

News Release

For Immediate Release

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New Report Shows Need for National Medicaid Out-of-Network Claims Policy

Washington, DC; July 16, 2009 — [The Lewin Group](#) today released a new report assessing the financial impact and administrative burden that out-of-network claims pose in Medicaid managed care. The authors of the report recommend a federally mandated payment standard for Medicaid health plans similar to that used in the Medicare Advantage managed care program.

The report, “*Medicaid Non-Emergency Out-of-Network Payment Study*,” was commissioned by [Medicaid Health Plans of America \(MHPA\)](#) and the [Association for Community Affiliated Plans \(ACAP\)](#). The report examined Medicaid non-emergency out-of-network payment policies in Arizona, California, Florida, Georgia, Maryland, Nebraska, New Jersey, New York, Pennsylvania, Tennessee, Texas and Wisconsin. Investigators found that out-of-network claims represented at least 8 percent of total Medicaid claims costs, with most out-of-network claims disputes coming from hospitals, pediatric subspecialty providers, academic medical centers and other public hospitals.

The study notes that Medicaid is unique with regard to out-of-network services and payment because providers cannot “balance bill” Medicaid members for covered services. “In the absence of a clear payment policy, providers will often bill the health plan for full charges and an unwelcome negotiation then ensues as both parties seek to arrive at a mutually acceptable amount,” noted Debbie Kilstein, ACAP’s Director of Quality Management and Operational Support.

Evelyn Murphy, the Lewin study’s principal author, emphasized that “Ultimately, states and taxpayers are the ones paying at commercial, or even above-commercial, levels for much of the out-of-network care rendered to Medicaid enrollees. Federal legislation has successfully addressed this problem in the Medicare Advantage program and with Medicaid emergency care. Our study finds that it is important to fix this loophole for all remaining Medicaid out-of-network care as well.”

“We need a solution that is fair, predictable, and encourages providers to contract with health plans,” said Thomas Johnson, executive director of MHPA. “Contracting with providers is always the preferred scenario for Medicaid health plan members to realize the full benefits of care coordination. In the small subset of claims that are out-of-network, we support Lewin’s recommendation to set payments at fee-for-service rates. A national policy setting all out-of-network payment at each state’s underlying Medicaid fee-for-service rates would reduce cost for health plans, Medicaid and taxpayers. It would also align Medicaid policy with Medicare. A clear, consistent policy would advance the goals of our health plans, which is to provide broad access to providers that are culturally competent and convenient for their members in their communities,” said Johnson.

Section 6085 of the Deficit Reduction Act of 2005 (Pub. L 109-171), also known as the “Rogers Amendment,” set payment for emergency services provided by Medicaid health plan out-of-network providers at the Medicaid fee-for-service rates in each state. Lewin found the policy has generally been effective in establishing reasonable payments for out-of-network emergency services and in preventing disputes over payments.

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