked CMS representatives about the processing of out-of-state Medicaid claims. In response, CMS representatives cited the relevant federal regulations and policy. Robert Tomlinson, Center for Medicaid and State Operations, CMS, wrote:

“[A] recipient temporarily absent from his state of residence is entitled to receive care from providers in another state and have such care paid by his home state. Further, as a condition of being a Medicaid provider, the provider must accept as payment in full the amounts determined by the state for the care in question, even when the payment is zero.”

The applicable regulations are as follows:

42 CFR §431.52, Payments for services furnished out of State.

(a) **Statutory basis** Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) **Payment for services** A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:

1. Medical services are needed because of a medical emergency;
2. Medical services are needed and the recipient’s health would be endangered if he were required to travel to his State of residence;
3. The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State.
4. It is general practice for recipients in a particular locality to use medical resources in another State.

(c) **Cooperation among States** The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State’s plan.

42 CFR §447.15, Acceptance of State payment as payment in full
A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with §431.55(g) or §447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge.

Tim Roe, CMS, recommended contacting the responsible CMS regional office when an out-of-state hospital refuses to accept another state’s Medicaid payments. “The regions are the enforcers of our rules and contracts,” he said. Since our call, several health assistance programs have reported continuing problems with Medicaid interstate billing.

§ 6085(a), Section 1932(b)(2) of the Social Security Act (42 U.S.C. 1396u-2(b)(2)(D), Emergency services furnished by non-contract providers

The Deficit Reduction Act (DRA) of 2005 created a new section 1932(b)(2)(D) of the Social Security Act that established a limit on the amount to be paid to out-of-network providers of emergency services at the amount that would have been paid if the service had been provided under the State’s FFS Medicaid program. This provision became effective January 1, 2007.

Under section 1932(b)(2)(D) any provider of emergency services that does not have in effect a contract with a Medicaid MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), and that provides emergency services to a beneficiary enrolled in that Medicaid managed care entity, must accept as payment in full no more than the amount it would receive if the services were provided under the State’s fee-for-service (FFS) Medicaid program. These rules apply whether the non-contracting provider is within the State or outside of the State in which the managed care entity has a contract. If services are provided by an out-of-network provider in a state other than the beneficiary’s home state, payment is limited to no more than the rate that would have been paid by the beneficiary’s home state if the services were provided under the home state’s Medicaid FFS program. The amount of payment or methodology for establishing that amount is governed by the provisions in the home state Medicaid program’s State plan for payment of out-of-state providers. In the absence of such a state plan provision, the limit will be based on the FFS rate established for such services provided by the home state.

Below are (1) further details about interstate billing problems, (2) information about some good practices in states, and (3) proposed recommendations to CMS.

Reported Interstate Billing Problems:

HAP staff spoke to consumer health assistance programs and Medicaid administrators in four states regarding interstate billing. The most common reported interstate Medicaid billing issue involves reimbursement of out-of-state emergency services: A Medicaid beneficiary requires emergency medical
services while traveling in another state, but the hospital and/or the doctors in the emergency room refuse to accept out-of-state Medicaid payments and instead bill the beneficiary.

Other issues include:

- Beneficiaries, especially in rural areas, regularly using “border hospitals” closer in proximity than Medicaid providers of their own state.

- Difficulty filling prescriptions written by out-of-state providers. Often, this occurs when a person gets emergency treatment out-of-state but cannot get prescriptions filled or refilled on return to his or her home state. This problem can also arise in non-emergency situations.

- Problems getting pre-authorization for services only available out of state. Though this is not as common a problem, when medically necessary treatment cannot be provided within a beneficiary’s home state, consumer health assistance programs report difficulty getting services authorized initially and difficulty getting the out-of-state providers to accept another state’s payments.

Providers’ inability or unwillingness to seek reimbursement from other states’ Medicaid programs seems to be the root of the problem. Providers often face burdensome administrative requirements to enroll with the Medicaid program of the beneficiary’s home state. Many states require providers to enroll in the state Medicaid program of the beneficiary served in order to receive payment, even if the provider is already enrolled in Medicaid in another state. A quick survey of provider enrollment applications and agreement forms demonstrated the extent of the administrative burden this causes providers. For example, Wyoming has a 22-page Medicaid provider agreement and enrollment packet that all providers, even out-of-state providers, must complete.¹ Some states’ enrollment procedures require providers to furnish detailed information about their facilities, including financial statements and boards of directors.

Excessive delays in getting claims processed and problems in getting information from another state also discourage providers. A HAP staff member experienced waits of 10 minutes on hold when placing calls to one state’s “out-of-state billing unit.” As well, providers have little incentive to enroll in another state’s Medicaid program if this would entail accepting a reimbursement rate that is lower than Medicaid rates in the provider’s home state.

