

# **OVERVIEW OF FEDERAL STATUTES AND REGULATIONS GOVERNING MEDICARE ADVANTAGE PLANS AND MEDICAID MANAGED CARE PLANS**

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# OVERVIEW OF FEDERAL STATUTES AND REGULATIONS GOVERNING MEDICARE ADVANTAGE PLANS AND MEDICAID MANAGED CARE PLANS

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This White Paper addresses the federal laws, regulations, and other rules governing commercial insurers that contract with CMS to assist in the administration of health benefits through the Medicare Advantage Program and Medicaid Managed Care Program. Specifically, this White Paper provides a high-level review of the federal requirements that govern how commercial insurers must administer their plans, with a focus on the challenges faced by DME suppliers in gaining access to these plans.

## Summary and Overview

DME suppliers are negatively impacted by the lack of oversight of Medicare Advantage Plans and Medicaid Managed Care Plans when the commercial plans operate “closed panels” that prohibit some DME suppliers from being admitted to the plans. This limits the suppliers’ ability to access and serve their patients.

Federal statutes and regulations governing Medicare Advantage and Medicaid Managed Care organizations are quite extensive. However, only a small portion of the regulations govern the relationship between the organizations and the health care providers that serve the beneficiaries of the plans. Most of the regulations aim to protect beneficiaries of the plans and set minimum requirements for coverage, networks, and complex reimbursement mechanisms. Generally, the regulations that pertain to providers are aimed at protecting patients’ access to care and ensure that the plans have a baseline coverage of medical care and a network with at least a minimum number of providers within a specific geographic region. The regulations provide additional protections for beneficiaries by setting requirements for marketing of the plans. The statutes empower CMS to issue rules regarding the administration of the plans.

In addition to specific regulation regarding the managed care plans, the plans are also subject to other federal insurance regulations, including antitrust statutes.

### I. Medicare Advantage Plans

Medicare Advantage was created with the passage of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33) which amended the Social Security Act to create the “Medicare+Choice” program, more commonly known as Medicare Advantage or Medicare Part C. It has gone through several updates, which eventually culminated in the most recent and comprehensive update to the plan passed in the Affordable Care Act in 2010 (Pub. L. 111-152). Medicare Part C allows “eligible individuals ... to receive benefits ... through the original Medicare fee-for-service program under parts A and B, or through enrollment in a [Medicare Advantage] plan.”<sup>1</sup> The statute sets a baseline of the covered benefits in each Medicare Advantage plan. “Each [Medicare Advantage] plan shall provide to members ... through providers ... benefits under the original Medicare fee-for-service program option.”<sup>2</sup> This requirement is a baseline, but plans are free to provide additional benefits

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<sup>1</sup> 42 U.S.C. 1395w-21(a)(1).

<sup>2</sup> 42 U.S.C. 1395w-22(a)(1).

so long as they comply with the cost-sharing limitations set forth in the statute and the regulations issued by CMS.<sup>3</sup>

### *A. Benefits and Covered Services*

Medicare Advantage regulation is generally aimed at protecting beneficiaries by ensuring that they have the same or better access to services as those covered under traditional Medicare plans,<sup>4</sup> but this does not necessarily mean that it sets up the same level playing field for the providers' access to beneficiaries. The regulations grant the Medicare Advantage plans broad discretion to create a network of providers. Medicare Advantage plans “may select the providers from whom the benefits under the plan are provided” so long as the plan makes the benefits available to all members, and the benefits meet the minimum coverage requirements regarding emergency services, maintenance and post-stabilization, and other benefits provided under Medicare Parts A and B.

Medicare Advantage plans that operate on a fee-for-service model must demonstrate that the organization “has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.”<sup>5</sup> The plan can meet this requirement in one of two ways: (1) establish payment rates for covered services that are not less than the payment rates under traditional Medicare;<sup>6</sup> or (2) demonstrate that the plan has contracts or agreements with a sufficient number and range of providers to meet access requirements for each category of care provided under traditional Medicare.<sup>7</sup> The statute specifies that meeting the second requirement should not be construed as “restricting the persons from whom enrollees under such a plan may obtain covered benefits” but the plan may require a higher beneficiary copayment for providers that do not have contracts or agreements to provide covered services under the plan.<sup>8</sup>

### *B. Payments to Medicare Advantage Plans*

Medicare Advantage plans are reimbursed monthly in an amount determined by the model of the plan, whether the plan's bid was above or below the traditional Medicare benchmark, and adjustments based on demographics, geographic variations, etc.<sup>9</sup> Since 2006, Medicare Advantage plans have been required to submit an annual bid that states the aggregate monthly amount for the provision of all items and services under the plan determined by the average revenue requirements for an enrollee with an average risk profile.<sup>10</sup>

CMS exercises authority to oversee and approve the premiums and premium amounts that will be charged to beneficiaries under Medicare Advantage plans.<sup>11</sup> Generally, the statute simply requires plans to adhere to the premium and deductible amounts that shall be determined by the actuarial formulas utilized by CMS.

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<sup>3</sup> See 42 U.S.C. 1395w-22(a)(2)-(3).

<sup>4</sup> See 42 CFR § 422.101 setting forth requirements relating to “basic benefits.”

