Operational Policy Letter #43

Department of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

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LIMITS ON PHYSICIAN AND PROVIDER CHARGES FOR OUT-OF-PLAN SERVICES PROVIDED TO MEMBERS OF MEDICARE RISK AND COST HMO/CMPS

Question:

With the rapid growth in Medicare managed care, we have begun to receive a number of inquiries questioning exactly how Medicare's assignment and limiting charge provisions apply to services rendered outside an HMO/CMP's network. Questions concerning the application of Medicare charge limits arise because there are specific situations in which Medicare risk and cost HMO/CMPs **must** assume financial responsibility and pay for out-of-network care. These situations are:

- care rendered in an emergency,
- out-of-area urgently needed care,
- referral services,
- point-of-service benefit contained in the enrollee's benefit package, and
- any service the HMO/CMP accepts financial liability due to provisions contained in the enrollee's benefit package.

Section 1876(c)(4)(B) of the Social Security Act requires that Medicare risk and cost HMO/CMPs assume financial responsibility for all care that Medicare would cover. In addition, risk and cost HMO/CMPs **may** also assume financial responsibility for non-emergent or non-urgent care in certain situations, as in the case of referral services rendered by a provider of health care not under contract with the HMO.

Answer:

Where risk and cost HMO/CMPs assume responsibility to pay for out-of-network care, Medicare's charge limits apply in certain situations. For example, Section 1876(j) of the Act provides that out-of-network physician, providers of service, and end-stage renal disease (ESRD) facilities are precluded from collecting more for physician services or renal dialysis services than the amount that could be collected under fee-for-service.

Similarly, Section 1866(a)(1)(O) of the Act limits the amount that out-of-network hospitals (for inpatient services) or skilled nursing facilities can collect to the amount that they would have received under fee-for-service.

Beyond questions about the application of Medicare charge limits to out-of-network services, we also receive questions about beneficiary liability for out-of-network services. For example, some physicians and providers have questioned whether they are free to collect the same amount of coinsurance from the beneficiary that he or she would be responsible for had they not been enrolled in a Medicare risk or cost HMO/CMP.

When risk and cost HMO/CMPs accept financial responsibility to pay for physician services rendered by out-of-network health care providers, **the HMO/CMP must also pay balance-billed amounts** (not to exceed the amount that could have been collected under the fee-for-service system). The enrollee's **only** financial liability is for copayments or coinsurance amounts imposed by the HMO/CMP's benefit package.

To illustrate, the maximum amount an out-of-network hospital may collect from a risk HMO/CMP for a hospital inpatient stay will vary according to whether the hospital is paid under the Prospective Payment System (PPS). A PPS hospital, for example, is limited to collecting the DRG amount and hospital specific add-on amounts, e.g., capital and direct medical education expenses that Medicare would have paid for such services plus any beneficiary out-of-pocket charges (e.g., inpatient hospital deductible). Normally, Medicare would subtract any applicable inpatient deductible and coinsurance amount to establish its actual PPS payment. The HMO/CMP would be required to pay the full hospital charges up to the full PPS amount without regard to Medicare's deductibles and coinsurance amounts. If the HMO/CMP benefit package purchased contains a copayment for this service, the Medicare enrollee would be required to pay the hospital the copayment charge and the payment to the hospital would be adjusted accordingly.

Similarly, the maximum amount an out-of-network physician may collect from risk or cost HMO/CMPs for out-of-network physician services will vary depending upon whether a physician is participating, nonparticipating, or accepts assignment; but again, the amount of copayment or deductible a beneficiary is obligated to pay, will be the amount he or she would have to pay as described (and approved by HCFA) in the benefit package purchased. For example:

> A Medicare HMO beneficiary receives out-of-network physician services totaling $125.00 from a Medicare **participating** physician. (Due to the Medicare fee-schedule and the physician's participating agreement, the physician is limited to receiving only $100.00 for these services.) The beneficiary's HMO does not charge a deductible but does require a $10.00 copayment for this type of service. Under this scenario, the HMO must pay for the out-of-network services, and the plan calculates an approved amount of $100.00 derived from the Medicare fee-schedule. Accordingly, the HMO sends the participating physician a check for $90.00, and the beneficiary pays the physician $10.00.

Using the same scenario as outlined above but assuming that the physician is **non-participating and accepts assignment**, the HMO calculates an approved amount of $95.00 recognizing that the Medicare fee-schedule for non-participating physicians is reduced by 5%. Under this scenario, the HMO would pay the physician $85.00 and the beneficiary again pays only $10.00.

Finally, using the same scenario as outlined above but assuming that the physician does not accept assignment, the HMO calculates the limiting charge. In this instance, the limiting charge would amount to $109.25, 115% of the Medicare fee-schedule for non-participating physicians. The HMO/CMP would then pay the physician $99.25, and the beneficiary would again pay just $10.00.

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