



Medicaid Non-Emergency Out-of-Network Payment Study

Prepared for: Medicaid Health Plans of America and Association for Community Affiliated Plans

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Table of Contents

I. INTRODUCTION.....	1
A. Lewin’s Approach to the Study.....	2
II. DISCUSSION	3
A. Non-Emergency Out-of-network Payments.....	3
B. Regulation and Policy Surrounding Out-of-Network Payments	7
C. Perspectives on Policy/Regulatory Challenges and Opportunities	8
III. RECOMMENDATIONS.....	9
APPENDIX A: Data/Information Collection Tool	A-1
APPENDIX B: Summary o Select States’ Medicaid Out-o-Network Payment Policies	B-1

I. INTRODUCTION

The Medicaid Health Plans of America (MHPA) and the Association for Community Affiliated Plans (ACAP) hired The Lewin Group to analyze non-emergency out-of-network claims and payment issues, including quantifying the magnitude of the problem to the extent data are available from health plans, and assessing the qualitative impacts of the problem. Ultimately, MHPA and ACAP requested that Lewin provide policy recommendations to address the issues and challenges identified.

As a condition of participation in Medicaid managed care programs, states require health plans to develop a network of providers to assure access to Medicaid covered services within a plan's service area. Even with an extensive network, some out-of-network services do and will occur for a variety of reasons, ranging from emergency circumstances to situations where only one service provider is available in the area to provide the service needed. These out-of-network services can pose significant challenges for a variety of reasons:

- Out-of-network services can pose challenges to the health plan in managing member care in a cost-effective manner, because of the lack of an established utilization management and quality management relationship between the health plan and the provider.
- The non-existence of a contract between the health plan and the provider may create an opportunity for the provider to expect payment for their “usual and customary charges” that are far higher than the Medicaid payment the provider would have received for the same service if they were in-network. To the extent health plans are paying for out-of-network care at “above Medicaid” prices, the ultimate bearer of this additional cost may be the state Medicaid program, depending on the state's rate-setting methodology.
- Lack of clear payment terms eliminates the predictability of the payment the health plan would make for services rendered to a Medicaid member, pitting the provider and the health plan against one another to arrive at a mutually agreeable amount. This adversarial process is unpleasant for all involved parties and is also administratively costly.
- Providers are prohibited from billing Medicaid members for Medicaid covered services in accordance with Medicaid regulations. In cases where providers inappropriately bill members, MCOs must make efforts to request that the provider submit the claim to the MCOs and attempt to negotiate a payment rate. When an agreement cannot be reached these disputes can also escalate to litigation. Situations involving high cost cases (e.g., transplant and other services provided in the inpatient setting) can have significant financial implications for health plans and the Medicaid program.
- The occurrence of a large volume of out-of-network services may be indicative of any of the following issues (or oftentimes a combination) thus aggravating the impact:
 - Regional or statewide access deficiencies, due to a capacity shortfall among certain types of providers;
 - Perceptions that Medicaid does not pay enough leading to non-participation in the Medicaid program in its entirety, even though the health plan often pays a higher reimbursement rate than the fee-for-service system; or

- Shortfalls or “holes” in the health plans contracted provider network.

Health plans have attempted to address some of these challenges in a variety of ways, including:

- Periodically reviewing their provider network and claims data, identifying providers who routinely refer members out-of-network and providing education; and
- Identifying providers to whom members are consistently referred for out-of-network services and actively recruiting those providers in network, or negotiating case agreements for future services.

While all of the challenges discussed above are significant, the financial impact and administrative burden that out-of-network claims pose to the health plan is the primary focus of this study.

A. Lewin’s Approach to the Study

Our approach to this study included the following major components:

- We researched several states’ Medicaid out-of-network payment policies to gain an understanding of the scope and variation of payment policies in managed care programs. The selected states included Arizona, California, Florida, Georgia, Maryland, Nebraska, New Jersey, New York, Pennsylvania, Tennessee, Texas and Wisconsin.
- We interviewed individuals with knowledge and experience with out-of-network claims payment issues (including health plans, providers, and internal Lewin staff) to gain insight on the impact of the policies on states, health plans, and providers, how managed care entities have reacted to the policies, and the challenges and successes in implementing the policies.
- We collected information from health plans about their experience with out-of-network issues, including:
 - The proportion of claims and payments that occur out-of-network; the proportion of their out-of-network payments relative to what they would have paid for the same services had they occurred in-network (over the most recent twelve month period for which data were available);
 - The extent to which out-of-network services vary by provider type or population; their experience with states’ out-of-network policies and challenges, particularly with respect to provider claims and payment (we did not specifically address member balance billing policies, although issues do often arise with members being inappropriately billed for out-of-network care);
 - Their experience with the Deficit Reduction Act (DRA) emergency services out-of-network regulation; the administrative burdens associated with having/not having state or national policies on out-of-network payments; and
 - Their perspectives on having a national policy, including specific topics the policy must address.

Our data/information collection tool is provided as **Appendix A**.