Most often, out-of-state billing problems ultimately burden the recipient with debt and/or adversarial maneuvering to have services covered. When providers are unwilling to go through the paperwork to get services paid by another state, they either bill the Medicaid beneficiary or write-off bills as “uncompensated care.” These write-offs cause problems because the care may be charged to limited federal, state, local, or facility-based funds designated to cover the expenses of uninsured populations. Writing-off expenses that could be covered by Medicaid diminishes the resources available for the uninsured.
Despite regulatory protection for Medicaid recipients and the efforts of advocates, recipients often must fight for coverage after incurring the expenses. For example,

- While on a trip to Arizona, a California beneficiary had a heart attack and required treatment at an Arizona hospital. The providers refused to bill Medi-Cal (California’s name for Medicaid) due to the requirement to complete the lengthy provider enrollment packet. The hospital eventually relented by agreeing to complete the required enrollment packet and submit the claim to Medi-Cal. However, individual doctors continued to pursue the beneficiary for the cost of their services and refused to enroll or submit the claim to Medi-Cal. This example was furnished by the Health Consumer Alliance.

- A New York Medicaid beneficiary with HIV frequently visited his family in Tennessee for support near the end of his life. While in Tennessee, he required emergency hospitalization. To get the bills paid, New York Medicaid required that the providers become New York Medicaid participating physicians. They were instructed to call CIS, their administrative service organization, to start the process. The hospital was willing, but the doctors were not and continued to bill the client. Gay Men’s Health Crisis furnished this example.

State Good Practices in Processing Out-of-State Medicaid Claims:

From surveying some states approaches to out-of-state billing, we have assembled some practice that, while not perfect, may provide more efficient alternatives.

Border Communities:

Some states, especially those with borders in close proximity to several other states, have recruited out-of-state providers that fall within a certain distance to the border as “Border Providers.” Border providers have the opportunity to enroll with (and in some states must enroll with) their neighboring state(s) Medicaid program and submit claims using the same procedures as in-state providers. They are reimbursed not only for emergency services but also for all Medicaid-covered services that they furnish to residents of the neighboring state. This approach increases the number of providers available to beneficiaries in underserved areas of a state and eliminates the need to scrutinize each out-of-state claim from border providers.

Example: Terry Layman, Client Advisory Services Unit, Oregon Office of Medical Assistance, reported that the Oregon Medicaid agency has good procedures for paying for care in border communities. In a 75-mile contiguous area, providers in neighboring states are deemed as Oregon providers and treated identically in terms of enrollment as Medicaid providers and payment. Oregon also frequently pays for out-of-state emergency care. Though Oregon uses the same provider enrollment system for both out-of-state and in-state providers, it is a short and efficient process. When beneficiaries call to report that they are getting bills from an out-of-state provider, the Client Advisory Services Unit asks the patient to send a hard copy of the bill (by mail or by faxing it from a branch office near their home). The Client Advisory Services Unit checks to see whether the provider is enrolled with Oregon Medicaid and if not, explains to the provider that by completing a two-page enrollment form, they will be able to get paid Oregon’s
Medicaid rate and write off any unpaid balance to their own state’s Medicaid contract—a better option for most providers than beginning collection action against a patient who does not have the money to pay them. The Client Advisory Services Unit is often successful in getting the out-of-state providers to bill Oregon, especially larger providers such as hospitals. One barrier to interstate billing is that Oregon requires the provider to be a Medicaid provider in his or her home state, and many providers seen in emergencies are not.

**Streamlined Provider Enrollment:**

Some states have significantly streamlined their enrollment procedures for all providers, including those from out-of-state. In contrast to the lengthy provider enrollment packets of some states, Oregon has reduced its basic enrollment form to a two-page form by providing much of its enrollment packet background information online. Maryland has moved their entire provider application process to the web.² By using an online system, Maryland has eliminated the prior two-week processing period for provider enrollment.³ South Dakota provides a one-page, online out-of-state enrollment application that may be completed, printed and then mailed to their Medicaid program.⁴ Instead of one large application packet, North Carolina offers web-accessible, provider-distinct enrollment applications. Doing so alleviates the need for providers to sift through portions of large application packets that do not pertain to them.⁵

**Procedures for Single Out-of-State Claims:**

States have also had success in reducing barriers to providers’ reimbursement by offering procedures for reimbursement of single claims. Under this system, out-of-state providers that are Medicaid providers in their home state may submit a claim for a single Medicaid recipient on a single date-of-service without enrolling in the other state’s Medicaid program. Permitting providers to submit single claims alleviates providers’ fears that once they are a Medicaid provider of another state, they will be required to take any Medicaid recipient from that state and accept the other state’s reimbursement rates for all services.

