



AMERICAN OSTEOPATHIC ASSOCIATION

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Dear Osteopathic Family:

As most of you are well aware, physicians participating in the Medicare program had their payments cut 21% on June 1. The Centers for Medicare and Medicaid Services (CMS), after holding claims for several business days, instructed their intermediaries to pay claims reflecting this cut on June 18. This cut and the continued use of the sustainable growth rate (SGR) formula are having a devastating impact upon beneficiaries' access to health care and your practice. On June 24, Congress once again intervened and reversed this cut through November 30, 2010. This means that physicians and their patients have a total of 158 days until the next cut is implemented – not exactly stability.

Earlier this year Congress approved, and the President enacted, comprehensive health care reforms that will expand access to affordable health coverage; increase access to physicians – especially primary care physicians; transform our delivery system to promote quality and efficiency; and lower the cost of health care. The AOA supported each of these goals. However, we are both concerned and confused as to why Congress has failed to act on one element of health care reform that is widely acknowledged to be an enormous problem with an identified solution. Reform of the Medicare physician payment formula *is* health care reform and is sound economic policy. It is a reform that preserves access to health care for millions of our nation's seniors, the disabled, and military families. Additionally, long-term reforms are essential to preserving millions of jobs in the health care sector, advancing quality improvement, and achieving our goal of transforming our health care system through health information technology.

The AOA recently commissioned an independent poll of our members to determine the true impact current and proposed payment policies have upon their practices. When physicians who have at least some say in what kind of insurance they accept in their practices were asked about the pending 21% cut in Medicare payments, only 42% said they would definitely or probably continue seeing their current Medicare patients if the cut were to occur. Thirty-three percent were undecided as to whether they would continue to see their current Medicare patients, and 24% said they probably or definitely would not continue seeing Medicare patients. Additionally, only 30% of physicians currently accepting new Medicare patients said they would continue to do so if the cut were to be implemented (32% said they might, and 37% said they probably or definitely would not). When we asked these same physicians about their participation in the Medicare program if meaningful and long-term payment reforms were enacted, 94% said they would continue seeing their current Medicare patients and 92% indicated they would continue to accept new Medicare patients.

These numbers should be a “wake up” call to policymakers, but they seem to be falling on deaf ears. Since 2002, the flawed SGR formula has plagued the Medicare program. Congress has acted 10 times to prevent cuts from being implemented, including three times in 2010 alone. Each of these actions and their results are outlined in a chart included with this letter.

Despite its willingness to prevent cuts from being implemented, Congress has displayed on a bipartisan and bicameral basis that they are incapable of enacting meaningful, long-term reforms. In short, we are now at a point where the AOA has serious doubts that Congress is capable of ever fulfilling its responsibilities to the Medicare program, Medicare beneficiaries, TRICARE, or physicians with respect to payment issues. While the AOA remains confident that Congress and the Administration will take the necessary steps to prevent further implementation of the current 21% cut or similar future cuts, we do not believe that you or your patients can reasonably expect any type of meaningful payment reform in the near future. We believe that short-term, stopgap measures are the only achievable policies that Congress is capable of approving over the next few years. Based on this belief, we no longer view the Medicare program as a predictable and equitable payer of physician services.

A commitment to providing high quality health care to patients should remain your top priority. The AOA does not promote, nor do we support, physicians abandoning patients regardless of the underlying circumstances. Patients place great trust in you as a physician, and you should honor that trust by ensuring that your patients have the care they need in a timely manner. However, we also recognize that physicians must be compensated equitably for the services they provide and that the current Medicare formula is falling short of this objective.

To this end, we feel it is important that the AOA provide all osteopathic physicians with unbiased, yet factual, information on your options as a practicing physician. The following information is designed to clearly articulate options available to you with respect to your participation in the Medicare program. Prior to taking any action with respect to the Medicare program, we urge all members to carefully evaluate their current practices to determine the impact of any change in participation status. Additionally, we urge you to familiarize yourself with applicable state laws related to participation in Medicare, Medicaid, CHIP, and other public programs. The AOA is not advising our members to take a specific action regarding 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 their 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.

1. Medicare Participating Physician

Physicians may sign a participation agreement (PAR) 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% that Medicare pays plus the 20% 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% 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 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. Given the projected 21.2 percent cut in Medicare physician payments, many physicians may consider balance billing an extra 9 percent as one means of helping close the gap between 2009 and the new 2010 payment amounts.

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.

In closing, I urge each of you to continue to voice your concerns with current Medicare payment policies to your elected officials. The AOA has numerous vehicles by which you can communicate with your Representatives and Senators on this issue. You may use the AOA's Legislative Hotline – (877) 262-9400 to call your elected officials or you can send a letter via the AOA's Advocacy Website – www.capwiz.com/aoa-aoia.

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,



Larry A. Wickless, DO
President

**Summary
Medicare Physician Payment Updates and Legislative Activity
2002-2010**

Year	Formula Update	Actual Update	Legislation
2002	-4.8%	-4.8%	
2003	-4.4%	1.4%	Consolidated Appropriations Resolution
2004	-4.5%	1.5%	Medicare Modernization Act (Public Law 108-173)
2005	-3.3%	1.5%	Medicare Modernization Act (Public Law 108-173)
2006	-4.4%	0.2%	Deficit Reduction Act of 2005 (Public Law 109-171)
2007	-5.0%	0%	Tax Relief and Health Care Act of 2006 (Public Law 109-432)
2008 – January to June	-10.1%	0.5%	Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173)
2008 – July to December	-10.6% from June 30, 2008 level	0% (0.5% above 2007)	Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275)
2009	0%	1.1%	Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275)
2010 – January to February	-21.3%	0%	Department of Defense Appropriations Act (Public Law 111-118)
2010 – March	-21.3%	0%	Temporary Extensions Act (Public Law 111-144)
2010 – April to May	-21.3%	0%	Continuing Extensions Act (Public Law 111-157)
2010 – June to November	-21.3%	2.2%	Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010