Provider Participation in Medicare

What it Means for SHIPs, SMPs & Beneficiaries

SHIP & SMP National Meeting, August 2016

Milwaukee, Wisconsin

The SHIP National Technical Assistance Center

ship NATIONAL NETWORK state health insurance assistance programs

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

Key Terms: Providers & Suppliers

- Participation
- Non-participation
- Opt-out
- Enrollment
- Exclusion

Key Terms: Medicare Claims

- Assigned Claims
- Non-assigned Claims
- Balance Billing
- Mandatory Assignment
- Mandatory Claims Filing

1982: Assigned Claim Example

Mrs. Smith goes to Dr. Lowe for an office visit.

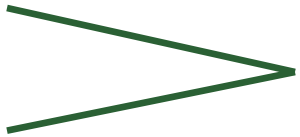
- Actual Charge: $150
- Approved Amount: $100
- Medicare Pays 80%: $ 80
- Mrs. Smith owes:
  - 20% coinsurance: $20

1982: Unassigned Claim Example

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

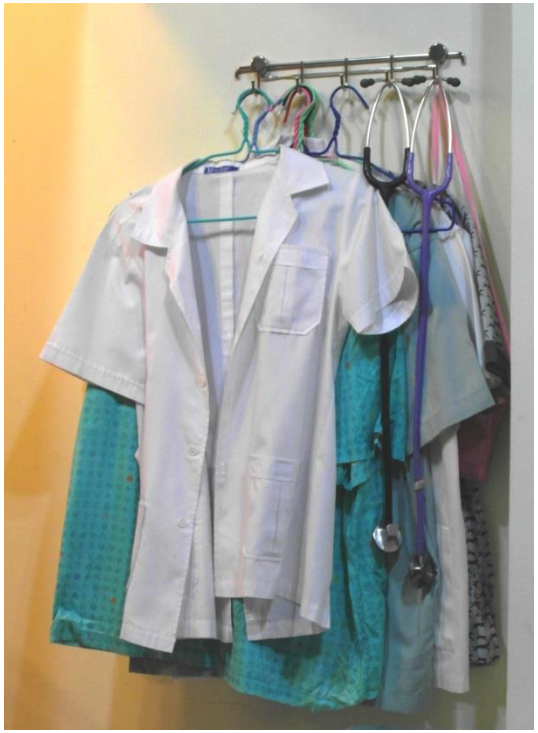
Total: **$70**



$50 difference = excess charge

1982: Assignment Rates

- Assignment rates were falling in general
  - 53% of claims, 54.2% of charges
- Higher assignment rates for…
  - 85 and older
  - Non-white
  - 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
  - Medical Licensing Boards; condition of licensure
- Mandatory Assignment Laws
  - Connecticut, Massachusetts, Rhode Island, Vermont
  - Enacted between 1985-1988
  - Law applied to all beneficiaries in Massachusetts
  - Others used income criteria
- Voluntary Assignment Programs
  - 26 states: some statewide, others certain counties

1984: Participating Physician & Supplier Program

- Deficit Reduction Act (DEFRA) of 1984
  - Voluntary program; annual sign-up
  - "Participating Physicians" agree to accept assignment on all Medicare claims
    - Payment & claims processing incentives
    - Medicare Participating Provider Directory (MedPARD)
    - Fee Freeze
  - Assignment rate jumped to 68.5% in 1986
  - Initial physician participation rate was near 30% in 1985 and rose to 96% in 2011
  - 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!

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

SEND COMPLETED FORM TO:
Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box – Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the illness or injury for which patient received treatment

4b Condition was related to:
A. Patient's employment
☐ Yes ☐ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5
a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No
b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No
c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

6 Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Form CMS-1490S (SC) (01/05) EF 02/2005

1989: Physician Payment Reform

- Omnibus Budget & Reconciliation Act of 1989
  - Established Medicare Fee Schedule
    - Resource-Based Relative Value Scale
    - Replaced Customary, Prevailing, Actual Charge Methodology
  - Established Limiting Charge for all Physician Services
    - 115% of the Approved Amount for Unassigned Claims; took effect in 1992
  - 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
  - Physician Assistants
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Certified Registered Nurse Anesthetists (CRNA)
  - Clinical Psychologists
  - Clinical Social Workers
  - 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

  - 42 CFR §424.500 mandates enrollment for payment
  - Extension of program integrity, i.e., anti-fraud, efforts
  - Screens for unqualified/uncertified providers and suppliers
  - Requires periodic revalidation

Provider Enrollment-Physicians & NPP

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

Provider Enrollment-DMEPOS

- 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)
  - Educate & warn providers
  - Revoke assignment privileges
  - Suspend payments
  - Recover overpayments
  - Refer to state licensing boards and medical societies

- OIG has Exclusion & Civil Monetary Penalty Authority
  - List of Excluded Individuals & Entities (LEIE) Database

Assignment Update

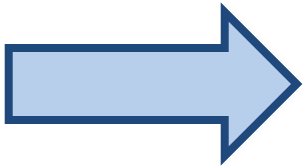
- Assigned Claims in 2012:
  - 99.6% rate for physicians and other Part B providers
  - Average balance bill (excess charge): $53 per person
- Participating Physician & Supplier Program
  - 981,644 of 1,022,909 enrolled MDs, DOs, NPPs in 2011
  - 96% participation rate
  - Participating in at least one practice setting
  - 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.

Sample MSN:

Unassigned Claim



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.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. Since your provider hasn't agreed to accept assignment, you might be charged up to 15% more than this amount. Medicare usually pays 80% of the Medicare-approved amount.

Medicare Paid You: When a provider doesn't accept assignment, Medicare pays you directly. You'll usually get 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

June 18, 2011
Steven Thiele D C, (555) 555-1234
Orange Chripractic, 370 Boston Post Rd, Orange, CT 06477-3534

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Medicare Paid You	Maximum You May Be Billed	See Notes Below
Chiropractic manipulative treatment, 3 to 4 spinal regions (98941-GA)	Yes	$65.00	$35.55	$0.00	**$40.88**	**A,B**
Total for Claim #02-11040-017-700		$65.00	$35.55	$0.00	**$40.88**	**C**

Questions?

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