2026
Medicare Participation Kit

Tools to help you understand your Medicare participation options and educate your patients.

This kit includes:

- **A summary of Medicare Participation Options**
- **Sample Patient Cover Letter for Practices Not Accepting New Medicare Patients**
- **Sample Patient Cover Letter for Practices Opting Out of Medicare**
- **Sample Medicare Private Contract**
- **Sample Affidavit for Medicare Private Contract Opt-Out**

For additional assistance, please contact ASCRS Government Relations at 703-591-2220.

Medicare Participation Options

In April 2015, MACRA permanently repealed the flawed Sustainable Growth Rate (SGR) formula for determining Medicare payments for providers' services. MACRA changed the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models. While MACRA included five years of a positive payment update from 2015 to 2019, five years of 0% updates began in 2020. For 2026 and beyond, providers who remain in fee-for-service will receive a 0.25% update, while alternative payment model (APM) participants will receive a 0.75% update.

2026 Medicare Physician Fee Schedule (MPFS) Update

In the 2026 Medicare Physician Fee Schedule (MPFS) final rule, the Centers for Medicare and Medicaid Services (CMS) finalized a conversion factor of $33.57 for qualifying alternative payment model (APM) participants (QP), and a conversion factor of $33.40 for nonqualifying participants. This represents a 3.77% and 3.26% increase from the CY 2025 MPFS conversion factor (CF) of $32.3465. The CY 2026 final MPFS conversion factors reflect the mandated updates of 0.75% for APM QPs and 0.25% for nonqualifying participants, a mandated 2.5% update for CY26 enacted in the One Big Beautiful Bill Act of 2025, and a budget neutrality adjustment of +0.49%.

For CY 2026, the Medicare payment rate for 66984 is $462.94, a decrease of 11% from the CY 2025 Medicare payment of $521.75. The significant reduction is due to two finalized policy changes, both based on faulty assumptions: a new 2.5% efficiency adjustment to the Work RVUs and changes to the indirect practice expense methodology.

CMS has finalized its proposal to apply a new -2.5% efficiency adjustment to work RVUs and the corresponding intraservice portion of physician time of non-time-based services beginning in 2026. As a result of the finalized efficiency adjustment, the work RVU for 66984 decreased from 7.35 to 7.17. The final rule contains a list of HCPCS codes that will be exempt from the efficiency adjustment, including time-based services and all new 2026 codes. CMS noted that while the 2026 efficiency adjustment was calculated using a five-year average of the Medicare Economic Index (MEI) productivity adjustment percentage, it is currently exploring the use of empiric time studies to determine service valuations in its upcoming 2029 update and in future updates.

CMS has finalized its proposal for services performed in the facility. CMS will reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. For CY26, the practice expense for 66984 will decrease from 8.23 to 6.16.

Once again, the CY 2026 MPFS final rule jeopardizes the financial stability of physician practices by implementing policy changes that will cause a substantial decrease in reimbursement for anterior segment surgeons. ASCRS and the medical community are working together, urging Congress to avert these flawed policies.

2026 Quality Payment Program (QPP)

Additionally, the CY 2026 MPFS final rule also includes changes to the QPP, which will impact 2028 payments. The QPP provides options for Medicare participants: the Merit-based Incentive Payment System (MIPS) or Advanced APMs. Nearly all ophthalmologists will continue to participate in the MIPS program since there are very few Advanced APMs available for participation for ophthalmologists.

For the 2026 performance year/2028 payment year, CMS will maintain the CY 2025 performance category weights of 25% for Promoting Interoperability, 15% for Improvement Activities, 30% for Quality, and 30% for Cost. CMS has maintained the 75% data completeness criteria it adopted in 2024 and has extended this threshold through performance year 2028. Finally, CMS also maintained the performance threshold to avoid a MIPS penalty at 75 points through the 2028 performance year.

CMS did not adopt its initial proposal to remove the MIPS CQM collection type from *Q117: Diabetes: Eye Exam*. CMS also imposed a one-year delay on implementing a modification to *Q141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care* which will require

documentation of a care plan within 7 days after the patient encounter when IOP was assessed.

In 2023, CMS initiated a new pathway within the MIPS program called the MIPS Value Pathway (MVP). An ophthalmology MVP—the Complete Ophthalmic Care MVP—was finalized for inclusion in the 2025 MPFS final rule. The Complete Ophthalmic Care MVP limits reporting to what CMS classifies as clinically-related measures and activities across the 4 MIPS performance categories within the MVP. To report an MVP, participating clinicians or groups will pick 4 quality measures from a limited set of measures, at least one of which much be an outcome measure, attest to one Improvement Activity from a limited selection, and report on and satisfy all Promoting Interoperability objectives. CMS will use administrative claims data to score the clinician or group on population health measures and the sole cost measure—the Cataract Removal with IOL Implantation measure—included in the MVP.

