
Opting Out of Medicare

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To begin this discussion, it is important to note that this article is not to be considered as advising or recommending any specific Medicare participation option described within. Instead, this article is intended to provide readers of *Medicare Patient Management* with information so that they may make an educated decision about Medicare participation. With that said, “What are the options when it comes to caring for seniors with regards to payment?” Of course, most senior care providers fully participate in the Medicare program. However, at the other end of the spectrum, there are increasing numbers of providers who are choosing to withdraw completely from Medicare participation, deciding instead to bill their senior patients directly. Furthermore, somewhere in the middle, are the nonparticipating providers who still receive payment from Medicare based on a different fee schedule or, in some cases, do not receive coverage directly from Medicare.

So the question is, “What are a physician’s options when it comes to dealing with Medicare?” Basically, there are 3 options with regard to participation in the federal Medicare program.

- 1) A physician can choose to participate directly in Medicare; these physicians are referred to as PAR physicians.
- 2) A physician may elect to be a non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and bill patients for more than the Medicare allowance for unassigned claims.
- 3) Lastly, a physician can choose to opt out of participation in the Medicare program completely, developing a private relationship with his or her patients.

PAR Physicians

Participating physicians, or PAR

physicians, agree to accept what Medicare pays in full for each service for all of their Medicare patients. This payment is listed on the Medicare fee schedule, which is adjusted annually on the basis of the sustainable growth rate (SGR) formula or by an Act of Congress.

Medicare payments to PAR physicians are made up of 20% of the patient’s copayment, either directly or through the patient’s secondary insurer, and 80% paid directly from Medicare. PAR physicians are not permitted to bill patients above the Medicare-allowable rate. Although PAR physicians are required to bill all their patients in this manner, they are not required to accept all Medicare beneficiaries into their practice. Instead, practices can choose to become closed to new Medicare patients, accept only

current patients who become Medicare beneficiaries, or remain open to all Medicare beneficiaries. Currently, very few physicians do not accept new Medicare patients. Those who don’t accept new Medicare patients claim to do so because of reimbursement issues, administrative burden, and the inability to handle additional patient volume, especially given the needs of the Medicare patient population. Whatever level of Medicare beneficiaries a practice chooses to accept does not affect physicians’ payments.

Medicare considers participation by physicians to be very important, and access to services is a measure that is monitored closely. Besides adjustments to the fee schedule to encourage or maintain participation in the program, Medicare also provides other incentives for PAR physicians, including:

- A 5% higher rate than non-PAR physicians from Medicare;
- Inclusion in physician directories provided to Medicare beneficiaries to aid them in the selection of a physician; and
- A toll-free line to aid in the processing of claims that is available only to PAR physicians.

Non-PAR Physicians

Decisions to work with Medicare can be made on an individual patient basis by non-PAR physicians. These physicians can bill patients above the Medicare allowance for unassigned claims.

Medicare pays non-PAR physicians based on a fee schedule that

is set at 95% of the Medicare-allowable amount. Non-PAR physicians are then allowed to charge their patients above this amount directly, although these charges cannot exceed 115% of the Medicare-approved amount. Thus, this is not a true 15% increase over that available to PAR physicians because PAR physicians are already receiving a 5% higher rate than non-PAR physicians. As a result, the actual difference collected by non-PAR physicians is 9.25% over that of PAR physicians. Of course, this additional 9.25% does have costs associated with it, including the fees associated with bill handling and bad debit.

Within non-PAR practices, there are 2 options: to be either an assigned or nonassigned non-PAR physician. Assigned non-PAR physicians accept payment from Medicare directly, but forgo the opportunity to bill patients over

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the 95% Medicare-allowable rate. A physician who chooses to be a non-PAR unassigned physician can bill at 115% of the Medicare-allowable fee, with Medicare paying 80%; however, this is paid to the patient and it then becomes the patient's responsibility to pay the physician despite the fact that the physician is required to submit the

bill to Medicare. This accounts for some of the added expenses imposed on non-PAR unassigned physicians.

So by becoming a non-PAR physician, one would receive 5% less than a PAR physician who accepts assignment on claims and 9.25% more on claims than a non-PAR physician who does not accept assignment (otherwise known as an unassigned claim) (Table 1). In an evaluation completed by the American Medical Association and published in their November 7, 2005 "Medicare Participation Options for Physician," report, it is noted that non-PAR physicians would be required to collect the full limited charge roughly 35% of the time they provide a given service for the revenues from the service to equal those received by PAR physicians for the same service. Because non-PAR physicians can choose the patients to whom they apply this extra charge, for those practices considering only applying extra fees in only a limited number of cases, PAR practices may be more financially beneficial (Table 2).

Private Physicians

Billing the patient directly and thus having no involvement with Medicare is possible for those who completely opt out of Medicare participation to become private physicians. Private physicians forgo any payments from Medicare. Only 3% of physicians with practices open to private patients have completely closed their practice to new Medicare patients (Table 3). The main reasons cited by private physicians include inadequate reimbursement, billing

Table 1.

99205: Comprehensive History and Examination/High Complexity \$166.41

Payment Type	Total Reimbursement	Payment from Medicare	Payment from MediGap	Payment from the Patient
PAR	\$166.41	\$133.13	\$33.27	0
Non-PAR/ assigned claim	\$158.09	\$126.47	\$39.93	0
Non-PAR/ unassigned claim	\$181.80	\$126.47, but this is paid to the patient	\$39.93	\$15.39
Private	The amount the physician chooses to charge for their services that the patient is willing to pay	None	None	The amount charged by the physician

Table 2.

