Medicaid Payment Policy for Out-of-State Hospital Services

Although most Medicaid enrollees obtain medical services within their state of residence, some enrollees seek care out-of-state under certain circumstances. Current Medicaid regulations describe four situations in which states must provide out-of-state coverage:

- a medical emergency;
- the beneficiary's health would be endangered if required to travel to the state of residence;
- services or resources are more readily available in another state; or,
- it is general practice for recipients in a particular locality to use medical resources in another state (42 CFR § 431.52).

States have broad flexibility to determine payment rates for services provided out of state and the processes that providers must follow to enroll as an out-of-state Medicaid provider. Specifically, many states pay out-of-state providers at lower rates than in-state providers and require out-of-state providers to undergo provider screening and enrollment even if the provider is already enrolled in Medicare or Medicaid in another state. Some providers have raised concerns that these policies may reduce providers' willingness to serve out-of-state Medicaid beneficiaries and may result in delays in care while provider enrollment is processed (Manetto et al. 2018).

Hospital services comprise the largest category of Medicaid spending and the only one for which we have reliable data about out-of-state service use. This brief reviews the use of out-of-state hospital services in Medicaid and the various ways that states pay out-of-state hospitals. Overall, we find that children who are eligible for Medicaid on the basis of a disability are more likely to have out-of-state hospital stays than other types of Medicaid enrollees and that children's hospitals serve a higher share of patients from out-of-state than other types of hospitals.

The use of out-of-state care may increase in the future as a result 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. The ACE Kids Act also requires the Centers for Medicare & Medicaid Services (CMS) to issue guidance by October 2020 on best practices for ensuring that children with complex medical conditions receive prompt care out of state when medically necessary.

More information about state payment policies for hospital services is available in MACPAC's compendia of state payment policies for inpatient and outpatient services (MACPAC 2018, 2016).

Use of Out-of-State Hospital Services

In fiscal year (FY) 2013, about 2 percent of Medicaid hospital stays occurred out of the patient's state of residence (Table 1). About half of these stays occurred at hospitals in neighboring states that were located in the same hospital-referral region (HRR) where the patient lived. An HRR is a geographical designation that describes regional health care markets tertiary medical care.[1] In 2017, about one-third of HRRs overlapped multiple states.

TABLE 1. Out-of-State Medicaid Inpatient Hospital Stays by Eligibility Group, FY 2013

Eligibility group	Total number of stays (millions)	Share of stays out of state	Share of out-of-state stays in a different HRR than enrollee
Total	**6.5**	**1.9%**	**1.0%**
Non-disabled children	2.2	2.2	1.1
Non-disabled adults	2.7	1.5	0.7
Disabled children	0.2	4.1	2.7
Disabled adults	1.5	2.0	1.0

Notes: FY is fiscal year. HRR is hospital-referral region. Analysis excludes individuals enrolled in both Medicare and Medicaid and those age 65 and older. Ten states are excluded because of lack of complete managed care encounter data (Alaska, Kansas, Maryland, Missouri, Nebraska, Nevada, Oregon, Rhode Island, Washington, and West Virginia). For more information on our method for classifying out-of-state hospital stays, see Appendix B.

Source: MACPAC, 2020, analysis of FY 2013 Medicaid Statistical Information System data.

Children who qualify for Medicaid on the basis of a disability have a higher share of out-of-state inpatient hospital stays than other eligibility groups. These children are also more likely to access care outside of the HRR where they reside.

Use of out-of-state hospitals varies widely by state, based in part on the extent to which residents live near other states. For example, Hawaii, which does not border any states, had the lowest share of Medicaid hospital stays out of state (0.1 percent), while Vermont had the highest (19.0 percent). As discussed further below, Vermont reduces barriers to out-of-state care by designating certain border hospitals as Vermont Medicaid providers and paying these hospitals the same rates as in-state hospitals. Complete information on the distribution of out-of-state hospital stays by state is provided in Appendix A.

Hospital characteristics

In FY 2013, less than half of hospitals (44.9 percent) provided care to Medicaid enrollees who resided outside the state where the hospital was located (Table 2). However, 86.4 percent of children's hospitals served out-of-state patients, a higher share than other types of hospitals. Psychiatric, long-term care, and children's hospitals were more likely to serve out-of-state patients from outside their HRR than from within their HRR, while the majority of out-of-state stays for other hospital types came from within the same HRR as the hospital.