II. DISCUSSION

A. Non-Emergency Out-of-Network Payments

For purposes of this study, we limited our discussion to non-emergency services as those are not governed by the Deficit Reduction Act. Section 6085 of the Deficit Reduction Act of 2005 (Public Law 109-171, commonly referred to as the “DRA”) governs emergency out-of-network services. It requires Medicaid health plans to pay non-contracted providers the same rate as the provider would have been paid if the services were provided in the fee-for-service environment.¹ This regulation has been effective in establishing payment for these providers, both in-state and out-of-state. Both through our interviews and limited data, we found that out-of-network emergency services posed the fewest challenges for health plans. We provide more information about the DRA later in this report.

1. *Summary of the Problem*

Health plans enter into negotiated contracts with a network of providers to assure access to quality care for their members in the most appropriate, cost-effective manner. Health plans may also negotiate “agreements” with providers not considered to be “participating providers;” this includes agreements with providers who are out of the health plan’s state-contracted Medicaid managed care service area to whom the health plan may regularly refer patients for services. While these agreements are with out-of-network providers, if these types of agreements set out the payment terms for services, they do not, for the most part, pose claims/payment challenges to the health plans and providers involved. However, in the absence of a contract or regulatory guidelines, payments for out-of-network care frequently require case-specific negotiation between the involved parties, a costly and oftentimes unpleasant adversarial process. Also, in the absence of contractual payment rates, many providers expect payment in full for “usual and customary charges” which are often vastly higher than costs, and even commercial payment rates.

For the purpose of our study, we narrowly define non-emergency “out-of-network” claims/payments to include those claims/payments that are the result of services rendered to a health plan’s members by a provider for whom the health plan has no contract or agreement with pre-established payment terms. The following are examples of circumstances in which these non-emergency out-of-network claims/payments may occur:

- Out-of-network Medicaid covered non-emergency services rendered by a provider in state (including out of the health plan’s service area); and
- Out-of-network Medicaid covered non-emergency services rendered by a provider out-of-state.

¹ 42 USC 1396u-2(b)(2)(D) provides as follows: “Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity’s Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.”

In either of the above cases, the provider may or may not be participating in the Medicaid program, or may be participating in a Medicaid program in a state that is different from the health plan state. This adds another level of complexity to the issue because it limits the plan's ability to tie the provider to the Medicaid payment rate as the provider has no contract with the state's Medicaid program. As a result of the limited data sample available for this study, we cannot draw any conclusions as to the magnitude of the problem. However, we are able to draw general observations from data that are informative in identifying opportunities for policy solutions.

First, the proportion of out-of-network claims to total Medicaid claims and the proportion of out-of-network claims by service to total out-of-network claims vary widely. We received data for out-of-network claims representing anywhere from 8 percent to 21 percent of total Medicaid claims. While there is a wide range in the proportion of out-of-network claims to total Medicaid claims, the out-of-network claims occur primarily for hospital-based care and involve high cost cases. In addition, providers identified as most often having out-of-network claims payment disputes with Medicaid health plans included hospitals, pediatric subspecialty providers, academic medical centers, and other public hospitals.

The wide variance in the proportion of out-of-network claims to total Medicaid claims does not in any way diminish the negative financial impact because these claims predominantly involve high cost cases (e.g., transplant and other services in the inpatient setting).

Second, out-of-network claims are more likely to come from in-state providers than out-of-state providers.² Generally, the volume of out-of-state out-of-network claims is, often, primarily related to the health plan location. In some parts of the U.S., there are strong interdependencies across state boundaries. Examples of such geographic areas are northern and southern New Jersey (with out-of-network services being provided to New Jersey residents by New York City and Pennsylvania providers, and vice versa), as well as Maryland, Virginia and the District of Columbia (where DC Medicaid residents receive out-of-network services from Maryland and Virginia, and vice versa). In these geographic areas, out-of-network services are more likely to occur "out-of-state."

Overall, we found no evidence that certain populations are disproportionately responsible for using services out-of-network. Regardless of the circumstances, except for emergency services governed by the DRA, out-of-network services raise different issues and challenges which we discuss, for Medicaid/CHIP programs as well as for health plans and providers.

2. Implications for the Medicaid/CHIP Programs³

Health plans interviewed stressed that while out-of-network claims in proportion to total Medicaid claims may not be significant, the financial impact on the Medicaid program can be significant.

² From the data we received, seven percent to 65 percent of out-of-network claims occur in-state and in the health plan's service area. In comparison, 33 percent to 60 percent come from in-state, but outside the plan's service area.

³ For purposes of this study, we use the term CHIP interchangeably with Medicaid, to include programs that are implemented as Medicaid expansions; about one-half of states have CHIP as Medicaid expansions. We did not investigate the impact of out-of-network claims in separately-run CHIP programs.

