

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

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It is important for providers, primarily skilled nursing facilities (SNF) and home health agencies (HHA), to understand Medicare Advantage (MA) plan payment obligations to out-of-network providers. There are rare instances when providers will encounter a situation where a MA plan enrollee receives or seeks services from a provider that is not part of the MA plan's network. When these situations arise, providers are often confused about the payment rate 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 summarize the MA plan payment obligations to out-of-network providers and provide helpful links to additional resources.

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

### **Types of Services Covered**

The Manual [Chapter 4](#) identifies the types of services for which MA plans must pay out-of-network providers and states that MA plans must make timely and reasonable payment to those out-of-network providers. The limited types of services MA plans must pay out-of-network providers include emergency and urgently needed services, dialysis when outside of the network area, and placements when necessary and approved by the MA plan. See Chapter 4, Section 110.1.3 - Services for Which MA Plans Must Pay Non-Contracted Providers and Suppliers.

As the guidance states, the obligations to pay for out-of-network services rendered for MA plan enrollees are limited so providers should contact the MA plan as soon as possible to inquire about coverage when MA plan enrollees seek services. These issues are better addressed at the front end to avoid issues collecting payment from the MA plan or the enrollees after services are rendered.

Manual Chapter 4 directs providers to additional information contained in the [MA Payment Guide for Out-of-network Payments](#). The MA Payment Guide addresses SNFs and other provider types.

### **Payment Amounts**

Guidance outlined in [Chapter 6](#) of the Manual, and consistent with §1852(a)(2) and §1852(k)(1) of the Social Security Act, states that out-of-network SNF and HHA providers must accept as payment in full for services rendered amounts applicable in Original Medicare (a.k.a. FFS 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. It also ensures that out-of-network providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.

If the MA organization has not arranged for the services and the out-of-network SNF's or HHA's bill is less than the Original Medicare amount, the MA organization is only required to pay the billed amount.

If out-of-network providers accept more than Original Medicare amounts for services rendered, they are subject to penalties. See Chapter 6, Section 100 – Special Rules for Services Furnished by Non-Contract Providers.

In practice, some providers have signed contracts as in-network providers that reimburse SNFs and HHAs at less than FFS Medicare. This would mean that an out-of-network provider may be paid a higher rate for an approved service, but would have less predictability on whether an MA plan will approve these services and, in turn, pay for them at the out-of-network rate.

### **Different Types of MA Plans**

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. The different types of plans – Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-For-Service (PFFS), and Special Needs Plan (SNP) - have different coverage rules for out-of-network services. These issues are addressed in various sections of Chapter 4 of the Manual.

Within the regulations and manual guidance, each MA plan may also have created their own internal policies, procedures, documentation requirements and timelines that out-of-network providers are expected to follow; and these policies, procedures, and requirements may change periodically without notice to out-of-network providers. For that reason, taking a proactive approach at the outset for each MA enrollee will be the best way for out-of-network providers to understand all current requirements and procedures to facilitate timelier, more accurate payments.

MA plans must also clearly communicate to their 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 section on relationships with providers in the Manual Chapter 6.

### **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 SNF to return to their home SNF after a hospital stay, even if their SNF is not part of the provider network of the MA plan they are enrolled in. However, the home SNF must either have a contract with the MA 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). [Read 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>

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