TABLE 2. Medicaid Stays by Hospital Type and Out-of-State Status, FY 2013

Hospital type	Number of hospitals in analysis		Total Medicaid stays	Out-of-state stays as a share of total Medicaid stays		Average number of states represented by out-of-state Medicaid stays
	Total	Share of hospitals with out-of-state Medicaid stays		Share from out-of-state patients	Share from out-of-state patients in a different HRR	
Total	**4,616**	**44.9%**	**6,024,307**	**1.4%**	**0.6%**	**3.1**
Short-term acute care hospital	2,966	59.4	5,600,348	1.3	0.5	3.2
Critical access hospital	998	16.2	91,488	1.5	0.4	1.2
Psychiatric hospital	172	18.6	50,049	1.0	0.8	1.2
Long-term care hospitals	238	11.3	7,483	2.2	1.6	1.3
Rehabilitation hospital	161	11.8	6,654	2.2	0.7	1.4
Children's hospitals	81	86.4	268,285	3.8	2.9	6.6

Notes: FY is fiscal year. HRR is hospital-referral region. Average number of states out-of-state Medicaid patients are from excludes hospitals without out-of-state visits and does not include the state the hospital is located in. Analysis excludes individuals enrolled in both Medicare and Medicaid and those age 65 and older. Ten states are excluded because of lack of complete managed care encounter data (Alaska, Kansas, Maryland, Missouri, Nebraska, Nevada, Oregon, Rhode Island, Washington, and West Virginia). Analysis also excludes stays that could not be linked to Medicare cost report data (n=512,407). For more information on our method for classifying out-of-state hospital stays, see Appendix B.

Source: MACPAC, 2020, analysis of FY 2013 Medicaid Statistical Information System data and Medicare cost report data.

States also vary in the extent to which hospitals receive Medicaid payments from multiple states. On average, hospitals with out-of-state Medicaid patients received Medicaid payments from about three different states in FY 2013, but children's hospitals received Medicaid payments from more than six states, on average. Some children's hospitals received Medicaid payments from more than 25 states in FY 2013.

Provider Enrollment Requirements

In order to receive payment for Medicaid services, providers must enroll with the program in the patient's state of residence and meet federal screening requirements. These requirements are similar to those under Medicare, and states are not required to conduct additional screening for limited risk providers, such as hospitals, that have been previously screened by Medicare or another state (CMS 2018). However, states are not required to use screening data from Medicare or other states and they are allowed to conduct additional screening beyond the minimum federal requirements. As of June 2019, 24 states and the

District of Columbia relied on screenings conducted by Medicare to facilitate their Medicaid provider enrollment (GAO 2019).

Current state requirements for screening and enrolling out-of-state providers vary widely (GAO 2019 and HMSA 2018). Some states, such as California, do not require separate screening for out-of-state providers and have established an express enrollment process for out-of-state providers (DHCS 2020). Other states require out-of-state providers to follow the same process as in-state providers regardless of whether they are enrolled in Medicaid in another state. In addition, state requirements for screening and enrolling providers sometimes differ for services provided under fee-for-service (FFS) and managed care delivery systems.

Payment Methods for Out-of-State Hospital Services

States have considerable flexibility in how they set hospital rates, including those for hospitals in other states. States that establish different rates generally pay out-of-state hospitals less than in-state providers.

As of November 2018, 18 states and the District of Columbia paid out-of-state hospitals using the in-state rate for inpatient hospital services in their fee-for-service (FFS) Medicaid programs, and the remaining 32 states paid a different out-of-state rate (MACPAC 2018). As of July 2016, 14 states paid out-of-state hospitals the in-state rate for outpatient services provided under FFS, and the remaining 36 states and the District of Columbia paid a different out-of-state rate (MACPAC 2016). We do not have information on how managed care plans pay hospitals.

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 percent 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 (MACPAC 2018).

Some states base payments to out-of-state hospitals using the payment rates for the state in which the hospital is located. For example, New Jersey pays out-of-state hospitals the lower of the New Jersey state rate or the Medicaid payment rate for the state in which the hospital is located for both inpatient and outpatient hospital services (MACPAC 2018 and 2016).

States can establish different payment rates for out-of-state hospitals located in particular geographic areas. For example, Vermont's Medicaid state plan designates eight hospitals in neighboring states as border hospitals that are paid the same rate as in-state hospitals due to their close proximity and the general practice of Vermont residents to access care at these hospitals (DVHA 2017). However, Vermont makes lower payments to other out-of-state hospitals that are not designated as border hospitals.

Some states also make supplemental payments to out-of-state hospitals, including disproportionate share hospital (DSH) payments.[2] However, the vast majority of supplemental payments are made to in-state

hospitals. In state plan rate year (SPRY) 2015, 10 states made $44.3 million in DSH payments to out-of-state hospitals (0.2 percent of total DSH payments in that year). Most of these hospitals also received DSH payments from the state in which they were physically located.

Endnotes

[1] The Dartmouth Atlas defines HRRs based on where patients are referred for major cardiovascular surgical procedures and for neurosurgery (Dartmouth 1999).

[2] The two broad categories of Medicaid payments to hospitals are (1) base payments for services and (2) supplemental payments, which are typically made in a lump sum for a fixed period of time. For more information, see MACPAC's issue brief on *Medicaid Base and Supplemental Payments to Hospitals*.

