DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: December 20, 2013

TO: All Medicare Advantage Organizations, Section 1876 Cost Based Contractors, PACE Organizations, and Health Care Prepayment Plans

FROM: Danielle R. Moon, J.D., M.P.A., Director

SUBJECT: Non-Contract Provider Payment Dispute Program

In 2009, the Centers for Medicare & Medicaid Services (CMS) contracted with an independent contractor, C2C Solutions, Inc. (C2C), to adjudicate disputes between non-contracted and deemed providers and Private Fee-for-Service Plans. CMS later extended this voluntary dispute resolution process (in 2010) to include disputes between non-contracted providers and Medicare Advantage Organizations (MAOs), Section 1876 Cost-Based Contractors, PACE Organizations, and Health Care Prepayment Plans. While it has always been a contractual, statutory, and regulatory requirement for MAOs and other payers to pay non-contracted providers no less than the amount received under original Medicare for Medicare-covered services, CMS has provided the services of C2C as a convenience for MAOs and providers. However, due to budgetary constraints, CMS is no longer able to offer these services effective January 1, 2014, C2C will adjudicate all payment disputes received by January 31, 2014 that meet the filing requirements. After that date, C2C will return to providers any payment disputes received after January 31, 2014, with instructions to contact the MAO or other payer directly to dispute the payment.

CMS would like to take this opportunity to remind MAOs and the other payers included as addresses above of their responsibilities, under sections 1852(k) and 1894(b)(3) of the Act and CMS regulations at 42 CFR §§422.214, 417.558 and 422.520, when reimbursing non-contracted providers for services provided to Medicare beneficiaries. Specifically, MAOs and other payers must reimburse non-contracted providers no less than the amount that would be paid under original Medicare and non-contracted providers are required to accept as payment, in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare. Plans should refer to the MA Payment Guide for Out of Network Payments in situations where they are required to pay at least the Medicare rate to out of network providers. A link to the guide can be found on http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/oon-payments.pdf.

In addition, CMS expects all MAOs and payers to act promptly to resolve these disputes and to ensure that payments are made in accordance with the law. In the event that a provider has difficulty accessing the plan's dispute resolution process, s/he may file a complaint with 1-800-MEDICARE indicating that the plan's internal dispute process has failed to resolve the issue. CMS Account Managers have been instructed to closely monitor MAOs' actions in this regard and will take compliance actions as necessary.

Please direct any questions about this memorandum to your account manager.