

## **“Opt Out”: Objective Guidance for Physicians’ Practices**

The Washington State Medical Association (WSMA) receives frequent inquiries from its physician members regarding the mechanisms for severing their ties with payers, commonly called “Opt Out”, particularly with the Medicare and Medicaid programs.

To assist our members and their staff, the WSMA has assembled material. **Note:** The WSMA is *not* actively encouraging medical practices to cease caring for Medicare or Medicaid patients. Rather, we wish to ensure that clear, consistent and accurate guidance is available, so that physicians and their staff can appropriately traverse these issues.

### **Medicaid**

*Source: Medical Assistance Administration*  
( <https://wws2.wa.gov/dshs/maa/ProvRel/FAQ.htm> )

### **Core Provider Agreement Questions**

**Question:** Is the Core Provider Agreement (CPA) required for fee for service and Healthy Option (HO) providers?

**Answer:** The CPA is required for providers who see fee for service Medical Assistance clients with respect to services included in the scope of the client's Medical Assistance program.

The CPA is not required for providers who see clients enrolled in HO. However, the provider should have an agreement with the client's HO plan(s). If the provider chooses to treat the HO client without such an agreement, but has a CPA, the provider is bound by the CPA to seek reimbursement from the plan for services included in the plan's contract with the department. See WAC 388-502-0100(6); WAC 388-538-070(3).

If the provider does not have a CPA or a contract with a HO plan, the provider should not be seeing the client. However, an individual, whether receiving medical assistance or not, has the right to obtain medical services from providers that do not accept the patient’s insurance/Medical Assistance, as long as the individual is willing to accept financial responsibility. A Medical Assistance client who seeks services from a provider that does not have a CPA or a contract with a HO plan may do so, but MAA expects the provider to inform the client that the provider does not accept Medical Assistance and if the client still chooses to have the provider treat him/her, he/she will be billed.

**Question:** How does a provider "opt out" of Medical Assistance?

**Answer:** Medical Assistance, unlike Medicare, does not have an "opt out" provision. However, the provider may terminate his/her CPA. The CPA includes provisions related to termination. In general, providers may terminate their CPAs at any time by providing written notice to the department. See CPA; WAC 388-502-0030(5)(e).

The provider is considered "inactive" if there has been no billing activity in a 24 month period. In these cases MAA notifies the provider his/her CPA will be terminated, unless we are notified that the provider wants to remain active. See WAC 388-502-0030(5)(b).

Termination of the CPA does not assume termination of HO provider participation. If a provider chooses to terminate his/her contract with a HO plan, he/she must abide by the procedures in his/her contract with the plan.

**Question:** I am a new provider, how do I get a Medicaid Provider number?

**Answer:** You must complete the Core Provider Agreement. To get more information on this, please [click here](#) to go to the Provider Enrollment page or call 1-866-545-0544.

**Question:** How do I add a new provider to my existing group number?

**Answer:** You must complete appendix A of the Core Provider Agreement. To get more information on this, please [click here](#) to go to the Provider Enrollment page or call 1-866-545-0544.

**Question:** How do I terminate my provider number?

**Answer:** To terminate your provider number, please [click here](#) to go to the Provider Enrollment page or call 1-866-545-0544. This will terminate you entirely from the Medicaid program.

## **Policy Questions**

**Question:** Can a provider limit the number of fee for service Medical Assistance clients he/she sees?

**Answer:** A provider may limit the number of Medical Assistance clients he/she sees as long as he/she does not limit the practice based on the clients' diagnosis, age, race, sex, disability, etc. See WAC 388-502-0020(1)(h). He/she may limit the practice to established clients and not accept new clients. The provider may also limit his/her practice based on his/her specialty (e.g. OB/GYNs may restrict their practices to women's health care.)

We expect that the provider will abide by this limit and not use the limit as a method to bill clients. For example, if the Medical Assistance practice is limited to 30 percent of the provider's total patient load, he/she cannot continue to treat Medical Assistance clients above the 30 percent and bill these clients for their care.

**Question:** Can a provider limit the number of HO clients he/she sees?

**Answer:** The provider and his/her HO plan(s) should include in their contract any agreements regarding limitation of HO members. The department is not a party to such decisions.

**Question:** Are there situations when the nonparticipating provider can bill Medical Assistance clients for their care?

**Answer:** MAA assumes that nonparticipating providers do not treat Medical Assistance clients. If a provider wishes to treat Medical Assistance clients, the provider needs to enroll with MAA.

However, if a Medical Assistance client seeks care from a nonparticipating provider, is informed and understands that the provider does not accept Medical Assistance, and the client still chooses to receive services from that provider with the understanding that the services are available at no cost to the client from a Medical Assistance provider, then the client will be financially responsible for the services. See also WAC 388-502-0160 regarding when participating providers may bill Medical Assistance clients.

**Question:** When is it ok to bill the client?

**Answer:** Refer to WAC 388-502-0160, WAC 388-538-095(5), Memo 01-13 or the General Information Booklet for specific information on billing the client. This also includes a waiver for a client to sign. To link to MAA memos, [click here](#).

**Question:** Who is responsible for payment of professional services when a medical assistance client is treated in the hospital and the provider does not have a CPA?

**Answer:** We expect that hospitals have provisions in their provider contracts to address the treatment needs of the Medical Assistance population and payment mechanisms for any provider that does not have a CPA or contract with a HO plan (non-participating provider). Each hospital's approach may be different, but in general the following policies are applicable.

In the case of emergency treatment, the client cannot be told to wait until a Medical Assistance provider is available to treat him/her. The client must be treated timely. The hospital may bill MAA for the facility costs, but not for the professional fee. The non-participating provider cannot bill MAA either, and the client cannot be billed for the professional fee. The hospital may choose to pay the non-participating provider.