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Appendix A: State-Level Data

TABLE A-1. Out-of-State Medicaid Hospital Stays by State, FY 2013

State	Total number of stays	Total out of state		Different HRR	
		Number of stays	Share of total	Number of stays	Share of total
Alabama	111,217	2,407	2.2%	776	0.7%
Arizona	177,524	1,824	1.0%	754	0.4%
Arkansas	76,531	5,660	7.4%	1,190	1.6%
California	554,236	3,137	0.6%	2,371	0.4%
Colorado	62,445	330	0.5%	255	0.4%
Connecticut	93,911	1,046	1.1%	853	0.9%
Delaware	23,016	1,177	5.1%	789	3.4%
District of Columbia	23,619	1,275	5.4%	974	4.1%
Florida	426,310	1,425	0.3%	922	0.2%
Georgia	242,698	4,333	1.8%	1,753	0.7%
Hawaii	23,522	34	0.1%	32	0.1%
Idaho	29,805	1,987	6.7%	647	2.2%
Illinois	247,043	10,867	4.4%	3,404	1.4%
Indiana	135,191	2,749	2.0%	996	0.7%
Iowa	54,517	4,566	8.4%	2,533	4.6%
Kentucky	81,068	4,138	5.1%	2,606	3.2%
Louisiana	136,446	1,328	1.0%	1,019	0.7%
Maine	25,738	581	2.3%	366	1.4%
Massachusetts	168,977	2,235	1.3%	1,813	1.1%
Michigan	228,034	2,125	0.9%	958	0.4%
Minnesota	101,837	4,166	4.1%	939	0.9%
Mississippi	103,636	4,813	4.6%	2,100	2.0%
Montana	17,443	518	3.0%	482	2.8%
New Hampshire	13,477	924	6.9%	623	4.6%
New Jersey	120,451	4,460	3.7%	3,570	3.0%
New Mexico	58,687	4,165	7.1%	713	1.2%
New York	1,103,320	5,498	0.5%	3,380	0.3%
North Carolina	226,278	2,145	0.9%	953	0.4%
North Dakota	10,115	388	3.8%	242	2.4%
Ohio	288,754	7,001	2.4%	2,573	0.9%
Oklahoma	118,329	3,907	3.3%	1,220	1.0%
Pennsylvania	239,792	2,185	0.9%	1,447	0.6%
South Carolina	137,559	17,080	12.4%	12,322	9.0%
South Dakota	19,027	981	5.2%	481	2.5%
Tennessee	132,831	1,301	1.0%	575	0.4%

State	Total number of stays	Total out of state		Different HRR	
		Number of stays	Share of total	Number of stays	Share of total
Texas	642,368	959	0.15%	689	0.1%
Utah	50,855	348	0.7%	249	0.5%
Vermont	12,359	2,350	19.0%	607	4.9%
Virginia	111,570	4,522	4.1%	2,171	1.9%
Wisconsin	95,537	3,239	3.4%	1,059	1.1%
Wyoming	10,641	1,449	13.6%	978	9.2%
Total	**6,536,714**	**125,623**	**1.9%**	**62,384**	**1.0%**

Notes: FY is fiscal year. HRR is hospital-referral region. Analysis excludes individuals enrolled in both Medicare and Medicaid and those age 65 and older. Ten states are excluded because of lack of complete managed care encounter data (Alaska, Kansas, Maryland, Missouri, Nebraska, Nevada, Oregon, Rhode Island, Washington, and West Virginia). For more information on our method for classifying out-of-state hospital stays, see Appendix B.

Source: MACPAC, 2020, analysis of FY 2013 Medicaid Statistical Information System data.

Appendix B: Methodology and Data Limitations

Out-of-state hospital stays were examined using fiscal year (FY) 2013 claims and encounter data from the Medicaid Statistical Information System (MSIS). Below we describe the data included in our analysis and our method for classifying out-of-state stays.

Data Included in Analysis

Using MSIS, we examined Medicaid fee-for-service claims and managed care encounter data for inpatient hospital stays that began during FY 2013. Claims that occured on the same, consecutive, or overlapping days were merged into a single stay for this analysis.

Because hospital care for patients dually eligible for Medicare and Medicaid is primarily covered by Medicare, this analysis excluded stays for dually eligible patients and patients over age 65. We also excluded stays without complete data on Medicaid enrollee's age and basis of eligibility.

We excluded data from ten states without complete claims or encounter data for FY 2013:

- three states (Alaska, Kansas, and Rhode Island) had no data for at least one quarter in in FY 2013;
- two states (Nevada and West Virginia) did not have managed care encounter data; and,
- five states (Oregon, Washington, Nebraska, Missouri and Maryland) did not have valid national provider identifiers (NPIs) for at least 80 percent of inpatient hospital stays.

Classifying Hospital Stays

For inpatient hospital stays included in our analysis, we collected information about the hospital's NPI, the enrollee's zip code, and the enrollee's basis of Medicaid eligibility. A total of 6,770,107 stays were identified at this stage of the analysis.

The National Plan and Provider Enumeration System was used to validate each NPI and get information about the zip code associated with the provider's practice location. Zip codes for providers and enrollees were then used to determine the state and hospital referral regions (HRR) for the enrollee and provider and classify out-of-state visits. A total of 233,393 stays (3.4 percent) were excluded because they did not have valid zip code information that could be linked to a HRR.

To provide descriptive information about the types of hospitals that serve out-of-state patients, each hospital's NPI was linked to the CMS certification number (CCN), which was used to identify hospitals in Medicare cost reports. CCN data were not available for 512,407 stays (7.8 percent of the stays in our analysis with valid zip codes).