Medicare Advantage Plan Payment Obligations to Out-of-Network Providers

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Issue: Medicare Advantage Plan Payment Obligations to Out-of-network Providers

There are a couple of reasons why it is important for providers to understand Medicare Advantage (MA) plan payment obligations to out-of-network providers. First, providers should understand these obligations in order to effectively evaluate if they want to contract with an MA plan and become a network provider. Second, providers may be presented with a situation where an MA plan enrollee receives or seeks services from a provider that is not part of the MA plan's network. In this scenario, providers are often confused on what the payment rate is for the services provided. Many providers wonder if they are entitled to the Medicare Fee-for-Service (FFS) rate, or the rate set under the MA plan for similar providers. This guidance will explore the MA plan payment obligations to out-of-network providers.

CMS Guidance and Analysis

The analysis begins with the Center for Medicare and Medicaid Services (CMS) Medicare Managed Care Manual (Manual). The Manual identifies all the rules that MA plans must follow and how they interact with network and out-of-network providers. The relevant sections of the Manual on this issue are Chapter 4 – Benefits and Beneficiary Protections, and Chapter 6 – Relationships with Providers.

Under guidance outlined in Chapter 6, services furnished by non-contract (or out-of-network) providers must accept as payment in full rates applicable in Original Medicare (a.k.a. FFS Medicare). The relevant language is below:

> Consistent with §1852(a)(2) and §1852(k)(1) of the Social Security Act, non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.
> - Note that non-contract facility providers identified at §1861(u) of the Social Security Act (the Act), which includes hospitals, skilled nursing facilities and home health agencies, must accept as payment in full payment amounts applicable in Original Medicare less any payments under 42 CFR 412.105(g) concerning indirect medical education payment to hospitals for managed care enrollees and 42 CFR 413.86(d) concerning payment for direct graduate medical education costs.
> - In cases where the MA organization has not arranged for the services, if the non-contract provider's bill is less than the Original Medicare amount, the MA organization is only required to pay the billed amount.
>
> In addition, under Federal law, non-contract providers are subject to penalties if they accept more than Original Medicare amounts. (Source: 42 CFR 422.214 and preamble to June 29, 2000, rule.)

See Chapter 6, Section 100 – Special Rules for Services Furnished by Non-Contract Providers (Rev. 24, 06-06-03).

In addition, Chapter 4 states that MA plans must make timely and reasonable payment to non-contract providers and identifies the types of services for which MA plans must pay non-contracted providers, which include:

- Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the beneficiary's health, as provided in section 20.1 of this chapter;
- Emergency and urgently needed services under the circumstances described in sections 20.2 through 20.4 of this chapter;
- Maintenance and post-stabilization care services under the circumstances described in section 20.5 of this chapter;
- Medically necessary dialysis from any qualified provider selected by an enrollee when the enrollee is temporarily absent from the plan's service area and cannot reasonably access the plan's contracted dialysis providers. An MA plan cannot require prior authorization or notification for these services. However, the MA plan may provide medical advice and recommend that the enrollee use a qualified dialysis provider if the enrollee voluntarily requests such advice because he/she will be out of area. The MA plan must clearly inform the enrollee that the plan will pay for care from any qualified dialysis provider the enrollee may independently select. Furthermore, the cost-sharing for out-of-network medically necessary dialysis may not exceed the cost-sharing for in-network dialysis;
- Services for which coverage has been denied by the Medicare Advantage Organization (MAO) and found (upon appeal under subpart M of 42 CFR Part 422) to be services the enrollee was entitled to have furnished, or paid for, by the MAO; and
- Regardless of the MA plan type being offered, arrange for specialty care outside of the network, but at in-network cost-sharing, in order to provide all Medicare Part A and Part B benefits. That is, if an enrollee requires a very specialized covered service that is not provided by the physicians in the network, the plan must arrange for that service to be provided by a qualified non-contracted provider.

See Chapter 4, Section 110.1.3 - Services for Which MA Plans Must Pay Non-contracted Providers and Suppliers **(**Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16).

Section 110.1.3 goes on to further state that in the absence of an agreement between the non-contracted provider and the MA plan, the non-contracted provider must accept the original Medicare amount as payment in full:

> An MA plan (and an MA Medical Savings Account (MSA) plan, after the annual deductible has been met) offered by an MAO generally satisfies its requirements of providing basic benefits with respect to benefits for services furnished by a non-contracting provider if that MA plan provides payment in an amount the provider would have been entitled to collect under original Medicare (see section 170 for guidance on balance billing). MAOs may negotiate payment amounts with their contracted providers and need not follow original Medicare payment rates. However, in the absence of a mutual agreement between the non-contracted provider and the MAO to receive less than the original Medicare rate, non-contracted providers must accept the original Medicare amount as payment in full.

This section also directs providers to additional information contained in the MA Payment Guide for Out-of-network Payments. This document contains guidance for skilled nursing facilities as well as a variety of other provider types.

Finally, providers need to be aware of the type of MA plan the resident is enrolled in and any unique rules to that type of plan as well as any special billing obligations for services under a specific plan. These issues are addressed in various sections of Chapter 4 of the Manual and include the following sections:

Section 110.5 – Special Rules for RPPOs

Section 110.7 – Access, Gatekeeper and Cost-Sharing by Plan Type

Section 170 – Balance Billing

Moreover, MA plans must clearly communicate to enrollees through the Evidence of Coverage (EOC) and Summary of Benefits (SB) their cost-sharing obligations as well as the enrollees' lack of obligation to pay more than the allowed plan cost-sharing. For information about payments to providers that have "opted-out" of Medicare, refer to chapter 6 of the MMCM, Relationships with Providers.

Return to Home

One additional issue providers need to be aware of when interacting with MA plans and residents with MA plans is the "return to home" provision in the law. Added in 2000, this provision addresses the rights of a resident of a life plan community or skilled nursing facility (SNF) to return to their home SNF after a hospital stay, even if their SNF is not part of the provider network of the Medicare Advantage plan they are enrolled in. However, the home SNF must either have a contract with the Medicare Advantage plan or be willing to accept payment similar to what the MA plan typically pays their network SNFs (which may be less than Medicare FFS rates). More information on the return to home provision and how it impacts providers.

Resources

Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS019326.html

Manual Chapter 4: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

Manual Chapter 6: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c06.pdf

MA Payment Guide for Out-of-network Payments: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf