



Landon State Office Building
900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov/hcf/

Robert Moser, MD, Secretary
Kari Bruffett, Director

Sam Brownback, Governor

MEMORANDUM

Re: Reimbursement for Out-of-Network Care to Medicaid Beneficiaries Enrolled in KanCare

Date: September 2012

The State has recently adopted a provision in its KanCare contracts with managed care organizations (MCOs) that will govern reimbursement rates for out-of-network care provided to Medicaid beneficiaries once KanCare is implemented. The State's contract with Medicaid MCOs provides that **"if [providers] do not contract with the MCO, out-of-network providers will receive 90% of fee-for-service rates."** This memorandum explains the implications to providers that provide care to a Medicaid beneficiary who is enrolled in a managed care in which the provider is not participating.

General Rule

KanCare will operate under a Medicaid freedom-of-choice waiver. In general, that means that the beneficiary may only access Medicaid services within the MCO's network. There are some exceptions to this general rule that are set forth in federal law, and the State has created other exceptions in its KanCare contracts that require or permit payment to out-of-network providers. Except in the situations described below, neither the KanCare MCO nor Kansas Medicaid is required to reimburse an out-of-network provider who provides a service to a managed care enrollee.

Emergency Care

Federal law requires MCOs to cover and pay for emergency services, including services needed to evaluate or stabilize an emergency medical condition, regardless of whether the provider that furnishes the services has a contract with the MCO. 42 C.F.R. § 438.114.

Out-of-network hospitals and their providers that treat Medicaid beneficiaries enrolled in managed care must accept as payment in full no more than the Medicaid fee-for-service rate established by the State. 42 U.S.C. § 1396u-2(b)(2)(D). Under federal law, the Medicaid beneficiary cannot be held liable for the difference in standard rates and those paid by the MCO. 42 C.F.R. § 438.106(b)(2).

Once the patient has been stabilized, he or she should be transferred to an in-network provider, unless non-emergency care is authorized.

Non-Emergency Care

Unlike with emergency services, under federal law the MCO is under no obligation to provide care out-of-network, except in circumstances where the MCO is unable to provide adequate and timely services within network. 42 C.F.R. § 438.206(b)(4). In that situation, the MCO must authorize the beneficiary to go out-of-network. For example, the MCO may determine that the beneficiary needs specialized services that are not available within the network.

In KanCare, if an MCO is unable to provide medically necessary services in its network, it must adequately and timely cover those services out of network, and is required to negotiate and execute single-case arrangements or agreements with non-network providers to ensure access to covered services. The rate will be negotiated between the plan and the provider, and providers cannot “balance bill.”

For other out-of-network services, the State contract provision provides that MCOs will reimburse out-of-network providers that choose to serve Medicaid beneficiaries enrolled in managed care at **90% of the fee-for-service Medicaid rate**. Because there is no contract between the MCO and the out-of-network provider, this language creates the only legal obligation under state or federal law for MCOs to reimburse a provider for services provided to a beneficiary out-of-network. If the out-of-network provider does not want to accept this amount, it need not accept the out-of-network beneficiary. The 90% fee-for-service Medicaid rate is **payment in full**. Federal law prohibits providers who choose to provide a service out-of-network from billing the beneficiary for payments in excess of any cost-sharing that the enrollee would pay if the care was provided in-network. 42 C.F.R. § 438.106(b)(2); *see also* § 438.206(b)(5). In KanCare, beneficiaries will not have co-pays. Likewise, the provider may not submit a claim to the State because of the waiver of Medicaid’s “freedom of choice” rules limiting the beneficiary to providers participating in the MCO.

MCOs may require prior authorization for out-of-network services. If so, the MCO is not obligated to reimburse providers to who provide services without authorization. If payment is made, it must be contingent upon the provider agreeing it will not balance bill the beneficiary for any amount.