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# Retro-Eligibility: How the Process Works

Retroactive eligibility is a standard functionality that many providers are already familiar with if they serve uninsured clients and/or Medicaid participants. The purpose of the retroactive eligibility functionality is to update participant eligibility in response to the addition of new coverage, for example when a patient switches from uninsured to Medicaid, and ensure services are charged to the correct funding stream.

Because Medicaid eligibility is retroactive for three months, the retroactive eligibility functionality will automatically update a participant's authorization and flag claims for reprocessing using the participant's revised eligibility.

Claims are paid out of one of two funds, Medicaid and State, depending on the patient's eligibility. These funding sources are outlined below:

## MEDICAID

Covered mental health and substance use services for participants enrolled in or eligible for Medicaid at time of service

## STATE

- Services for eligible uninsured individuals
- Some grant-funded and waiver services
- Non-Medicaid reimbursable behavioral health services available to qualifying individuals:
    - Supported employment
    - Respite care
    - Crisis services
    - Recovery services
    - Residential rehabilitation programs
    - And others

Below is an example of how eligibility switches between these two funds in the retro-eligibility process:

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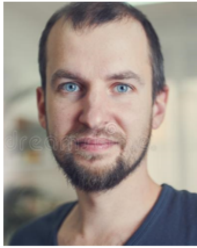
## January 2021



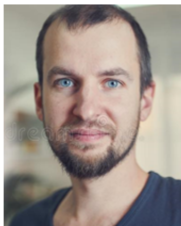
An individual is not enrolled in Medicaid but receives eligible services

Their provider submits authorization and identifies funding source as “Uninsured” at time of service

STATE FUNDS

Once the authorization is approved and the claim is paid, payment is issued to the provider from the State account

## March 2021



The same individual applies for Medicaid and is approved for benefits

The individual’s eligibility status is updated in the system and claims from the 3-month retroactive period are automatically flagged for reprocessing

MEDICAID

The claim for January services is re-processed, at which time the system creates a negative adjustment from the State account for the reprocessed claim and a second payment is issued from the Medicaid account.