Example: Scott Richmond, Medi-Cal Managed Care Ombudsman in California’s Department of Health Services, said that when consumers are in Medicaid managed care in CA, neither out-of-state providers nor in-state providers must be enrolled in Medi-Cal in order to be reimbursed by the plan. It is up to the managed care plan to pay for necessary out-of-state services in an emergency or when they cannot be provided in-state. Mr. Richmond frequently deals with other provider billing issues and is hopeful that a recent court decision, which requires an appeal procedure and a reimbursement mechanism when beneficiaries pay out-of-pocket for services that should have been paid by Medi-Cal, will help resolve the problems.

For fee-for-service claims, California permits the direct reimbursement for services provided out-of-state as long as the providers are Medicaid providers in their home states and the cost incurred for the service does not exceed a capped amount. For claims falling under the capped amount, the out-of-state provider may submit a claim form to Medi-Cal (California’s Medicaid program). If the service expense exceeds the capped amount, the out-of-state provider must enroll as a provider in California.
While expedited procedures for services falling within a cap are a good idea, it is important to make sure that the capped amounts are sufficient to really serve the needs of out-of-state claimants. States should periodically update any caps to ensure that they are adequate to cover average emergency claims.

**Out-of-State Claims Unit:**

Many states have developed special claims staff designations or even whole units to process out-of-state claims. Once these special designations or units have been created, state programs benefit from clearly advertising their existence on Web sites and in provider enrollment packets.

**Recommendations:**

The following recommendations were presented to CMS and discussed during a June 27, 2003 conference call with Ms. Ginni Hain, Director of the Division of Eligibility, Enrollment and Outreach, Disabled and Elderly Health Programs Group, Centers for Medicaid and State Operations, CMS.

1) CMS should further study interstate billing problems and procedures. From our brief survey, it seems best for states to have separate procedures for handling infrequent emergency claims and for handling claims of providers that frequently serve residents in another state. For emergency claims, Medicaid providers should not have to enroll in the other state’s Medicaid program, and for those who frequently serve out-of-state beneficiaries, there should be streamlined enrollment procedures. We do not know how many states actually have distinct procedures for these situations.

2) CMS should gather and disseminate information about promising state strategies to resolve billing problems in a “Dear Medicaid Director” letter.

3) CMS should investigate the possibility of standardizing Medicaid and provider enrollment billing procedures.

**Response from CMS**

Ms. Hain explained that Medicaid is a state-run program and the federal administration’s emphasis is currently on giving states flexibility to run the program within federal guidelines. CMS is interested in providing states with technical assistance and tools, such as best practices, that will help states run Medicaid well in these trying economic times. On the interstate billing issue, she offered to disseminate best practices that we call to her attention. CMS may be able to use Technical Advisory Group (TAG) team meetings, monthly conference calls with states, and regional office staff to inform state Medicaid programs about these best practices.

**Questions to Ms. Hain included the following:**

Q: How does CMS enforce the federal requirement that states develop reciprocity agreements and mechanisms to handle out-of-state claims?

A: The federal government responds to cases and complaints brought to its attention, but it does not otherwise actively examine state procedures regarding interstate claims.
Q: Where in the federal government should people send anecdotes of interstate problems?

A: People should go through normal channels to resolve these complaints, but can bring instances that cannot be resolved to the attention of CMS. Ms. Hains is the person at CMS Headquarters to hear these problems. So far, the regional CMS offices have not noted a high volume of such cases.

Q: Is there any possibility of nationally standardizing Medicaid billing and provider enrollment procedures?

A: CMS does not have legal authority to require such standardization. The standardization of electronic claims that is taking place under HIPAA may help with third party billing eventually, but it will not remedy provider’s reluctance to enroll in another state’s Medicaid program.

Q: What is the next step in gathering and disseminating best practices? Could CMS help with a more comprehensive survey to states about how they handle interstate claims?

A: CMS cannot survey states without OMB clearance due to the Paperwork Reduction Act. CMS may be able to share data that the Health Assistance Partnership pulls together, whether it is from informal discussions or a more comprehensive survey.

This fact sheet was originally prepared in conjunction with two Health Assistance Partnership conference calls.

² See https://encrypt.emdhealthchoice.org/_Portal/provWelcome.jsp for Maryland’s online enrollment application.
⁴ See https://www.state.sd.us/eforms/secure/eforms/E0996V1-OutOfStateProviderEnrollmentApplication.pdf for South Dakota’s online enrollment application.
⁵ See http://www.dhhs.state.nc.us/dma/provenroll.htm for North Carolina’s Provider Enrollment page.