Commentary: Medicare Options

By Barbara L. McAneny, MD

This has been an troubling year for Medicare payment. We have had so many short-term fixes to the Sustainable Growth Rate (SGR) formula that many physicians are becoming increasingly frustrated with participating in Medicare at all. All physicians are currently being paid at little more than 2001 levels while hospitals get an approximately 3% market basket increase in Medicare payments every year. Practices are discussing whether or not they can afford to continue seeing Medicare patients because the payments do not cover overhead costs.

Oncologists are no exception. Oncology practices are finding themselves losing money on every Medicare patient treated, particularly with the new targeted agents. It is therefore no surprise that oncologists, like other specialists, are looking for options other than continuing to lose money on every Medicare patient. The American Medical Association, ASCO, and other specialty societies are trying hard to make a dysfunctional Congress understand the importance of permanently fixing the SGR formula, but in the meantime, practices must pay their bills.

The contractual options for physicians with Medicare are confusing. Changing Medicare contractual status is a significant decision, and it is important to understand what the implications of each option are for physicians. Accepting assignment is another decision physicians must make. Accepting assignment determines whether the check goes to the practice or to the patient and can occur with either participation or nonparticipation.

1. Participation. Most of us are participating providers. This means that we accept Medicare's allowed charges as payment in full for a Medicare patient, and that we agree to accept assignment on all Medicare claims. We receive payment of the Medicare-approved amount, which is 80% of the Medicare-allowed charge. In addition, we receive the 20% patient copayment, which is either paid by the patient themselves or by a medi-gap policy. The Medicare checks for the 80% come directly to the practice rather than going to the patient. With unassigned claims, patients often get confused as to why the government is sending them money, and cash the checks and spend it on other items. The Medicare-approved payment amount for participating physicians is 5% higher than it is for nonparticipating physicians. Medicare tends to be a rapid payer and pays in 10 days. Claims processing is usually pretty quick for Medicare, it is simply the level of reimbursement that is the problem.

2. Nonparticipation. A physician who is not participating has the ability to charge approximately 15% more than the Medicare-approved amount. However, the Medicare-approved amount for nonparticipating physicians is set at 95% of the rates for the participating physician. Medi-gap policies still only pay 20% of the Medicare-approved amount. Therefore, if you are a nonparticipating provider and you accept assignment on a

claim, you only get 95% of what the Medicare fee schedule is from Medicare directly, and the remainder has to be collected from the patient and their medi-gap policy. If you do not accept assignment, you can still bill up to the limiting charge for Medicare fee schedule, which is effectively 109.25% of standard Medicare. However, Medicare does not pay you directly; you need to collect the full amount from the patient. Then Medicare sends the check for 80% of the Medicare-approved amount to the patient. The medi-gap pays its 20% of the Medicare-approved amount to the patient. The remainder of the higher fee is not reimbursed to the patient.

This is a confusing system, and it is designed to encourage physicians to participate. A participating physician with a \$100 charge will get \$80 from Medicare and \$20 from the patient or the medi-gap. The nonparticipating physician only gets 95% of the Medicare fee schedule paid by Medicare. If you accept assignment but are nonparticipating, you get \$76 from Medicare directly and \$19 directly from the supplemental insurance.

If you are nonparticipating and do not accept assignment, your limiting charge for that \$100 charge becomes \$109.25. Medicare will send \$76 to the patient, and the supplementary insurance company will send them \$19. You need to collect both of those amounts, plus an additional \$14.25 from the patient in order to be paid your full \$109.25. Obviously, the difficulty here is collecting that money from the patient.

3. Opting out of Medicare. The Balanced Budget Act of 1997 gave physicians the ability to opt out of Medicare and to privately contract. However, this decision must apply to all Medicare patients for a 2-year period. You cannot opt out on a given patient and opt back in on another. You must sign an affidavit agreeing to forgo receiving any payment from Medicare for any items for 2 years. Medicare will not pay either the patient or you for services provided. The contract has to be in writing and must be signed by the Medicare beneficiary. You cannot sign such a contract when the beneficiary is facing an urgent or emergent health situation.

If you elect to opt out, you must file this affidavit with your Medicare carrier 30 days before the first calendar day of the quarter. If you change your mind, you have a 90-day period to revoke the decision to opt out and return to Medicare.

So, the decision to opt in or out of Medicare must be made on the basis of your ability to actually collect payments effectively from your patients. You also should consider whether or not your referring physicians will be upset with you if you are not taking Medicare and stop sending private pay patients as well. More information regarding opt out is available on the AMA Web site, www.ama-assn.org.

This is a difficult decision in this time of economic recession when more and more patients are having a difficult time meeting copays and deductibles and when the economic forecast for

Medicare itself is bleak. Oncology practices tend to have significant amounts of Medicare patients, often more than 50%, so the decision to continue taking Medicare patients or to opt out of Medicare becomes increasingly important and difficult to properly evaluate. Before making such a move, I would suggest having careful conversations with referring physicians and with your accountants and then looking carefully at the economics of the situation. The most difficult part of this, however, is balancing the ethics of opting out of taking care of patients on Medicare, and the need to keep the practice viable so that you are there to take care of anyone at all. I encourage everyone faced with this dilemma to join with the AMA and ASCO so that we can appeal to Congress with a united voice to structure

Medicare in a fiscally responsible way and to eliminate the SGR formula that has created this problem.

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