Historically, the Medicaid fee-for-service program covers less than the actual cost of providing services, in comparison to Medicare and private payers. For example, in 2001, according to the American Hospital Association, Medicaid payments were 91.3 percent of costs compared to Medicare which paid 98.4 percent of costs, and private payers which covered 116.5 percent of costs. By 2006, Medicaid paid even less than Medicare and private payers; specifically Medicaid payments covered only 85.8 percent of hospital costs compared to Medicare which covered 91.3 percent of costs, and private payers which covered 130.3 percent of costs.⁴ Given the differences in payment levels, providers (and in particular hospitals) have little incentive to accept Medicaid payment in the absence of a negotiated contract or other agreement with the health plan, which may often pay more than the provider would receive in the Medicaid fee-for-service program.

While we did not request or review out-of-network claim-level data, our interviewees expressed concern regarding out-of-network providers expecting full payment based on their usual and customary charge which is at a minimum equal to, but in most instances significantly greater than what the health plan would pay their in-network providers.

Even though health plans generally pay higher rates than Medicaid fee-for-service, the differences in overall payment levels when compared to other payers further accentuate the inequity of Medicaid funding being used to pay some providers higher than payments under the same program for the same service for the same member, in-network. Furthermore, as Medicaid managed care programs are established prospectively, higher payments for out-of-network services could inappropriately skew future capitation rates, assuming the capitation rates are based on actual provider reimbursement. The extent to which higher out-of-network payments by the health plan to the provider impacts the capitation rate that Medicaid pays to health plans over time, would depend largely on each state's capitation rate-setting methodology.

3. Implications for Health Plans and Providers

As mentioned earlier, the DRA provisions regarding payment for out-of-network emergency services has leveled the playing field for health plans and providers with respect to these types of services. While there are differences from state to state in the size of the Medicaid payment for emergency services, there is greater predictability of expected payments within a given state, and among health plans and providers. Thus, since implementation of the DRA policy, emergency services provided out-of-network no longer pose significant payment disputes or challenges for Medicaid health plans. Similarly, federal regulations stipulate that Medicare health plans are required to pay providers at the Medicare payment rate for all out-of-network care.^{5,6}

⁴ "TrendWatch Chartbook 2008", American Hospital Association.

⁵ **42 CFR § 422.214 Special rules for services furnished by noncontract providers.**

(a) **Services furnished by non-section 1861(u) providers.** (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare. (2) Any statutory provisions (including penalty provisions) that apply to

In contrast, Medicaid-covered, non-emergency out-of-network services pose a different set of challenges, primarily because there is no federal law or regulation currently governing how these services should be reimbursed. Some states have taken steps to enact legislation, promulgate regulations, impose out-of-network payment terms in health plan contracts, or otherwise provide policy guidance to govern how health plans pay for out-of-network services. We discuss select state policies in more detail later in this report. In states where there is no policy, providers bill their usual and customary charges, which are usually significantly higher than the Medicaid fee-for-service reimbursement, and health plans have little leverage in negotiating reimbursement at or near Medicaid payment levels. In extreme cases (e.g., where the health plan refuses to pay charges) the situation can escalate to legal action with both sides incurring more costs in the form of attorney's fees up to settlement, or until final resolution through litigation.

The complexities of out-of-network, non-emergency services are further accentuated when provided out-of-state. These cases usually occur when members receive services from bordering states and create the greatest challenge for the health plan. When

Provider expectation of payment close to charges is a strong disincentive for providers to join Medicaid health plan networks which present a significant barrier to members' access to care.

the out-of-network provider is enrolled in the state's Medicaid program, we found through our interviews that health plans have argued that as a state Medicaid provider, they are tied by the state's Medicaid requirements regarding reimbursement, and barring the existence of a contract to the contrary, they cannot be reimbursed at a higher rate than what would be paid in the Medicaid fee-for-service program. This has provided some leverage to the health plan in negotiating payments. Medicaid agencies' involvements in providing clarification regarding Medicaid payment policies generally help facilitate resolution.

While health plans have raised Medicaid member protection requirements against providers who inappropriately bill their Medicaid patients (i.e., Medicaid providers must accept Medicaid payment as payment in full) in an attempt to lower payment (below charges), this has not generally been successful. It is important to note that this is in contract to the commercial world, where members are often faced with partial or total financial responsibility for accessing out-of-network care, without referral. Despite efforts by Medicaid health plans to raise member protection issues on behalf of the member, if the provider is not a Medicaid-certified provider, the health plan has even less leverage as the provider is not bound by any Medicaid contract.

payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

b) **Services furnished by section 1861(u) providers of service.** Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §412.105(g) and §413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 4724, Jan. 28, 2005; 70 FR 47490, Aug. 12, 2005]

⁶ Social Security Act, Section 1861(u). The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program.

B. Regulation and Policy Surrounding Out-of-Network Payments

1. Federal Regulation

Emergency out-of-network services pose the fewest challenges for health plans, providers, states, and members. Section 6085 of the Deficit Reduction Act of 2005 (Public Law 109-171), effective January 1, 2007, mandates that payments for emergency services to providers who do not have a contract with the Medicaid managed care plan but provide services to plan members must be limited to the payment the provider would have received in the Medicaid fee-for-service program (less any payments for indirect costs of medical education and direct costs for graduate medical education). Furthermore, the DRA mandates that if a state keeps payment rates confidential, payment to out-of-network hospital providers must be limited to the average contract rate for tertiary hospitals under the fee-for-service program in the state.

