



Out-of-Network Study Findings & Recommendations

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Nature of the Problems Created by OON Care

- For the member:
 - Lack of adequate access to care
 - Inappropriate billing by provider
- For the health plan
 - Inability to appropriately manage/coordinate member care
 - Administrative burdens resulting from protracted negotiations/litigation
 - Financial impact (based on limited data available in study, OON dollars tend to involve high cost care/other services in a hospital setting)
- For the State
 - Substantial out-of-network claims may indicate:
 - Inadequate supply of provider type in the state
 - Inadequate access to services in a plan or SA
 - Decline in member satisfaction with program
 - May reflect provider perceptions about Medicaid program or plan
 - Longer term, higher than Medicaid payments by the plan impact future program expenditures

Contributing Factors to Out-of-Network Situations

- Provider Access
 - Single provider in multi-county area
 - Recognized specialty provider/public hospital/academic medical center
- Inpatient vs. Outpatient
 - Limited data available suggests OON dollars involve high cost care/other services in a hospital setting
 - Lack of opportunity to coordinate care
- DRA only addresses emergency OON services
- Geography
 - Out of state OON services are more likely to occur in cross border states
 - Generally OON services occur in state
- Existence/effectiveness of state policy on OON payment
 - Provider enrollment in Medicaid
 - Plan access to Medicaid fee schedule

Key Findings

- Small sample from which to draw conclusions:
 - Wide range of OON claims in proportion to total Medicaid claims
 - Generally in-state except states contiguous to urban areas in other States (e.g., NJ and DC)
 - OON services occur in hospital settings, and involve high cost cases
- All parties need regulatory guidelines so that OON payments become more routine and less adversarial

DRA Policy for ER Services and Medicare Policy for ER and Non-ER Services Offer Key Precedents

- Deficit Reduction Act
 - OON hospital payments must be limited to the payment the provider would have received in the Medicaid FFS program (less any payments for indirect costs of medical education and direct costs for graduate medical education)
 - OON hospital must accept the payment as payment in full
 - DRA applies only to emergency services
 - DRA applies regardless of whether the OON provider is located in, or out of the state in which the Medicaid health plan has a contract
- 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.

States OON Policies

- Effectiveness of states policies:
 - Provides predictability for both provider and plan
 - Creates an incentive for coordination and transition of member to in-network provider, if available
 - Controls program costs (higher payments are reflected in future capitation payments, depending on state's reimbursement methodology)
- Limitations:
 - Generally do not apply to out-of-state providers or in-state providers not enrolled in Medicaid
 - Access to the Medicaid FFS rate limits effectiveness of policy and limits health plan negotiating power—need for transparency for it to work
 - States are generally reluctant to get involved in disputes between health plans and providers

State policy examples for non-emergency OON services

- Lack of national policy results in too much variation between states
 - Few states address OON payment for non-emergency services
 - Tennessee prohibits non-emergency OON without referral
 - New Jersey: if plan referred services, plan is limited to what it would have paid if the service was provided in-network
- Existing precedent for tying payments to Medicaid FFS:

Georgia	MCOs are limited to paying for out-of-network services at 90 percent of the Medicaid fee-for-service rate.
Texas	Plans must pay OON providers at 100% of Medicaid fee for service rate.
Wisconsin	HMO must ensure costs for OON providers are no greater than they would be if services are furnished in-network.

Recommendations

- Federal Legislation should be enacted that requires OON providers to accept Medicaid FFS rate
 - States should have the latitude to pay less than 100% of Medicaid FFS as an incentive for providers to participate in State Medicaid managed care programs
 - Policy recommendation is similar to DRA which so far appears to be effective
 - Policy should provide transparency—examples:
 - Medicare Advantage program operates well with this type of requirement
 - States should provide full access to Medicaid fee-schedule
 - States should provide mechanism for plans to request from the state what the payment rate would be for the service
 - Eliminates the need for single case agreements
 - Health plans may be willing to trade in predictability of broad-based policy for non-emergency OON services in place of flexibility of single case agreement
- In absence of federal legislation we recommend states establish an OON payment policy as described above
 - Should lower MCO net claims cost
 - Saving should accrue to the states in the long-term