Physician Participation and Payment Options in Medicare and the Effects on Patients

Payment Type	Affected Medicare Patients	Patient Payment Levels	Percentage of Physicians
PAR	Applies to all Medicare patients within the practice	Medicare patients are not liable for charges other than 20% of the Medicare-allowable fee	96.1%
Non-PAR/assigned claim	Determined on a case-by-case basis	Medicare patients are not liable for charges other than 19% of the Medicare-allowable fee	
Non-PAR/unassigned claim		Medicare patients are not liable for charges other than 23.25% of the Medicare-allowable fee	3%
Private	Unable to bill Medicare for any services	Patients are responsible for 100% of the agreed-upon payment with their physician	0.9%

Table 3.

Physician Acceptance of New Medicare Patients Has Stabilized

Patients	Percentage of Physicians Accepting New Patients		
	1996-1997	2001-2002	2004-2005
New Medicare			
All	75%	71%*	73%
Most	13%	15%*	14%
Some	10%	10%	10%
None	3%	4%*	3%
New privately insured			
All	71%	68%*	72% [†]
Most	16%	17%	15%
Some	10%	10%	9%
None	4%	5%*	4%

Note: Medicare rates exclude pediatricians, pediatric specialists, nephrologists, and physicians accepting no new privately insured patients.

*Change from 1996-1997 is statistically significant at $P < 0.05$.

[†]Change from 2000-2001 is statistically significant at $P < 0.05$.

Source: Center for Studying Health System Change (Cunningham et al., 2003).

and paperwork, high clinical burden, and an already too-full practice.

Becoming an opt-out physician requires the physician to sign and submit an affidavit stating that he or she agrees to forego Medicare payments, either directly or indirectly, for a period of 2 years. Private physicians also are required to have a written agreement with each patient. The beneficiary must sign this agreement before any services are rendered and can never sign the agreement during an emergent or urgent situation. The patient agreement must state that the patient is responsible for all charges related to claims that could be covered by Medicare or MediGap. In addition, the patient acknowledges that he or she has the option to receive the same services for a 20% copayment of the Medicare-allowable fee by utilizing a PAR physician.

Timing

Physicians can change how they participate in Medicare within defined periods of time. Changes must occur between November 15 and December 31, becoming effective on January 1 of a given year. Medicare participation and non-participation are binding for an entire year. However, this is subject to change if, as in 2006, Congress enacts a change to the fee schedule after January 1. If a physician does not plan on changing their level of Medicare participation, they do not need to do anything to maintain their current status.

With regard to completely opting out of Medicare participation to become a private physician, a
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Report to Congress

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Inpatient Rehabilitation Facility Services

This year, also for the first time, the Commission is assessing the adequacy of payment for inpatient rehabilitation facilities. IRFs provide intensive rehabilitation services. **To be eligible for treatment in an IRF, beneficiaries must be able to tolerate and benefit from three hours of therapy per day.**

Indicators of payment adequacy were generally positive through 2004. Supply and volume increased, quality was stable, and access to capital was good. Medicare payments grew rapidly from 2002 to 2004, resulting in high margins for IRFs. A recent regulatory change—CMS's 2004 modification of the 75 percent rule—complicates analysis of this sector. This rule has led to decreased admissions in 2005 and will affect Medicare margins. However, **the Commission estimates margins will still be more than adequate and that IRFs can accommodate price changes without an increase in payments.** Therefore, the Commission recommends that the Congress eliminate the update to payment rates for inpatient rehabilitation facility services for fiscal year 2007. *MPM*

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The highlighted areas are based on those points that the MPM editorial staff feels are most important to our readers.

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physician must file an affidavit with their carrier at least 30 days before the first day of the next calendar quarter. Private physicians are not permitted to submit a claim to Medicare for any patient for a period of 2 years. Because this is such a significant option, CMS provides a 90-day grace period after the effective date of the opt-out affidavit during which the physician may revoke their decision, thus returning as a Medicare PAR physician.

Specific information regarding the fee schedule, as well as the Medicare participation physician/supplier agreement is available through local Medicare carriers. In addition, all communications regarding participation need to be provided to local Medicare carriers.

The Decision

The decision to opt out of Medicare and become a private physician is significant. These types of practices are commonly referred to as concerti practices. Choosing this option can limit the size of a practice and place a hardship on less affluent patients who are not able to bear physician fees outside of Medicare. Non-PAR status is much less extreme, since Medicare beneficiaries can still receive payment from Medicare. Unlike private physicians who can charge whatever the market can bear, non-PAR physicians are limited to charging just 9.25% above the Medicare-allowable fee, thus limiting the financial benefit of this option.

In conclusion, the level of Medicare participation requires a

Take-Away Message

- PAR—Participating physicians agree to accept what Medicare allows for payment in full for each service for all of their Medicare patients.
- Non-PAR—Non-participating physicians are then allowed to charge their patients above this amount directly, although there are limits on these charges.
- Private—Bill the patient directly, thus having no involvement with Medicare. This is only possible for those who opt completely out of Medicare, becoming private physicians.
- Physicians can only make a change in how they participate with Medicare within defined periods of time.

ROI

- Careful consideration is required based on one's desired practice type and lifestyle, as well as one's market situation before deciding on a change in Medicare participation.
- Clear understanding of the implementation of moving from a PAR Medicare provider to either Non-PAR or private provider is required to achieve the desired outcome.

very careful analysis of one's market potential, desired practice, and lifestyle goals. Clearly, as a new group of seniors is being found with increased wealth that they are willing to spend on their health care at the same time that Medicare is reducing physician reimbursement, many physicians may make this difficult decision and change their level of participation in Medicare. Only time will tell. *MPM*

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