In addition, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states (SMDL #06-010) which further specified that out-of-network providers of emergency services to health plan members must accept the payment (described above) as payment in full. This prohibits the provider from balance billing the member. The DRA provisions are applicable regardless of whether the out-of-network provider is located in or out of the state in which the Medicaid health plan has a contract. Finally, the DRA makes no distinction between Medicaid and non-Medicaid providers, thus we assume that the regulation will also be applicable to non-Medicaid providers. As the DRA provisions have been in effect for only a year, there is no data or information currently available on its financial impact on payments for emergency out-of-network services.⁷ However, our interviews suggest that the policy has been effective in establishing reasonable payments for out-of-network emergency services, and in preventing disputes over the payment amount from routinely occurring.

We found one instance through our interviews in which an out-of-state hospital provider refused to bill a health plan for emergency services provided and chose to bill the member. Even so, if the providers were to bill the plan, they would be required to accept the Medicaid fee-for-service reimbursement payment for the services provided. While there are no specific enforcement provisions tied to this DRA provision, generally, Medicaid providers are by contract, required to abide by all applicable state and federal regulation governing the program. Presumably, existing sanctions for noncompliance with payment requirements, up to and including provider contract termination, subject to due process requirements, could be applied. In our study, we have found no examples of enforcement action taken against a provider or a health plan that was non-compliant with the DRA provision.

2. State Policy/Regulation

State policies vary widely based on a number of factors, such as whether the out-of-network service is in-state or out-of-state, the type of service, and the payment level. Among the states'

⁷ The Congressional Budget Office (CBO) estimated that the changes in payment would reduce Medicaid spending by \$15 million in 2009 with a total reduction of \$130 million in 2006-2015.
www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf.

policies we reviewed, we identified two prevalent policy directions to limiting the amount paid for out-of-network services:

- Payment may be tied to the Medicaid fee-for-service rate, or
- Payment may take into consideration the amount the plan would have paid for the same service in-network.

In general, we found that policies addressed hospital services (inpatient and outpatient) and self-referral services. Among the states reviewed, few specifically addressed out-of-network services provided outside state boundaries. New Jersey, however, specifically addresses out-of-network, out-of-state hospital payments. As stated early, this is likely a result of many New Jersey residents' proximity to providers "across the river" in New York and Pennsylvania (and vice versa). In some states, payment for out-of-network, non-emergency services are permitted only with prior approval (e.g., Florida and New Jersey). Conditioning payment on prior approval allows for a modicum of service coordination, thus allowing continuity of care and appropriate management of service utilization by the plan.

One critical aspect of states' policies that tie payment to the Medicaid fee-for-service rate is the inclusion of a method for the health plan to access or otherwise discern what that rate would be. In California, for example, individual hospital rates are confidential. However, California's policies governing payment for out-of-network emergency and non-emergency hospital care are based on regional per diem rates, which are published annually. This creates transparency of expected payment for all parties (providers, plan, and state). A summary of selected states' policies is provided in **Appendix B**.

C. Perspectives on Policy/Regulatory Challenges and Opportunities

Several themes emerged from our interviews with health plans (including provider-based plans) regarding out-of-network claims/payments. These themes were helpful in crafting recommendations for addressing the out-of-network claims/payment issues raised by MHPA and ACAP.

- **Payment Amount:** Given the differences in payment levels between Medicaid and private pay, and because Medicaid pays lower than cost in comparison to Medicare and private pay, providers have little incentive to bill for, or accept Medicaid payment barring a contract or other mandate requiring that they accept Medicaid payment. Out-of-network services provided out-of-state will likely remain a challenge unless there is a national payment policy governing out-of-network services, similar to the DRA policy on emergency services.
- **Network Participation:** At least two states, Georgia and Texas, have stipulated that providers will receive less than the Medicaid rate for out-of-network care, as an incentive for providers to participate in the Medicaid health plans' networks.
- **Transparency:** In states where the Medicaid program has a policy to guide payment for out-of-network services, the state must provide options for the plan to determine or obtain the fee-for-service rate for the same type of services. The level of transparency that is afforded to the health plan and the provider about the expected rate is an important component to determining what the payment should be.

- **Provider Behavior:** Out-of-network providers have an expectation that they should be paid charges for services provided to members. Thus, providers routinely expect payment from health plans based on their charges and have no incentive to accept lower payment. Health plans feel they have no recourse when providers refuse anything other than charges. When the health plan fails to pay, providers may inappropriately bill the member for the services provided.
- **Care Management:** Out-of-network claims reduce the ability of health plans to coordinate care for their members. In addition, because there is no contract between the provider and the health plan, the provider is not subject to the same utilization management and quality assurance provisions that in-network providers are subject to, and the health plan has no leverage to require that the provider comply with care management protocols.
- **Administrative Burdens:** Regardless of the volume of out-of-network claims, they consistently impose a significant administrative burden on health plans to resolve. Resolution usually requires substantial staffing resources, including the director of contracts and utilization/quality management staff, and could involve legal interventions.
- **Enforcement:** There should be an enforcement mechanism to assure that providers comply with states policies governing out-of-network payments in order for the policies to be effective.

