Provider Participation in Medicare

What it Means for SHIPs, SMPs & Beneficiaries

SHIP & SMP National Meeting, August 2016
Milwaukee, Wisconsin
Workshop Objectives

1. Distinguish between participating, opt-out, enrolled, and contract Medicare providers

2. Recognize link between non-participating providers and unassigned claims

3. Identify concerns for beneficiaries

4. Identify problem-solving strategies
<table>
<thead>
<tr>
<th>Key Terms: Providers &amp; Suppliers</th>
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<tbody>
<tr>
<td>Participation</td>
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<tr>
<td>Non-participation</td>
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<tr>
<td>Opt-out</td>
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<tr>
<td>Enrollment</td>
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<td>Exclusion</td>
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Key Terms: Medicare Claims

- Assigned Claims
- Non-assigned Claims
- Balance Billing
- Mandatory Assignment
- Mandatory Claims Filing
Mrs. Smith goes to Dr. Lowe for an office visit.

- Actual Charge: $150
- Approved Amount: $100
- Medicare Pays 80%: $80
- Mrs. Smith owes:
  - 20% coinsurance: $20
Mrs. Smith goes to Dr. Cole d’Hands for an office visit.

- **Actual Charge:** $150
- **Approved Amount:** $100
- **Medicare Pays 80%:** $80
- **Mrs. Smith owes:**
  - 20% coinsurance: $20
  - Excess charge: $50

**Total:** $70

$50 difference = excess charge
1982: Assignment Rates

• Assignment rates were falling in general
  o 53% of claims, 54.2% of charges

• Higher assignment rates for...
  o 85 and older
  o Non-white
  o Disability

• Rates varied by state & region

• Rates varied by physician specialty
Beneficiary Liability on Unassigned Claims

- Physician decides to accept assignment or not on patient-by-patient or claim-by-claim basis
- Nearly 80% of Part B enrollees with physician claims owed (and most paid) an “excess charge” in 1982
  - Varied by beneficiary status and state
  - Annual Avg: $154 per person with an unassigned claim
  - One million beneficiaries owed $500 or more
The Problem(s)

• Medicare’s “net contribution” toward physician bills was 30.8% of total charges in 1975; 49% in 1984

• In 1988, Part B providers billed beneficiaries $2.25 billion more than Medicare’s approved amount.

• Few Medigap policies covered the “excess charge”

• Many beneficiaries did not submit claims

• In 1989, 1 in 9 Part B claims (45 million) were sent to Carriers with incomplete information

• Medicare costs for physician services were rising

• States were reacting while HCFA studied the problems
State Level Solutions

• Assignment Rate Reporting Laws
  o Medical Licensing Boards; condition of licensure

• Mandatory Assignment Laws
  o Connecticut, Massachusetts, Rhode Island, Vermont
  o Enacted between 1985-1988
  o Law applied to all beneficiaries in Massachusetts
  o Others used income criteria

• Voluntary Assignment Programs
  o 26 states: some statewide, others certain counties
1984: Participating Physician & Supplier Program

• Deficit Reduction Act (DEFRA) of 1984
  o Voluntary program; annual sign-up
  o “Participating Physicians” agree to accept assignment on all Medicare claims
    ▪ Payment & claims processing incentives
    ▪ Medicare Participating Provider Directory (MedPARD)
    ▪ Fee Freeze
  o Assignment rate jumped to 68.5% in 1986
  o Initial physician participation rate was near 30% in 1985 and rose to 96% in 2011
  o DEFRA also established mandatory assignment for lab services
1984: Non-participating Physicians

- **DEFRA-1984**
  - Non-participating physicians could still accept assignment on claim-by-claim basis
  - Physicians may submit claim to Part B Carrier as a “service” to the beneficiary
  - Medicare Carrier sends payment to beneficiary
    - Lower payment rates than for “PAR physicians”

- **OBRA-1986 imposes balance billing (excess charge) limitations**
  - “Maximum Allowable Actual Charge” (MAAC)
Blast from the Past!
1989: Physician Payment Reform

• Omnibus Budget & Reconciliation Act of 1989
  o Established Medicare Fee Schedule
    ▪ Resource-Based Relative Value Scale
    ▪ Replaced Customary, Prevailing, Actual Charge Methodology
  o Established Limiting Charge for all Physician Services
    ▪ 115% of the Approved Amount for Unassigned Claims; took effect in 1992
  o Established Mandatory Claims Filing for Physicians
    ▪ Applies to Assigned and Unassigned Claims, effective 1990
Mandatory Assignment

• Medicare law requires some non-physician practitioners and providers to accept assignment
  o Physician Assistants
  o Clinical Nurse Specialists
  o Nurse Practitioners
  o Certified Registered Nurse Anesthetists (CRNA)
  o Clinical Psychologists
  o Clinical Social Workers
  o And others
1997: Opt-out Physicians and Private Contracts

- Balanced Budget Act (BBA) of 1997
  - Enables physicians and Medicare beneficiaries to enter private contracts to pay for Medicare-covered services
    - Beneficiary agrees to pay out-of-pocket
    - Neither can receive Medicare payment for the service
  - Physician must file affidavit with CMS to opt-out of Medicare program for 2 years
    - Opt-out period designed to prevent fraud
    - Relatively few physicians decide to opt-out of Medicare

