



Medicaid: Payment Challenges and Solution

Anand Laxman Mhatre

Senior Program Manager / Technical Architect, USA

ABSTRACT

Medicaid claims processing is a painstaking undertaking prone to delays, mistakes, and appeals. These issues are attributable to the inefficiencies of the legacy systems used to process claims. Updates in legacy systems are manual, and the systems are poor in handling reimbursement rate variability across states. Modern comprehensive claims processing systems are designed to address limitations in legacy approaches. These systems automate rates and policy updates and can be configured to handle rate variability across states. This document assesses challenges in Medicaid claims processing and explores the benefits of moving to a modern comprehensive claims processing system.

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Introduction

Medicaid is a novel program that helps patients with limited income and resources cover medical expenses. It is one of the few healthcare programs in the United States that have democratized access to healthcare for middle- and low-income citizens. Although Medicaid is a product of the federal government and has general rules that govern the program, each state has its own Medicaid program, and regulations governing the programs differ across states. The variability of Medicaid regulations across states complicates Medicaid payments, making it difficult for health plan executives to keep up with payment policies and schedules.

Payment Challenges

Payment challenges are synonymous with Medicaid programs. These issues affect healthcare providers, patients, and state agencies responsible for the programs. These issues stem from Medicaid's complex structure, varying state rules, and ever-shifting regulatory landscape. Top Medicaid payment challenges include;

Complex and Varying Reimbursement Rates

Medicaid is funded by the federal government and state governments. This implies states offer varying reimbursement rates. The lack of uniform reimbursement rates obscures the processing of payments [1]. Payers must process payments for patients in different states separately, which is time-consuming and arduous. There is also a challenge of states delaying updating reimbursement rates to reflect inflation and surging healthcare costs. This results in payments that do not match the actual cost of healthcare.

Payment Delays

Reviewing and approving Medicaid claims is a slow and complex process. The process involves extensive documentation and adherence to specific billing codes and procedures. This results in payments delays that harm providers' cash flows. Besides, the payment process is characterized by frequent denials due to technical or procedural reasons. Providers must resubmit claims or make appeals, increasing administrative workload and extending payment timelines [2].

Managed Care Organizations (MCOs) Challenges

States usually contract MCOs to manage their Medicaid programs. Providers have to negotiate contracts with MCOs, which results in discrepancies in payment rates. These discrepancies complicate the billing process, causing delays. Besides, different MCOs have varying payment and authorization policies, which adds complexity to the billing process. This is even worse for providers working with multiple MCOs – they must comply with different rules, causing confusion and further delays.

Eligibility Fluctuations

Eligibility to Medicaid depends on income, employment, or family size. Changes in these factors affect eligibility for the program. Frequent fluctuations in eligibility are problematic to providers – they are at risk of treating patients who are no longer viable for the program, resulting in rejected claims [3]. Also, billing services for retroactively eligible patients is a complicated process vulnerable to delays and administrative burdens.

Contact: Anand Laxman Mhatre, Senior Program Manager / Technical Architect, USA.

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Limitations With Legacy Solutions

Healthcare executives attempt to resolve the aforementioned challenges by increasing the headcount of teams working on claims. Although this may seem a viable solution, evidence suggests that increasing the workforce alone is not a reliable solution. Keeping up with frequent updates and edits on reimbursement rates and policies is an uphill task for the human workforce. Regardless of the headcount, processing teams will always fall behind updates. This will result in slow and inconsistent payments and repeated overpayment recoveries. This can harm payer-provider relationships, which can affect the efficacy of health plans in securing contracts with healthcare providers.

Modern Comprehensive Claims Processing Systems

Although technology has been incorporated in various aspects of claims processing, it is not fully leveraged. Modern comprehensive claims processing systems automates virtually all vital processes in claims processing, reducing workload and expediting payments. These solutions are designed to autonomously keep up with updates in reimbursement rates and policy changes [3]. Comprehensive claims processing systems can also be configured to autonomously process payments per different states' reimbursement rates and MCOs' negotiated rates. Here are some critical ways advanced claims processing systems align claims operations.

- **Automate Updates:** These solutions automatically update reimbursement rates and coding policies, addressing delays and minimizing human errors. Unlike manual updates, these systems can handle frequent updates rather than waiting for quarterly updates. This is particularly useful for organizations that prefer reacting quickly to rates and policy changes.
- **Encapsulate Provider Settings:** The systems can hold each provider's data and apply the data to process claims. For example, the systems can process claims using unique MCOs and providers' negotiated rates. This versatility eliminates the need to piece together multiple data sources.
- **Enhanced Accuracy in Claims Processing:** Advanced claims processing systems are pretty accurate. They process payments using up-to-date rates and edits. The risk of human errors is also eliminated.
- **Reliable Claims Record:** Comprehensive claims processing systems automatically keep a trail of the claims processing course. This provides a complete archive that users can rely on when proving claims pricing results.
- **Reduces the Need for Large Headcounts:** Managing legacy claims processing requires 20 to 20 professionals. Modern claims processing systems based on the cloud obviates the need for large infrastructure support teams.

Legacy Claims Processing System	Modern Comprehensive Claims Processing System
Manual update of reimbursement rates and policies.	Automated update of reimbursement rates and policies.
High susceptibility to errors hence high reworks on claims.	Low susceptibility to errors hence low reworks on claims
Slow response to rates and policy changes	Fast response to rates and policy changes.
Poorly organized claims records.	Neatly organized and easily accessible claims records.
Requires big claims processing teams.	Can optimally function with lean claims processing teams
Negatively affects payer-provider relationships	Can enhance the payer-provider relationship.

Table Comparing Legacy Claims Processing Systems with Modern Comprehensive Claims Processing System

Impact of Comprehensive Claims Processing Systems

Comprehensive claims processing systems are crucial for health plans in various ways. These systems reduce the workload for claims teams. This translates to fast claims processing and reduces the costs of hiring large claims teams. They also enhance accuracy in claims processing, minimizing appeals and reducing payment delays and workloads. It is estimated these systems reduce appeals by 40 percent. Reduced delays and rejections translate to better payer-provider relationships. This creates an environment where providers enjoy working with health plans and enhances the ease of health plans securing contracts with providers. In other terms, comprehensive claim processing systems reduce operational inefficiencies, increasing payment speeds and eliminating provider abrasion.

Conclusion

Medicaid claims processing is a laborious undertaking prone to delays, mistakes, and appeals. These issues are attributable to the inefficiencies of the legacy systems used to process claims. Updates in legacy systems are manual, and the systems are ineffective in handling reimbursement rate variability across states. Modern comprehensive claims processing systems are designed to address limitations in legacy approaches. These systems automate rates and policy updates and can be configured to handle rate variability across states. Health plans that leverage modern comprehensive claims processing systems are assured of fast payments, minimal errors, and improved payer-provider relationships. Are you looking to improve operational efficiency in claims processing? Adopt a modern comprehensive claims processing system and see the workload in your organization reduce and payment processing speed increase tremendously.

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