Because of the limited sample of information we reviewed (primarily from single state plans), we expect that experiences of multi-state health plans may not all be reflected in the above discussion.

III. RECOMMENDATIONS

The scope and quantity of out-of-network claims/payments vary widely as shown in our findings. This variation is the result of several factors including, for example, variations in Medicaid programs and reimbursement levels from state to state, as well as other state or regional variations with respect to provider access.

Irrespective of these variations, a consistent theme that emerged from our review is that Medicaid payment levels, within a state, should not vary significantly for the same type of service provided to a Medicaid beneficiary simply because a provider chooses to not participate in a managed care network. In fact, allowing wide ranging differences in how providers are paid depending on their participation in-network, versus in Medicaid fee-for-service, provides a disincentive for providers to join a health plan network, creates administrative burdens on all involved parties, and increases the costs of state Medicaid capitated programs. Thus, our recommendations are based on the following guiding principles:

Any provider that does not have a contract establishing payment amounts for services furnished to a Medicaid beneficiary enrolled in a Medicaid MCO, must accept, as payment in full, the lower of what the provider would collect if the beneficiary were in FFS, or billed charges.

- Payment for out-of-network care made on behalf of Medicaid MCO enrollees should be at or very near the *Medicaid* payment rate in that state for that service. Whatever providers' concerns about Medicaid payment adequacy may be, the MCO enrollees are

Medicaid beneficiaries and the funding streams on which capitation rates are derived should reflect a Medicaid environment.

- The amount to be paid in a Medicaid MCO out-of-network situation should be *established in advance* through the regulatory process and made available to all involved parties. In the absence of this guidance, providers and health plans are forced into adversarial and often costly negotiation about what the appropriate payment amount should be.

Using the above guiding principles, we developed recommendations to address the issues and challenges that plans face with respect to out-of-network services/claims and to ensure access to necessary services. Based on the interviews we conducted, we found that the DRA has been effective in controlling the payment level of out-of-network emergency services for health plans. First, it discourages providers from expecting payment of full charges for services provided to members enrolled in a Medicaid health plan and, even though providers bill their full charges for the services, the plan is only obligated to pay up to the amount the provider would receive if the service were provided in the Medicaid fee-for-service environment.

Thus, following the DRA model as well as Medicare, we recommend a **national policy for non-emergency out-of-network services** as well. This closes the loop on out-of-network payment policy in the Medicaid program and

Medicare sets a precedent for federal policy limiting payment for both emergency and non-emergency out-of-network services to the program's fee-for-service rate.

creates an incentive for providers to participate in the Medicaid health plan networks. Although services other than those provided in the hospital setting did not appear to be a significant issue, our recommendation extends beyond inpatient and out-patient hospital services.

In recognition of the fact that the administration of each state Medicaid managed care program varies, it is important to build some flexibility for states to determine the payment range for out-of-network services, and how best to operationalize a policy governing payment for out-of-network services. Overall, a broad based policy, with built-in flexibility for states to account for differences in state Medicaid programs, would significantly reduce the administrative and financial burdens, both for providers and health plans, in resolving out-of-network claims/payment issues. For example, states that seek to build in incentives for providers to contract with health plans may choose to establish out-of-network payment levels slightly below or at the Medicaid fee-for-service rate as an incentive for providers to contract with health plans who would then negotiate higher rates with the provider. With respect to how the policy is rolled-out, states may opt to address specifics through changes in legislation, rulemaking, or provider or health plan contracts. **Figure 1** provides a summary of the components of our policy recommendations.

