

Know your options:

Medicare Participation Guide

For 2017 many physicians are appropriately focused on the initial implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). The American Medical Association provides many resources to help physicians prepare for MACRA, which are available at ama-assn.org/medicarepayment. The participation decisions that physicians will make for 2017, however, are not related to MACRA. Payment adjustments for 2017 are based on physicians' 2015 participation in the Physician Quality Reporting System (PQRS), the Meaningful Use of Electronic Health Records (MU) program and the Value-Based Modifier (VBM) program. These programs will be replaced by MACRA in the future, but they will continue to have an impact on physician payment rates for 2017.

This year, one factor for physicians to consider in making their participation decisions is that penalties will be imposed under the VBM program. For 2017, VBM penalties can range from 1 to 4 percent depending on the practice's size and its performance on cost and quality measures. Other penalties that will be applied in 2017 based on 2015 performance—including potential 2 percent cuts to quality reporting and cuts tied to meaningful use—will decrease the limiting charge amounts that nonparticipating physicians can bill to patients for

unassigned claims. The VBM penalties and bonuses, however, will *not* apply to unassigned claims. That means practices facing a VBM penalty next year could avoid the penalty by choosing the nonparticipating physician option. (Any VBM payment adjustments would still apply to claims for which nonparticipating physicians choose to accept assignment.)

In addition, physicians continue to face a 2 percent cut due to a budget sequester enacted by Congress to lower the deficit.

The decision period for physicians to change their Participation status ends Dec. 31, 2016. However, the decision to opt out of Medicare and privately contract with patients may be made throughout the year. To help ensure that physicians are making informed decisions about their contractual relationships with the Medicare program, the American Medical Association has developed the following overview of the various participation options available. The AMA is not advising or recommending any of the three options described in this kit. The purpose of the kit is to ensure that physician decisions about Medicare participation are made with complete information about the available options.

► Medicare participation options for physicians

Each year, the Centers for Medicare & Medicaid Services (CMS) provides physicians with the opportunity to change their Medicare participation status. Physicians will be notified by their Medicare administrative contractor when it's time to make their participation decision. Any change in status will be effective as of Jan. 1, 2017. There are three Medicare contractual options for physicians:

- 1) **Sign a participation (PAR) agreement** and accept Medicare's allowed charge as payment in full for all of their Medicare patients
- 2) **Elect non-participation (non-PAR)**, which permits physicians to make assignment decisions on a case-by-case basis and to bill patients for more than the Medicare allowance for unassigned claims
- 3) **Become a private contracting physician**, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves. To become a private contractor,

physicians must give 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. Physicians who want to continue their current PAR or non-PAR status do not need to take any action. However, those who want to change their status will need to notify their contractor in a written document that is received or post-marked on or before Dec. 31, 2016.

Those physicians who wish to change their status from PAR to non-PAR or from non-PAR to PAR are required to do so before Dec. 31, 2016. This decision is binding throughout the calendar year.

► Option 1: Medicare participation

PAR physicians agree to take assignment on all Medicare claims, which means physicians 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.

The Medicare participation agreement only governs how much physicians may charge patients for services. Medicare participation agreements do not require physician practices to accept new

Medicare patients who seek treatment from them. Medicare provides several incentives for physicians to participate:

- The Medicare approved amount for PAR physicians is 5 percent higher than the Medicare approved amount for non-PAR physicians
- For PAR physicians, Medicare will send claims directly to patients' Medigap plans for payment.
- The contractors who process Medicare claims process PAR physicians' claims more quickly than non-PAR physicians.

► Option 2: Non-participation in Medicare

Medicare-approved amounts for services provided by non-PAR physicians (including the 80 percent from Medicare plus the 20 percent copayment) are set at 95 percent of Medicare-approved amounts for PAR physicians, but non-PAR physicians can charge more than the Medicare-approved amount. The maximum amount that non-PAR physicians can charge for unassigned claims is called the “limiting charge.”

The “limiting charge” for a service is an amount equal to 115 percent of the Medicare-approved amount for non-PAR physicians. Note that, because Medicare-approved amounts for non-PAR physicians are 95 percent of the rates for PAR physicians, the 15 percent limiting charge is actually only 9.25 percent above the PAR-approved amounts for the services.

With a growing number of pay-for-performance penalties, many physicians may consider balance billing an extra 9 percent as one means of helping close the gap between the current and the new 2017 payment amounts.

Non-PAR physicians may decide on a claim-by-claim basis, or a patient-by-patient basis, whether they wish to accept assignment for the claim or not. This is not an “all or nothing” decision. When

considering whether to be non-PAR, therefore, physicians should consider whether their total revenues from Medicare—including amounts the program pays, patient copays and balance billing—would exceed their total revenues as PAR physicians, in light of collection costs, bad debts and claims for which they do accept assignment. It is important to understand that the lower Medicare-approved amount is not based on whether physicians accept assignment on the claim, but whether they are PAR physicians. When non-PAR physicians accept assignment for their low-income or other patients, their Medicare-approved amounts are still 95 percent of the approved amounts paid to PAR physicians for the same service.

The bottom line is that non-PAR physicians would need to collect the full limiting charge amount approximately 35 percent of the time they provide a given service in order for the revenues from the service to equal those of PAR physicians for the same service. If they collect the full limiting charge for more than 35 percent of the services they provide, their Medicare revenues will exceed those of PAR physicians.