- Assignment Rate in 1997: 96.5%
2006: Provider Enrollment

• “Qualified Providers” and “Billing Privileges”

• BBA of 1997 required providers and suppliers to disclose EINs and/or SSNs

• CMS issued an Enrollment Rule in 2006
  o 42 CFR §424.500 mandates enrollment for payment
  o Extension of program integrity, i.e., anti-fraud, efforts
  o Screens for unqualified/uncertified providers and suppliers
  o Requires periodic revalidation
Provider Enrollment-Physicians & NPP

• Requires all providers & suppliers to submit enrollment application
  o Exception for “Opt-Out” physicians and suppliers
  o Separate applications for physicians/NPPs, “certified providers/suppliers,” and DMEPOS suppliers
  o CMS issues National Provider Identifier (NPI) number
  o Provider Enrollment, Chain & Ownership System (PECOS)
    ▪ On-line system for applications, changes, revalidation
  o Sign up for Participating Provider Program while enrolling
Provider Enrollment-DMEPOS

• ACA of 2010 and DMEPOS Suppliers
  - Accreditation
  - Surety Bonds
  - National Supplier Clearinghouse (NSC) Enrollment
  - “High Screening” Category
    ▪ Site visit and National Criminal Background check
  - Comply with 30 standards to maintain billing privileges
• **DMEPOS Competitive Bidding Program**
  - Medicare Modernization Act of 2003 (MMA)
  - **Contract Suppliers**
    - Bids evaluated on basis of supplier eligibility, financial stability, bid price
    - Agree to accept assignment on all claims for bid items
• **Participating Suppliers**
• **Non-participating Suppliers**
Administrative Sanctions

• CMS Center for Program Integrity, est. 2010
• CMS Contractors (MACs, ZPICs, etc)
  o Educate & warn providers
  o Revoke assignment privileges
  o Suspend payments
  o Recover overpayments
  o Refer to state licensing boards and medical societies
• OIG has Exclusion & Civil Monetary Penalty Authority
  o List of Excluded Individuals & Entities (LEIE) Database
Assignment Update

• Assigned Claims in 2012:
  o 99.6% rate for physicians and other Part B providers
  o Average balance bill (excess charge): $53 per person

• Participating Physician & Supplier Program
  o 981,644 of 1,022,909 enrolled MDs, DOs, NPPs in 2011
  o 96% participation rate
  o Participating in at least one practice setting
  o Lower assignment rates for DMEPOS suppliers outside competitive bidding areas?
Case Study

• With a physician’s prescription, Mr. Franklin ordered a DME item through his local pharmacy. He was surprised when the pharmacist told him that he would have to pay for the item up-front, and even more surprised to learn that Medicare would eventually send a check to him. The pharmacy delivered the DME item, but the check from Medicare never arrived.
Your Unassigned Claims for Part B (Medical Insurance)

Medicare claims may be assigned or unassigned. Your claims below are **unassigned**—meaning the provider hasn’t agreed to accept the Medicare-approved amount as payment in full.

**Do Unassigned Claims Cost More? Maybe. A provider who doesn’t accept assignment may charge you up to 15% over the Medicare-approved amount. This is known as the limiting charge. You may have to pay this amount, or it may be covered by another insurer.**

For a list of providers that always accept Medicare assignment, visit www.medicare.gov/physician or call 1-800-MEDICARE (1-800-633-4227). You may save money by choosing providers who accept assignment.

**Definitions of Columns**

**Service Approved?** This column tells you if Medicare covered the service.

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### June 18, 2011

**Steven Thiele D.C., (555) 555-1234**

Orange Chiropractic, 370 Boston Post Rd, Orange, CT 06477-3534

<table>
<thead>
<tr>
<th>Service Provided &amp; Billing Code</th>
<th>Service Approved?</th>
<th>Amount Provider Charged</th>
<th>Medicare-Approved Amount</th>
<th>Medicare Paid You</th>
<th>Maximum You May Be Billed</th>
<th>See Notes Below</th>
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<tbody>
<tr>
<td>Chiropractic manipulative treatment, 3 to 4 spinal regions (98941-GA)</td>
<td>Yes</td>
<td>$65.00</td>
<td>$35.55</td>
<td>$0.00</td>
<td>$40.88</td>
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<td><strong>Total for Claim #02-11040-017-700</strong></td>
<td></td>
<td>$65.00</td>
<td>$35.55</td>
<td>$0.00</td>
<td>$40.88</td>
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Questions?

The production of this webinar was supported by Grant No. 90ST1001 from the Administration for Community Living (ACL). Its contents are solely the responsibility of the SHIP TA Center and do not necessarily represent the official views of ACL.
Selected Sources

• Participating Providers and Assignment


• **Opt-out Physicians**
  
  o MLN Matters® Fact Sheet MM 6081, “Private Contracting/Opting out of Medicare,” June 27, 2008
  

• **Enrollment**
  
  o 71 Federal Register 20754 (April 21, 2006).
  
  
  o MLN Matters® Fact Sheet SE1605, “Provider Enrollment Revalidation-Cycle 2"