Figure1
Summary of Recommendations

Topic Area	Issue	Recommendation
Payment Amount & Network Participation	1. Not all states have a policy governing payment for out-of-network services that occur in-state. This creates a disincentive for providers to participate in managed care plans, as providers may feel they have access to full charges or other amounts well above Medicaid FFS rates for the care they render on an out-of-network basis.	Establish a Federally mandated payment level for Medicaid MCOs to pay when covered services occur out-of-network. For example: <ul style="list-style-type: none"> ▪ Payment would be at the Medicaid fee-for-service rate. States can be given the latitude to modify this provision within a ten percentage point corridor. For example, states could require that MCOs pay as little as 90% of the Medicaid FFS rate (as occurs in Georgia), however the MCO should be restricted to paying no more than the 100% of the FFS rate. ▪ In no event should plan be required to pay more than billed charges.
	2. States' Medicaid programs and payment levels can vary significantly. Policy should address how out-of-state services may be paid.	Require that one of the following payment policies apply: <ul style="list-style-type: none"> ▪ Payment would be made at the same amount the State Medicaid agency (in the enrollee's home state) would have paid had the beneficiary been covered by FFS Medicaid. (Most states have arrangements and policies for paying out-of-state providers.) ▪ If no such payment rate/policy exists, the required payment amount would become the established payment rate in the Medicaid program in the state in which the provider entity is based.
Transparency	3. In states that do have payment policies tied to the Medicaid fee-for-service rate, plans may face challenges in determining what the rate is as provider-specific rate information may be confidential and not readily accessible to plans.	A national policy should require states to provide access to the Medicaid fee schedule such that the underlying amount a Medicaid program will pay for a given service can be discerned by the Medicaid MCOs and the provider community.
Provider Behavior	4. Barring a federal law, it is difficult to control provider expectations/behavior for providers that do not have a Medicaid provider agreement. However, payment expectations for out-of-network services can be established in the contracts for Medicaid (non-MCO participating) providers.	As a condition of participating in the Medicaid program, providers enrolled in a state's Medicaid fee-for-service program should expect to receive payment from managed care plans for out-of-network service that is limited to the Medicaid fee-for-service payment amount for the service.

Topic Area	Issue	Recommendation
Care Management	5. Out-of-network services reduce the ability of plans to manage members' care.	States should develop policies requiring Medicaid-certified providers to notify the health plan if a service is being provided out-of-network and requiring the health plan to coordinate with the provider to transition the member "in-network" if appropriate.
Administrative Burdens	6. Both providers and health plans spend significant time and effort attempting to resolve out-of-network issues.	States should require that health plans assure that out-of-network providers have access to the same due process/appeals procedures established by the health plan in resolving claims disputes.
Enforcement	7. Health plans expressed some concern regarding whether/how they would enforce payment provisions.	Providers enrolled in the Medicaid program should be subject to the same provisions that the state has in place regarding compliance with other payment requirements in the Medicaid program.

APPENDIX A: DATA/INFORMATION COLLECTION TOOL

Medicaid Out of Network Study: Blinded MCO Data/Information Request

All information provided will be confidential and not disclosed to any entity

Organization Name:

Respondent Name/Title

Respondent Contact

(Contact information requested for follow up by Lewin if needed)

1.A. Approximate Total Medicaid Enrollment as of October 2008

1.B. Approximate Total Medicaid Enrollment under age 19:

2.A. Approximate Total Medicaid Enrollment for period for which data is provided in answers to questions below

2.B. Approximate Total Medicaid Enrollment under age 19 for the period for which data is provided in answers to questions below

1. Across your Medicaid membership, what percentage of your medical claims expense was for services rendered by out-of-network providers? (Use any recent timeframe for which data are available; please define the timeframe used in your response.)
2. Across your Medicaid membership, are there particular populations that disproportionately use out-of-network services? (Please quantify the size of the problem for a defined timeframe).
3. For out-of-network services, approximately what was the aggregate paid amount relative to what would have been paid for these services had they occurred in network for the same time period used above? (e.g., 115% of prevailing Medicaid, 125%, etc.) If possible can you break it out by Emergency versus Non-Emergency Out-of-Network paid amounts
4. Approximately what was the aggregate paid amount for out-of-network services relative to what would have been paid at the underlying Medicaid fee-for-service payment schedule for the same time period?
5. To what degree is your out-of-network care occurring:
 - a. out-of-state;
 - b. in-state, but outside your MCO's service area; and
 - c. in-state and inside your service area?(Please respond in terms of dollar outlays for the same time period above.)
6. Are specific provider types (e.g., certain types of hospitals, physician specialties, etc.) or services (heart transplant, outpatient dialysis, etc) disproportionately responsible for the out-of-network claims expenses that are paid at what you believe are inappropriately high rates for services rendered to a Medicaid recipient?

If so, please describe these provider types, quantify (if possible) the magnitude of the problem you are having with these providers, and describe the efforts you have undertaken to address these challenges.

7. Describe the process for determining whether a claim will be paid for an out-of-network event.

How often is this process creating a large administrative burden for your MCO (and/or for the provider)?

How prolonged do these discussions/negotiations become?

How often do they escalate into legal conflicts?

8. Does your organization's contract with the State Medicaid agency provide any guidelines or regulations for reimbursement of out-of-network, non-emergency services? If yes, describe what they are.

How have these guidelines or regulations been working?

Has your organization been able to operationalize them effectively?

9. What has your organization's experience been with the Emergency Room policies or regulations that define payment parameters for out-of-network care? Describe these out-of-network payment policies/regulations.

How have these new policies worked for hospitals, in your opinion?

To what degree might these ER payment policies serve as a useful model to expand to other provider types?

Are you aware of any concerted efforts to overturn these ER policies?

Have you observed any changes in the amount of out-of-network ER care that occurs under the new payment policies versus beforehand?

10. What steps has your organization undertaken to effectuate change among the Medicaid population who are high users of out-of-network services?

How effective have steps taken been in changing member's use of out-of-network services?

