

Medicaid Managed Care Out-of-Network Payments

Issue Background

As a condition of participation, Medicaid health plans are required to establish relationships with a network of healthcare providers so that enrollees will have access to Medicaid covered services. However, even with an extensive network of providers, some out-of-network services do and will occur for a variety of reasons. In the absence of a contract or state regulatory guidelines, charges to the health plan (and ultimately the state's Medicaid program) for these out-of-network services are often significantly higher than the fee-for-service rate schedule in that state. Out-of-network payment disputes lead to an adversarial and costly negotiation process that often leads to litigation, driving up costs in Medicaid.

Congress fixed this problem in the Deficit Reduction Act of 2005 - but only for "emergency services" with the passage of the Rogers Amendment that tied payment to no more than fee-for-service rates. Many states - such as Washington, Texas, Georgia, Michigan, and New Jersey - have passed state laws expanding the federal Rogers Amendment to all Medicaid health services in order to improve access to these services for their Medicaid-eligible populations. Current Medicare law requires non-contracted services provided to Medicare Advantage enrollees to be paid at the prevailing Medicare fee-for-service rate.

Congressional Action Required:

Extend Rogers Amendment to All Health Care Services

Congress should extend the Rogers Amendment to all health care services in order to:

- Conform Medicaid law with the current Medicare law;
- Close a structural loophole in the Medicaid system;
- Reduce costs for State Medicaid programs;
- Improve access to services in urban and rural settings for Medicaid beneficiaries, and
- Provide an incentive to health care providers serve more Medicaid enrollees by joining Medicaid health plan provider networks