Example: A service for which Medicare fee schedule amount is \$100

| Payment arrangement | Total payment rate | Amount from Medicare | Payment amount from patient |
|---------------------------------|--|--|---|
| PAR physician | 100% Medicare fee schedule = \$100 | \$80 (80%) carrier direct to physician | \$20 (20%) paid by patient or supplemental insurance (e.g., Medigap) |
| Non-PAR/assigned claim | 95% Medicare fee schedule = \$95 | \$76 (80%) carrier direct to physician | \$19 (20%) paid by patient or supplemental insurance (e.g., Medigap) |
| Non-PAR/unassigned claim | Limiting charge of 115% of 95% Medicare fee schedule (effectively, 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 |

In addition to this illustration of the Medicare payments and cost-sharing for an individual service, physicians can estimate how much their total revenues from Medicare patients would change if they switched from PAR to non-PAR. In general, revenues for non-PAR physicians' assigned claims would decrease by 5% from PAR rates and revenues for unassigned claims would increase by 9.25% from PAR rates.

Consider, for example, a PAR physician who currently receives \$100,000 in Medicare revenues. If the physician was able to collect the full limiting charge amount for 50% of claims and accepted assignment for the other 50%, revenues from Medicare patients would increase to \$102,125. Obtaining the full limiting charge from 75% of Medicare patients with 25% of claims assigned would increase revenues to \$105,688. On the other hand, if the full limiting charge could only be collected for 25% of Medicare claims and 75% were assigned, revenues would fall to \$98,462.

Practices also need to consider collection charges in these calculations, since payments for nonassigned claims must be collected directly from patients. Of the full limiting charge amount, patients will be reimbursed 70% by the Medicare program and will pay 30% out-of-pocket. Non-PAR physicians may decide on a claim-by-claim basis, or a patient-by-patient basis, whether they wish to accept assignment for the claim or not.

It is not an “all or nothing” decision. To estimate how your Medicare revenues would change if you choose non-PAR, use the worksheet in this kit, or visit www.ama-assn.org/go/medicareoptions to use our online calculator.

Assignment acceptance, for either PAR or non-PAR physicians, also means that the Medicare program pays the physician directly for the 80 percent Medicare payment. When it comes to 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.

In addition, in 2017 physicians potentially face a number of penalties that could affect their decision to be PAR or non-PAR. The 2017 fee schedules

published on the Medicare carrier websites display multiple columns for limiting charges, depending on whether non-PAR physicians are subject to penalties under PQRS and/or MU. And as noted above, the VBM program penalties (and bonuses) will not be applied to unassigned claims at all. This means that a practice facing a VBM penalty for 2017 that chooses to be non-PAR will not see any reduction in its limiting charges due to the VBM.

► **Option 3: Private contracting**

Provisions in the Balanced Budget Act of 1997 set the terms for physicians and their Medicare patients to privately contract for health care services outside the Medicare system. **However, private contracting decisions may not be made on a claim-by-claim or patient-by-patient basis. Once physicians have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period.**

A physician who has not been legally excluded from providing Medicare services may, however, order, certify or refer a beneficiary for Medicare-covered items and services, as long as the physician is not paid, directly or indirectly, for such services (except for emergency and urgent care services). For example, if a physician who has opted out of Medicare refers a patient for services, such as durable medical equipment or inpatient hospitalization, those services would be covered by Medicare.

To privately contract with a Medicare beneficiary, a physician must enter into a private contract that meets specific requirements, as set forth in the sample private contract included in this kit. In addition to the private contract, the physician must also file an affidavit that meets certain requirements, as contained in the sample affidavit (also included in this kit).

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. After the 90-day period, physicians cannot opt back into Medicare until two years have elapsed.

Emergency and urgent care services furnished during the “opt-out” period

Physicians who have opted out of Medicare under the Medicare private contract provisions may furnish emergency care services or urgent care services to a Medicare beneficiary with whom they have previously entered into a private contract so long as the physician and beneficiary entered into that contract before the onset of the emergency medical condition or urgent medical condition. These services would be furnished under the terms of the private contract.

Physicians who have opted out of Medicare under the Medicare private contract provisions may also furnish emergency or urgent care services to a Medicare beneficiary with whom they have not previously entered into a private contract, provided the physician:

- Submits a claim to Medicare in accordance with Medicare payment requirements and other Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians who have opted out of Medicare)
- Collects no more than the Medicare limiting charge

Note that a physician who has been excluded from Medicare must comply with Medicare regulations relating to scope and effect of the exclusion when the physician furnishes emergency services to beneficiaries, and the physician may not bill and be paid for urgent care services.

AMA efforts to change contracting law

Current law places a number of restrictions on private contracting, but the AMA is working to change the law to establish an option that would allow patients to continue using their Medicare benefits while freely contracting with physicians for Medicare services without restrictions. Legislation introduced in the 114th U.S. Congress, the “Medicare Patient Empowerment Act” (HR 1650 and S1849), would provide this contracting freedom if enacted. [Learn more about the MPEA.](#)

In addition, due to AMA advocacy, the MACRA legislation that Congress passed in 2015 eliminated the requirement for physicians who opt out to renew their opt-out status every two years.

Sample Medicare private contract and affidavit

The sample private contract and affidavit in this kit contain the provisions that Medicare requires (unless otherwise noted) to be included in these documents.

If you determine that you want to “opt out” of Medicare under a private contract, we recommend that you consult with your attorney to develop a valid contract containing other provisions that generally are included in any standard contract in addition to those required by Medicare. This document contains excerpts from [Medicare RBRVS 2016: The Physicians’ Guide](#), which is available from the AMA Store.

Please email medicareoptions@ama-assn.org if you have additional questions about Medicare participation options.