11. What suggestions do you have for designing new payment policies for out-of-network care rendered to Medicaid MCO enrollees?

12. What examples can you offer as to policies and/or approaches that have worked well with regard to out-of-network payments?

You may contact _____ at _____ or ____@lewin.com if you have any questions. Please provide answers via email to _____ by ____<date>_____.

APPENDIX B: SUMMARY OF SELECT STATES' MEDICAID OUT-OF-NETWORK PAYMENT POLICIES

State	Policy Description for Out-of-Network Services	
	In-State Providers	Out-of-State Providers
Arizona	<p>Plans are required to reimburse out-of-network providers only if the service is emergent or if the plan refers the member for the out-of-network service. Payment for out-of-network services includes in-state inpatient hospitals and in-state outpatient hospitals, according to AZ payment methodologies established by rule.</p> <p><u>References:</u> Arizona Administrative Code R9-22-705 governing payment in general. R9-22-705 rural hospital payments. R9-22-718 urban hospital payments. ARS §36-2903.01 governing rate methodologies.</p>	<p>Health plans must pay out-of-state inpatient and outpatient hospital services as follows:</p> <ul style="list-style-type: none"> • Covered <u>inpatient</u> services covered charges multiplied by statewide urban cost-to-charge ratio established by rule. • Covered <u>outpatient</u> services covered charges multiplied by statewide outpatient cost-to-charge ratio. <p><u>References:</u> R9-22-705 and R9-22-712.</p>
California	<p>Consistent with the DRA, effective 7/1/08, Medi-Cal plans must pay non-contracted hospitals for <u>emergency inpatient</u> services according to the average Standard Consolidated Statistical Area rate for the last year reported by the CA Medical Assistance Commission (CMAC). In CA, inpatient hospital payment rates are confidential for 4 years and Medi-Cal plans cannot compel hospitals to disclose the rate. Therefore, the state calculates the average rates for the purposes of the policy based on the unweighted average inpatient hospital per diem rates, trended forward. These rates are published annually by CMAC and provided to the legislature.</p> <p>For <u>post-stabilization</u> services following an emergency admission, plans must pay non-contracted hospitals the Medi-Cal fee-for-service rate for general acute care inpatient services.</p> <p>The fee-for-service rate is the lesser of:</p> <ol style="list-style-type: none"> 1. The hospital's cost-based interim percentage rate reduced by 10 percent or the hospital's regional average per diem rate for tertiary hospitals, or 2. The hospital's applicable regional average per diem rate for tertiary or non-tertiary hospitals, reduced by 5 percent. <p>For hospitals that do not qualify as small and rural hospitals, but are exempt from the "lesser of" requirements, the fee-for-service payment is based on (1) above.</p>	<p>No specific provisions for out-of-state, out-of-network providers. (Payments are tied in part to the non-contracted hospital's location in the state).</p>

State	Policy Description for Out-of-Network Services	
	In-State Providers	Out-of-State Providers
	<p>Hospitals that qualify as small or rural are paid in accordance with (1) but without the 10 percent reduction.</p> <p>The cost-based interim percentage rate for the purposes of (1) is available from DHCS and the state calculates and publishes the regional average per diem rates reduced by 5 percent for the purposes of (2).</p> <p><u>References:</u> Welfare and Institutions Code Sections 14091.3 and 14166.245. DHCS, MMCD All Plan Letter 08-008, "Reimbursement for Non-Contracted Hospital Emergency Inpatient Services", October 2, 2008. DHCS, MMCD All Plan Letter 08-010, "Hospital Payment for Medic-Cal Post Stabilization Services", November 10, 2008.</p>	
Florida	<p>The plan is not liable for non-authorized, non-emergency, out-of-network services. For authorized out-of-network services, the plan is required to reimburse hospitals or physicians the lesser of:</p> <ul style="list-style-type: none"> • The usual and customary charge made to the general public; or • The established Florida Medicaid rate for hospitals or physicians <p><u>Reference:</u> Florida Agency for Health Care Administration (AHCA) standard contract.</p>	No specific provisions for out-of-state, out-of-network providers.
Georgia	MCOs are limited to paying for out-of-network services at 90 percent of the Medicaid fee-for-service rate.	Unknown.
Maryland	<p>MD requires health plans to pay out-of-network providers as follows:</p> <ol style="list-style-type: none"> 1. Hospitals according to the rate approved by the MD Health Services Review Commission. 2. Trauma physicians for trauma care, the greater of: <ul style="list-style-type: none"> • 140 percent of Medicare for the same service provided to a similarly-licensed provider, or • The rate as of a specified date that the plan paid for the same service, to a similarly licensed provider in the same geographic area, published by CMS 3. Any other health care provider the greater of: <ul style="list-style-type: none"> • 125 percent of what the plan paid for the same service, to a similarly licensed contracted provider in the same geographic area, or 	The MD policy would not apply to out-of-state providers. Payments are tied in part to what the plan would pay in-network in the geographic area.

