

# Medicare participation options for physicians

## Many physicians face large Medicare pay cuts

In 2007, various changes in Medicare payments to physicians are expected to lead to cuts in excess of 5 percent for many physicians and cuts of 16 percent to 20 percent for some. While the impacts could change before new payment rates take effect in January, **some cuts seem inevitable and many physicians may want to reconsider their current Medicare participation arrangements as a result.**

The cuts were included in tables 7 and 35 of a final rule on the 2007 Physician Payment Schedule released on Nov. 1, 2006. ([www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CM S1188377](http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CM S1188377)) They include a 5 percent across-the-board cut associated with the sustainable growth rate (SGR) as well as a number of other changes that will vary by service and location. Another change will increase payments for visits and consultations enough to offset the SGR cuts for family physicians and even lead to slight overall improvements in the bottom line for a few specialties. But these increases will trigger budget neutrality adjustments that exacerbate cuts for others.

## The situation is very fluid

Based on the proposed rule, about 44 percent of physicians are facing potential cuts of 6 percent or more and 14 percent could see cuts of more than 10 percent. The AMA continues to lead an aggressive campaign to pass legislation that would prevent the SGR cut and it is possible that Congress will mitigate or avert some cuts—especially those related to the SGR. There is no guarantee that lawmakers will act or that they will do so before the final rule is issued as has happened in several past years. **Payment rates could change again even after a final rule is issued.**

The final 2007 Physician Payment Schedule was released by Medicare on Nov. 1 and physicians will be allowed to switch their current Medicare participation or nonparticipation status any time between Nov. 15 and Dec. 31, 2006. Prior to that time, carriers are expected to provide each physician in their area with a CD-ROM containing information about the 2007 participation sign-up and a “Medicare Participating Physician/Supplier Agreement.” Actual payment rates may not be included, in which case physicians will need to check the carrier Web site or ask the carrier to mail the payment rates at no charge.

In the event that Congress does step in with legislative relief at some point after the final rule is published, past experience suggests that the participation/nonparticipation enrollment period will be re-opened to provide physicians with another opportunity to modify their participation status. **Those who want to opt out of Medicare entirely and contract privately with Medicare patients may do so at any point in the year,** assuming they provide adequate notification and meet all the requirements associated with this option.

## An overview of the three options

To help ensure that physicians are making informed decisions about their contractual relationships with the Medicare program, the AMA has developed the following overview of the Medicare payment situation in 2007 and the various participation options available to physicians.

**The AMA is not advising or recommending any one of the options described in this document. The purpose of the document is to ensure that physician decisions about Medicare participation are made with complete information about the available options.**

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There are basically three Medicare contractual options for physicians. Physicians may sign a participation (PAR) agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients. They may elect to be a nonparticipating or NONPAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients for more than the Medicare allowance for unassigned claims. Or they may become a private contracting physician, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves for at least two years.

Physicians who wish to continue their current PAR or NONPAR status do not need to take any action. Those who wish to change must notify every Medicare carrier they do business with before Jan. 1, 2007. Once made, the decision will be binding throughout calendar year 2007 unless Congress modifies payment rules for 2007 or the physician's practice situation changes significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give each of their carriers a 30 days notice before the first day of the quarter the contract takes effect. **Those considering a change in status should first determine that they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be PAR physicians. In addition, some states have enacted laws that prohibit physicians from balance billing their patients.**

### Participation

PAR physicians must agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount (which is the 80 percent that Medicare pays plus the 20 percent patient copayment) as payment in full for all covered services for the duration of the calendar year. The patient or the patient's secondary insurer is still responsible for the 20 percent copayment but the physician cannot bill the patient for amounts in excess of the Medicare allowance. While PAR physicians must accept assignment on all Medicare claims, Medicare participation agreements do not require physician practices to accept every Medicare patient who seeks treatment from them.

Medicare provides a number of incentives for physicians to participate:

- The Medicare-approved payment amount for PAR physicians is 5 percent higher than the rate for NONPAR physicians.
- Directories of PAR physicians are provided to senior citizen groups and individuals who request them.
- Carriers provide toll-free claims processing lines to PAR physicians and process their claims more quickly.

### Non-participation

The primary advantage to becoming a NONPAR physician is the ability to charge 15 percent more than the Medicare-approved amount. Medicare-approved amounts for NONPAR physicians are set at 95 percent of the rates for PAR physicians, however, the 15 percent limiting charge is effectively only 9.25 percent above the PAR approved amounts for the services. Therefore, when considering whether to be NONPAR, physicians must determine whether their total revenues from Medicare, patient copayments and balance billing would exceed their total revenues as PAR physicians, particularly in light of collection costs, bad debts and claims for which they do accept assignment.

The 95 percent payment rate is not based on whether physicians accept assignment on the claim, but whether they are NONPAR physicians. When NONPAR physicians accept assignment for their low-income or other patients, they still receive only 95 percent of the amount PAR physicians receive for the same service. **NONPAR physicians would need to collect the full limiting charge amount roughly 35 percent of the time they provided a given service in order for the revenues from the service to equal those of PAR physicians for the same service.**

Assignment acceptance, for either PAR or NONPAR physicians, also means that the Medicare carrier pays the physician the 80 percent Medicare payment. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

<b>Example: A service for which Medicare fee schedule amount is \$100</b>			
<b>Payment arrangement</b>	<b>Total payment rate</b>	<b>Payment amount from Medicare</b>	<b>Payment amount from patient</b>
<b>PAR physician</b>	100% Medicare fee schedule = \$100	\$80 (80%) carrier direct to physician	\$20 (20%) paid by patient or supplemental insurance (i.e., Medigap)
<b>Non-PAR/assigned claim</b>	95% Medicare fee schedule = \$95	\$76 (80%) carrier direct to physician	\$19 (20%) paid by patient or supplemental insurance (i.e., Medigap)
<b>Non-PAR/unassigned claim</b>	Limiting charge/ 109.25% Medicare fee schedule = \$109.25	\$0	\$76 (80%) paid by carrier to patient + \$19 (20%) paid by patient or supplemental insurance + \$14.25 balance bill paid by patient

### Private contracting

Provisions in the Balanced Budget Act of 1997 give physicians and their Medicare patients the freedom to opt out of Medicare and privately contract to provide health care services outside the Medicare system. Private contracting decisions may not be made on a case-by-case or patient-by-patient basis, however. Once physicians have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period.

Private contracts must meet specific requirements:

- **The physician must sign and file an affidavit agreeing to forego receiving any payment from Medicare for items or services provided to any Medicare beneficiary for the following two-year period** (either directly, on a capitated basis or from an organization that received Medicare reimbursement directly or on a capitated basis)
- Medicare does not pay either the patient or the physician for the services provided or contracted for
- The contract must be in writing and must be signed by the beneficiary before any item or service is provided
- The contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation

In addition, the contract must state unambiguously that by signing the private contract, the beneficiary:

- Gives up all Medicare payment for services furnished by the “opt out” physician
- Agrees not to bill Medicare or ask the physician to bill Medicare
- Is liable for all of the physician’s charges, without any Medicare balance billing limits
- Acknowledges that Medigap or any other supplemental insurance will not pay toward the services
- Acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available

To opt out, a physician must file an affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter. There is a 90-day period after the effective date of the first opt-out affidavit during which physicians may revoke the opt-out and return to Medicare as if they had never opted out.

This document contains excerpts from the AMA-published *Medicare RBRVS: The Physicians’ Guide* 2006. The complete guide is available from the AMA by calling (800) 621-8335.