<sup>5</sup> 42 U.S.C. 1395w-22(d)(4).

<sup>6</sup> 42 U.S.C. 1395w-22(d)(4)(A).

<sup>7</sup> 42 U.S.C. 1395w-22(d)(4)(B).

<sup>8</sup> *Id.*

<sup>9</sup> 42 U.S.C. 1395w-23

<sup>10</sup> 42 U.S.C. 1395w-23(a)(1)(B).

<sup>11</sup> 42 U.S.C. 1395w-24

### C. Regulations Governing Medicare Advantage Plans' Relationships with Providers

In addition to the statutory requirements set forth in the Social Security Act, 42 CFR 422 Subpart E governs the relationships between Medicare Advantage Plans and health care providers under fee-for-service plans.

A Medicare Advantage organization “must have written policies and procedures for the selection and evaluation of providers.”<sup>12</sup> The policies and procedures must require determination and redetermination on a regular basis that each provider is licensed to operate in the state and accredited or meets standards similar to accreditation that are issued by the organization. Additionally, the policies and procedures must ensure compliance with the regulations that prohibit employment or contracts with individuals excluded from participation in the Medicare program.

Medicare Advantage organizations are expressly granted the discretion to “select the practitioners that participate in its plan of provider networks.”<sup>13</sup> Plans are prohibited from discriminating against providers solely on the basis of their license or certification, but this prohibition does not preclude the plan from refusing to grant participation to providers in excess of the number “necessary to meet the needs of the plans enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).”<sup>14</sup>

Medicare Advantage Networks must meet minimum requirements for providers within a certain distance and time of the beneficiaries of the plan but may request exceptions to network adequacy criteria in certain circumstances.<sup>15</sup> Network adequacy requirements were most recently updated in August of 2020.<sup>16</sup>

## II. Medicaid Managed Care Plans

At the same time Medicare Advantage was created, the BBA of 1997 granted states the ability to implement a mandatory Medicaid managed care program (“MMC”). Regulations of MMC programs are distinct in that the regulations generally set forth minimum requirements that states must enforce as a condition of continued federal funds for the program. Generally, the Social Security Act sets forth the requirements for an MMC program that include maintaining at least two programs from which enrollees can choose, minimum coverage benefits for beneficiaries, and processes for enrollment and termination. Federal regulations of MMC programs generally mirror the requirements for Medicare Advantage programs in terms of provider relations.<sup>17</sup> States must ensure that each MMC organization it contracts with “implements written policies and procedures for selection and retention of network providers.”<sup>18</sup> MMC organizations may not “discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law, solely on the

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<sup>12</sup> 42 CFR § 422.204(a).

<sup>13</sup> 42 CFR § 422.205.

<sup>14</sup> 42 CFR § 422.205(b).

<sup>15</sup> 42 CFR § 422.116(f)(1); *see also* [Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance \(cms.gov\)](#) Sec. 4.1 *Criteria for Submitting Exception Requests*.

<sup>16</sup> 85 Fed. Reg. 33796 (publ. on June 6, 2020).

<sup>17</sup> 42 U.S.C. 1396u–2.

<sup>18</sup> 42 CFR § 438.214.

basis of such license or certification.”<sup>19</sup> However, like Medicare Advantage, this requirement does not “prohibit an organization from including providers only to the extent necessary to meet the needs of the organization’s enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.”<sup>20</sup>

### **III. Other Federal Regulations**

In addition to the regulations specifically targeted at the regulation of managed care plans, other federal regulations that govern insurance apply to these plans. In *United States of America v. Aetna Inc.*, Civ. No. 16-1494 (U.S. Dist. Columbia, Jan. 23, 2017), a federal court enjoined the merger of Aetna and Humana because it found the merger would substantially lessen competition in the Medicare Advantage product market in violation of section 7 of the Clayton Act.<sup>21</sup>

Medicare Advantage and Medicaid Managed Care plans are also subject to the requirements of the Health Insurance Portability and Accountability Act (“HIPAA”) and are responsible for HIPAA compliance.<sup>22</sup>

### **IV. Conclusion**

Federal regulation of the plans offered by commercial entities through the Medicare Advantage and MMC programs is extensive, but there is very little regulation that protects DME suppliers from exclusion due to “closed panels.”

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THIS WHITE PAPER DOES NOT CONSTITUTE LEGAL ADVICE. THIS WHITE PAPER WAS PREPARED ON A SPECIFIC DATE. THE LAW MAY HAVE CHANGED SINCE THIS WHITE PAPER WAS WRITTEN. BEFORE ACTING ON THE ISSUES DISCUSSED IN THIS WHITE PAPER, IT IS IMPORTANT THAT THE READER OBTAIN ADVICE FROM A HEALTH CARE ATTORNEY.

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<sup>19</sup> 42 U.S.C. 1396u–2(b)(7).

<sup>20</sup> *Id.*

<sup>21</sup> *USA v. Aetna et al.*, 16-1494 (Dist. Columbia Jan. 1, 2017) Doc. 306, [Aetna-Humana Memorandum Opinion \(justice.gov\)](#)

<sup>22</sup> [Health Insurance Portability and Accountability Act of 1996 | CMS](#)