In the case of non-emergent services, the client can only be billed for professional services if the client understands that the provider does not accept Medical Assistance and he/she has agreed to accept financial responsibility even though he/she understands that the services can be obtained at no cost to the client from a Medical Assistance provider. . If the client does not consent to treatment by a non-participating provider, the hospital and the non-participating provider are responsible for the professional fees and neither can bill MAA for them.

**Question:** Can a nonparticipating provider bill a Medical Assistance client who is also eligible for Medicare for amounts above what Medicare pays that typically would be paid by Medical Assistance?

**Answer:** No. If a nonparticipating provider treats a client eligible for both Medicare and Medical Assistance, the provider must make arrangements with MAA to get paid for any amounts not paid by Medicare that typically would be paid by Medical Assistance. The provider may not bill the Medical Assistance client or any other person.

**Question:** What is the Medically Indigent (MI) program and how does it work?

**Answer:** The Medically Indigent program is used when a person is above the income level for Medicaid has either a major illness or accident that results in major hospital bills. They may be put on the program for a limited time and only the services in the hospital or ambulance are covered by Medicaid. **Out of state coverage is not covered under this program.** See, e.g. WAC chapter 388-438.

## **Medicare**

### **Private Contracts - Overview**

Source: *Medicare and You 2002 Handbook*  
( <http://www.hcfa.gov/medlearn/default.htm> )

#### **What is a “private contract” and how does it work?**

A private contract is an agreement between the Medicare covered patient and a physician who has decided not to provide services through the Medicare program. The private contract only applies to the services the patient receives from that physician named in the contract who also has signed that contract.

The patient cannot be asked to sign a private contract in an emergency or urgent health situation.

If the patient signs a private contract with that physician:

- Medicare will not pay any amount for the services rendered by that physician.
- The patient will have to pay whatever that physician charges for the services rendered, as the Medicare “limiting charge” will not apply.
- Medicare+Choice plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- The patient’s Medigap policy will not pay anything for those services. Many other insurance plans will not pay for those services either.
- The physician must tell the patient whether Medicare would pay for the service if the patient were to obtain that service from another physician who does participate in the Medicare program.
- The physician must tell the patient if he/she has been excluded from the Medicare program.

#### **Can the patient pay for a service, even if Medicare covers it?**

The patient can always choose to pay out-of-pocket for services that Medicare covers. If the patient wants to pay for the service, the patient should ask the physician to not bill Medicare or any other insurance.

The patient can always choose to receive services that are not covered under the Medicare program and to pay for those services themselves. In this case, the patient does not have to sign a private contract, and the physician does not have to stop providing services through Medicare.

### **Private Contracts – Physician’s Requirements**

See also: Noridian *Medicare Part B Basic Billing Manual*  
[http://www.noridianmedicare.com/provider/pubs/med\\_b/manuals.html](http://www.noridianmedicare.com/provider/pubs/med_b/manuals.html)

Pages 31 – 43: Private Contracting

Page 44: Disassociation from Medicare

**“Private Contract” Between Physician and Medicare Patient**

Dear Patient \_\_\_\_\_:

I have made the decision to terminate my relationship with the Medicare program, commonly called “Opting Out”, effective as of the following date: \_\_\_\_\_.

If you wish to continue under my care, the Medicare program requires that I enter into this “Private Contract” with you.

**Terms**

1) The Patient or Legal Representative certifies by signing his/her initials at the end of this line that the size of the text in this Contract is large enough to be read. \_\_\_\_\_.

In a situation where the Patient is unable to sign, the Patient’s Legal Representative will sign on his/her behalf.

- 2) The key provisions of this Contract are as follows, whereby the Patient or the Patient’s Legal Representative:
  - a) Accepts full responsibility for payment of the Physician’s charges for all services furnished.
  - b) Acknowledges that the Patient’s “Medigap” plan (if any) does not make payment for services or items not paid for Medicare.
  - c) Acknowledges that other Medicare supplemental insurance plans may elect not to make payment for services or items not paid for Medicare.
  - d) Agrees not to submit a claim to Medicare, or to ask the Physician to submit a claim to Medicare.
  - e) Acknowledges that Medicare’s limits do not apply to what the physician may charge for items or services furnished by the physician.
  - f) Understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
  - g) Enters into the contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
- 3) The Physician hereby confirms that he/she is not excluded from participation in the Medicare program under subsection 1128, 1156 or 1892 of the Social Security Act.
- 4) The time period during which the Physician is “Opting Out” of the Medicare program is expected to run from \_\_\_\_\_ to \_\_\_\_\_.

- 5) A Contract shall be completed between the Physician and the Patient for each "Opting Out" period.
- 6) The Patient and the Physician both certify that this Contract is not being entered into at a time when the Patient requires emergency care services or urgent care services. (Note that the Medicare program does allow a physician to furnish emergency or urgent care services to a Medicare patient in accordance with subsection 3044.28.)
- 7) A copy of this Contract has been provided to the Patient or the Patient's Legal Representative before services or items are furnished to the Patient under the terms of this Contract.
- 8) The original copy of this Contract, containing the original signatures of both parties, shall be retained by the Physician, as required by the Medicare program, for the duration of the "Opting Out" period.
- 9) This Contract shall be made available for inspection upon the request of the federal agency the Centers for Medicare and Medicaid Services.

I had read this "Private Contract". I understand its effects on my relationship with this physician.

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Printed Name of Patient

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Signature of Patient; Date

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Signature of Legal Representative,  
if the Patient Cannot Sign; Date

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Printed Name of Physician

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Signature of Physician; Date