Payment Policy:	**Out of Network Provider Policy**	
Original Date Approved: 12/4/2020	**Effective Date** 01/01/2021	**Date Revised:** N/A
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☒ One Care		

POLICY SUMMARY

CCA members are expected to receive services from in-network providers. In certain circumstances, CCA will reimburse Out-of-Network providers using the reimbursement methodology described within this policy.

DEFINITIONS

Out-of-Network Provider: Providers that do not have a valid contract or Letter of Agreement (LOA) with CCA for both the service rendered and the member's CCA plan, prior to the date that service was rendered. Services provided beyond the scope of an in-network provider's contract will be considered Out-of-Network and are subject to this policy.

Letter of Agreement: An agreement between a non-contracted provider and CCA for payment for specified services rendered to a specific member or members for a specific timeframe. All services rendered by non-contracted providers outside of the scope the LOA are considered Out-of-Network services and are subject to this payment policy.

Continuity of Care Period: The period of time during which newly enrolled members may continue to receive services from an Out-of-Network provider with whom they have an active care plan and/or prior authorization. This designated period for new enrollees protects enrollees' provider relationships, services, and prior authorizations during their assessment and care planning processes. Coverage for services is typically provided for up to a maximum of 90 calendar days after enrollment and coverage is often modified with a completed assessment.

AUTHORIZATION REQUIREMENTS

CCA requires a prior authorization for all Out-of-Network services be obtained prior to the date those services are rendered, with the exception of emergency services and services rendered under the Continuity of Care period. Services rendered by Out-of-Network providers will only be granted prior authorization if the provider can demonstrate that the service is medically necessary, urgent or emergent, and/or cannot be rendered by an equivalent contracted provider within a reasonable geographic distance or timeframe. CCA reserves the right to limit services and remit or recoup payment post-service if these requirements have not been met. Prior authorization will be considered on a case-by-case basis.

COVERAGE AND BILLING INFORMATION

Claims should be submitted following Medicare/Medicaid industry standards. CCA will not reimburse a provider who is not eligible to participate in Medicare and/or Medicaid. Providers are required to abide by all federal and state laws and regulations. Providers should reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

CONTINUITY OF CARE COVERAGE

During the Continuity of Care period, newly enrolled CCA members may continue receiving services from Out-of-Network providers with whom they have a pre-existing relationship and/or prior authorization. The Continuity of Care period is valid until the member has an initial clinical assessment with the CCA care team, or until the plan-specific Continuity of Care period expires.

Out-of-Network providers rendering services during this period are required to provide evidence of said pre-existing relationship and/or prior authorization. CCA reserves the right to deny services and/or remit or recoup payment for services rendered during this period if the provider cannot demonstrate a pre-existing relationship and/or prior authorization.

REIMBURSEMENT AND PAYMENT LIMITATION

CCA will not impose a deductible for covered services provided by an Out-of-Network provider. CCA will pay the appropriate Original Medicare payment amount under the terms of their three-way contract, as well as any Medicaid-covered cost-sharing under the terms of the Medicaid State Plan. Payments made to Out-of-Network providers constitute payment in full. Providers may not bill CCA members for the difference between the actual billed charges and the allowed amount paid by CCA. Providers shall not seek or accept payment, in any amount(s) or form, from CCA members for any Covered Service rendered, nor shall Providers maintain any action at law or in equity against CCA members to collect any sums Provider claims may be owed for services rendered.

If a provider disagrees with CCA's decision of denial or reimbursement of a claim, the provider can file an appeal for reconsideration. All provider appeals must be received in writing. All Out-Of-Network providers must submit a Waiver of Liability form with each appeal. For more information, please reference the Provider Manual.

In summary, CCA will pay qualifying Out-of-Network providers using the following methodology:

- For services/products payable under Original Medicare, CCA shall pay the Medicare rate, plus Merit-based Incentive Payment System (MIPS) incentive/penalty and less sequestration, and Medicare's cost-share shall be compared to the State Medicaid payable amount. [1] No more than 100% plus MIPS incentive and less sequestration will be paid.
- For services/products never payable under Original Medicare, but payable by Medicaid, the State Medicaid payable amount shall be paid.
- For services/products designated within an LOA, reimbursement will be provided at the agreed upon rate.

A member may utilize an Out-of-Network pharmacy if necessary but is limited to a 30-day supply of medication. The pharmacy will be reimbursed at the same rate as in-network providers.

AUDIT AND DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such and audit determines that your office/facility did not comply with this payment policy CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES

Massachusetts Website: http://www.mass.gov/courts/docs/lawlib/116-130cmr/130cmr433.pdf
CMS.gov website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html
CCA Website: http://www.commonwealthcarealliance.org/providers/pharmacy-program
CMS Memo – "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments -Update". Released 7/10/2020
CMS Memo – "2020 Merit-based Incentive Payment System (MIPS) Payment Adjustment Fact Sheet" - https://qpp-cm-prod-content.s3.amazonaws.com/uploads/0/2020%20Payment%20Adjustment%20Fact%20Sheet.pdf

RELATED POLICIES

Claims Reconsideration

POLICY TIMELINE DETAILS

1. December 2020 approval

[1] Positive incentive values will be paid if CMS data contains provider's incentive rate for this timeframe. CCA reserves the right to include negative incentives, should CMS provide this information to CCA. Per CMS's 1/7/2020 MIPS Memo, sequestration will be applied to the subtotal following MIPS value application.