State	Policy Description for Out-of-Network Services	
	In-State Providers	Out-of-State Providers
	<ul style="list-style-type: none"> The rate as of a specified date that the plan paid for the same service, to a similarly licensed contracted provider in the same geographic area <p>This provision would include providers of self-referral and emergency services. The MD Healthchoice provider manual and rules require health plans to pay for such services, when provided out-of-network.</p> <p><u>References:</u> Maryland Code, Section 17-710.1 MD "Healthchoice manual for Providers of Self-Referral and Emergency Services" (9/08) COMAR 10.09.62</p>	
Nebraska	<p>Health plans are responsible for out-of-network services only if they have an agreement with the provider. Health plans do not have to pay for out-of-network services provided by a non-Medicaid enrolled provider. Health plans are required to pay out-of-network providers for emergency services. (The emergency provision does not specifically provide an exception from payment for non-Medicaid enrolled providers for emergency services).</p> <p><u>References:</u> Nebraska HHS Finance and Support Manual, 482 NAC 4-004 (regarding emergency services) and 482 NAC 4-005-06 (regarding payment provisions).</p>	No specific provisions for out-of-state, out-of-network providers.
New Jersey	<p>Plan <u>may</u> pay the out-of-network, out-of-state hospital at the New Jersey Medicaid rates (§ G.2).</p> <p>If the plan made the referral, the out-of-network provider is required to coordinate with the plan with respect to payment and ensure that the cost to the enrollee is no more than the plan would have paid if the service was provided in-network (§ G.3).</p> <p><u>Reference:</u> Plan Contract § 4.1.1.G.</p>	<p>The NJ plan contract requires that health plans provide or arrange for out-of-area services both in emergency and non-emergency situations under certain circumstances:</p> <ul style="list-style-type: none"> When travel back to the service area is not possible or is impractical, or When medically necessary services could only be provided elsewhere. <p>Plan <u>may</u> pay the out-of-network, out-of-state <u>hospital</u> at the NJ Medicaid rates. The contract does not address payment to out-of-state providers other than hospitals.</p>

State	Policy Description for Out-of-Network Services	
	In-State Providers	Out-of-State Providers
		<u>Reference:</u> Plan Contract § 4.1.1.G
New York	<p>MCOs must pay for out-of-network services; however, the regulation is silent regarding payment limits. MCOs are required to set up a separate account from which to make out-of-network payments and amounts deposited must be reconciled annually.</p> <p><u>Reference:</u> "Provider Contract Guidelines for MCOs and IPAs".</p>	No specific provisions for out-of-state providers.
Pennsylvania	<p>The MCO must pay for emergency services in or outside of the HealthChoices Zone (including outside of Pennsylvania). Consistent with the federal requirements on emergency out-of-network services, the MCO must limit the amount to be paid to out-of-network providers of emergency services to no more than the amount that would have been paid for such services under the Department's fee-for-service program.</p> <p>The MCO must cover post-stabilization services and must limit charges to members for post-stabilization services to an amount no greater than what the MCO would charge the member if he or she had obtained the services through the MCO.</p> <p><u>Reference:</u> HealthChoices Standard Agreement.</p>	<p>The MCO must pay for out-of-state emergency services at no more than the Medicaid fee-for-service rate.</p> <p><u>Reference:</u> HealthChoices Standard Agreement.</p>
Tennessee	<p>For referred services, the plan must may not pay less than 80 percent of the rate the plan would have paid for the service in-network. Plan is prohibited from paying for non-referred, non-emergency, out-of-network services that are not emergent, unless there is judgment against the plan requiring payment.</p> <p><u>Reference:</u> Tennessee MCO contract.</p>	No specific provisions for out-of-state providers.
Texas	<p>Medicaid: Plans must reimburse providers at 97 percent of the Medicaid fee-for-service rate and must reimburse out-of-network, out-of-area service providers at 100 percent of the Medicaid fee-for-service rate.</p> <p>CHIP: MCOs must reimburse non-network physicians at the usual and customary rate or at an agreed rate.</p>	No specific provisions for out-of-state providers. (Texas' policy governs "out-of-area" but unclear if this will extend to out-of-state, out-of-network providers).

State	Policy Description for Out-of-Network Services	
	In-State Providers	Out-of-State Providers
	<p>The plan is not responsible for payment of unauthorized non-emergency services provided out-of-network.</p> <p><u>References:</u> Medicaid: Texas Administrative Code Title 1, Part 15, §353.4. CHIP: Insurance Code Sec. 1271.055.</p>	
Wisconsin	<p>The HMO must coordinate with out-of-network providers with respect to payment and ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network.</p> <p>When emergency services are provided by out-of-network providers, the plan is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, fee-for-service providers for services to the BadgerCare Plus and/or Medicaid SSI populations. In no case will the plan be required to pay more than billed charges.</p> <p><u>Reference:</u> BadgerCare Plus and Medicaid SSI Contract for February 1, 2008-December 31, 2009.</p>	No specific provisions for out-of-state, out-of-network providers.