



AMERICAN OSTEOPATHIC ASSOCIATION

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Dear Osteopathic Family:

As most of you know, physicians participating in the Medicare program face a 27.4 percent cut in their payments effective January 1, 2012. We once again find ourselves anxiously awaiting Congressional intervention at the 11th hour to stave off yet another devastating cut in Medicare physician payments. If Congress fails to act, the Medicare physician conversion factor will decrease to \$24.67. This is approximately \$15 less than it was in 2001. As we have articulated to Congress and the Administration on numerous occasions, this cut will have a devastating impact on beneficiaries' access to health care and your practice.

Our nation faces a tidal wave of new Medicare beneficiaries over the next two decades. In fact, 10,000 people will turn 65 years of age – an event that will be replicated every day for the next 19 years. Additionally, this cut comes at a time when physicians face potential penalties associated with HIPAA 5010, electronic prescribing, ICD-10, PQRS, and electronic health records. While the AOA believes each of these initiatives has potential to improve the quality and efficiency of health care, it is difficult to ask our physician members to accept responsibility for adhering to such mandates in a time of dramatically falling revenue. Thus, our continued claim that the sustainable growth rate (SGR) is an anchor on innovation in the Medicare program. Today, as in previous years, the SGR is the primary reason that physicians are hesitant to participate in practice transformations – largely based on their correct assertion that it is difficult to make investments at a time of unpredictable and falling revenues.

The threat of a cut in Medicare payments is not new; physicians and Congress have grappled with similar situations for each of the past 10 years. The differences are the severity of the cut, the escalating costs of a permanent solution, and the negative impact the SGR has on a growing health care program. The lack of a predictable and stable payment formula causes each of you to evaluate your participation in the Medicare program on an annual basis. We are always mindful that each of you operate a business and that few can continue to exist in an environment where revenues are cut by 27 percent while their costs continue to rise at a rate of 3 percent or higher. More troubling, the SGR is a primary reason why physicians are hesitant to participate in new and innovative Medicare programs such as the electronic health records incentive program or the physician quality reporting system.

This vexing payment formula has hindered Congress' ability to reform Medicare for more than 10 years and has been an anchor on innovation in the program. For the past decade Congress has

opted not to pursue a permanent solution to the SGR. Instead, lawmakers have chose to “kick the can down the road” with a series – 12 in 10 years to be exact – of short-term fixes.

As President, I feel it is important that the AOA provide all osteopathic physicians with a fair assessment of the current policy and political environment. Additionally, we believe it is important to provide you unbiased, yet factual information, on your options as a practicing physician.

While the AOA remains confident that Congress and the Administration will take the necessary steps to prevent the implementation of the 27.4 percent cut prior to its implementation on January 1, we are deeply concerned that actions taken by Congress will only provide a temporary reprieve versus the desired long-term solution we have been seeking for the past decade.

The AOA continues to believe that Congress must take the necessary steps to ensure that our nation’s seniors, disabled, and military families have access to physician services. To this end, we continue our advocacy efforts aimed at repealing the SGR formula and replacing it with a payment formula that compensates physicians in a fair and equitable manner for their services.

The following information is designed to clearly articulate options available to you with respect to your participation in the Medicare program. The AOA is not advising our members to take a specific action regarding your participation in the Medicare program nor offering legal advice regarding these issues. Participation decisions involve binding legal documents and all members are strongly encouraged to consult with your own legal advisors and consultants prior to making a decision on these matters. Our goal is to provide you with the necessary information, thus enabling you to make an informed decision.

The Centers for Medicare and Medicaid Services has established a deadline of December 31, 2011 for physicians to modify their Medicare participation or non-participation status in 2012. Physicians who wish to continue their current status are not required to take any action to maintain their status. Those who wish to switch their status need to notify their contractor through a written communication that is received or post-marked on or before December 31, 2011.

There are three Medicare contractual options for physicians:

1. Medicare Participating Physician

Physicians may sign a participation (PAR) agreement and accept Medicare’s allowed charge as payment in full for all of their Medicare patients. Participating physicians agree to accept 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 participating physicians must accept assignment on all Medicare claims, Medicare participation agreements do not require physicians to accept every Medicare patient who seeks treatment from them or their practice.

2. Medicare Non-Participating Physician

Physicians may elect to be a non-participating (Non-PAR) 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. Non-participating physicians agree to accept 95 percent of the Medicare approved amounts for services provided. Non-participating physicians may charge more than the Medicare approved amount, but are limited to 115 percent of the Medicare approved amount for non-participating physicians. Since approved amounts for non-participating physicians are 95 percent of the rates for participating physicians, the 15 percent limiting charge is effectively 9.25 percent above the participating approved amount for services provided.

3. Private Contracting

Physicians may become a private contracting physician, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves. Provisions in the Balanced Budget Act of 1997 afford physicians and their Medicare patients the freedom to privately contract for health care services outside the Medicare program. However, private contracting decisions may not be made on a patient-by-patient basis. To become a “private contracting physician,” a physician must first opt-out of the Medicare program. Once a physician has opted out of Medicare, they cannot submit claims to Medicare for services provided to any Medicare patients for a two-year period. To privately contract with a Medicare beneficiary, a physician must enter into a private contract that meets specific requirements. In addition to the private contract, the physician must also file an affidavit that meets certain requirements. 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 of the Medicare program.

A physician who has not been excluded under Sections 1128, 1156 or 1892 of the Social Security Act (SSA) may order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided 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 beneficiary for medically necessary services, such as laboratory, DMEPOS, or inpatient hospitalization, those services would be covered by Medicare.

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 the physician has previously entered into a private contract so long as the physician and beneficiary entered into the private 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 continue to furnish emergency or urgent care services to a Medicare beneficiary with whom the physician has not previously entered into a private contract, provided the physician submits a claim to Medicare in accordance with both 42 C.F.R. part 424 (relating to conditions for Medicare payment) and Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare) and collects no more than the Medicare limiting charge, in the case of a physician (or the deductible and coinsurance, in the case of a

practitioner). A physician who has been excluded from Medicare must comply with Medicare regulations relating to scope and effect of the exclusion (42 C.F.R. § 1001.1901) when the physician furnishes emergency services to beneficiaries, and the physician may not bill and be paid for urgent care services.

Again, any physicians electing to change their status from PAR to Non-PAR or vice versa are required to do so on or before December 31, 2011. Unless CMS reopens the enrollment period, once made, the decision is binding throughout the calendar year except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect. Prior to making a determination of a change in participation status, all osteopathic physicians should review all contracts with hospitals, health plans, or other entities to verify that they are not required to be a Medicare participating physician as a condition of their contract.

In closing, I urge each of you to continue to voice your concerns with current Medicare payment policies to your elected officials. The AOA, through our Department of Government Relations, continues to advocate for fair and equitable payment policies on your behalf. I assure you that we are deploying all available resources to protect your ability to provide quality health care to your patients. Again, I urge you to join our advocacy efforts by expressing your concerns to your elected officials today.

Fraternally,



Martin S. Levine, DO
President