For 2026, CMS will continue to allow small multispecialty practices to choose whether to report MVPs as a single group or to form and report MVPs through subgroups. Multispecialty practices that do not meet this small practice exception must report MVPs at the subgroup or individual level starting in 2026. CMS will also allow groups to self-attest whether they are single- or multispecialty groups at registration.

It is important to note that, for 2026, participation in the Complete Ophthalmic Care MVP remains voluntary. Medicare participants still have the option to participate in the traditional MIPS pathway at this time.

CMS does have plans to sunset traditional MIPS and transition to mandatory MVP reporting in the future. Although a year has not yet been specified, CMS has discussed the potential of sunsetting traditional MIPS in 2029. The establishment of a timeline must be proposed via the rulemaking process before it is finalized, so any proposal to sunset traditional MIPS will be made in future rulemaking. ASCRS maintains that the traditional MIPS pathway should continue to be a voluntary option.

As a reminder, in the CY 2019 MPFS final rule, CMS also implemented policies related to MIPS payment adjustments for non-participating providers. MIPS payment adjustments are applied to the Medicare paid amount on all assigned claims, but they are not applied to non-assigned claims.

Full details on MIPS and its four categories are available to all ASCRS and ASOA members on the ASCRS MACRA Resource page (https://ascrs.org/advocacy/macra-center).

Medicare Status

In April 2015, MACRA also amended the process for providers opting out of Medicare. Previously, if physicians wanted to continue their opt-out period longer than two years, they were required to file new affidavits. However, MACRA changed the process so that affidavits filed by physicians after June 16, 2015, will automatically renew every two years. If a physician does not want their Medicare opt- out status to renew automatically, they must submit written notice canceling the automatic renewal at least 30-days prior to the end of their current two-year opt-out period. This change does not allow for automatic renewal of the private contract between the physician and Medicare patients.

Physicians who opt-out would still be required to enter into a new private contract with their Medicare patients every two years.

Physicians' choices with respect to their Medicare status

(1) **Participating Provider:** Sign participation agreements and agree to accept assignment for all claims in exchange for various benefits provided by Medicare, including approved reimbursement rates;

(2) **Non-participating Provider:** Decline to sign participation agreements, accept assignment on a case-by-case basis, and balance bill subject to limits imposed by Medicare and/or state law, or;

(3) **Private Contracting:** Opt out of Medicare completely and enter into so-called "private contracts" with Medicare beneficiaries. In addition, physicians should keep in mind that they are not subject to Medicare charge limits and do not need private contracts for non- covered services.

ASCRS is not recommending any one of the three options described in this document. The purpose of the document is to ensure that ASCRS members can make informed decisions about their Medicare participation status.

1. Participating Provider

Physicians who sign a participation agreement agree to accept assignment for all services they provide to Medicare patients and to accept the Medicare-approved charge as payment in full for the physician's services.

Medicare sends out participation agreements for the following calendar year to all eligible physicians during the Medicare open enrollment period, typically from mid- November through December 31. Physicians who are currently participating do not need to take any action to continue participating. ***Those who wish to sign or terminate a participation agreement must do so during the open enrollment period and their decision must be postmarked no later than December 31, 2024***; except that physicians signing up with Medicare for the first time can execute participation agreements at the time they first enroll. Once made, the decision will be binding throughout the following calendar year, except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice.

Participating physicians are entitled to the full Medicare-approved charge for each service, whereas nonparticipating providers receive 95% of the approved fee schedule amount. Participating physicians submit claims to Medicare on behalf of their patients and receive 80% of the full approved charge directly from Medicare. They collect the remaining 20% copayment and any applicable deductible from the patient or secondary insurer (*i.e.*, Medigap).

Participating physicians receive certain other benefits. For instance, Medicare provides toll-free claims processing lines, reimburses participating physicians more quickly, and will automatically submit claims to many Medigap insurers for payment of copayments and deductibles. Participating physicians are also included

in a directory of physicians distributed by Medicare.

2. Non-Participating Providers

Physicians who choose not to sign a participation agreement may accept assignment on a case-by- case basis. In nonassigned cases, the physician may "balance bill" the patient up to 115% of the reduced Medicare-approved charge for nonparticipating providers (*i.e.*, 95% of the full approved charge) for the particular service. Therefore, the most the physician can receive is 109.25% of the full Medicare- approved charge.

In cases where the physician does not accept assignment, the physician still submits the claim to Medicare, but receives payment from the patient. The patient receives the reimbursement from Medicare and pays the remainder—*i.e.*, the 20% coinsurance plus the balance bill amount—out of his or her pocket. In some cases, Medigap plans will cover the balance bill charge as well as the patient's coinsurance amount.

Nonparticipating providers who accept assignment receive payment directly from Medicare, but still are subject to the 5% reduction in the approved charge and must collect copays and deductibles from the patient. The physician collects 80% of the reduced fee schedule amount from Medicare and 20% from the patient. Balance billing is not permitted on an assigned claim.

As noted above, MIPS payment adjustments will be made on all assigned claims, but not on non- assigned claims.

Physicians who wish to terminate a participation agreement and become a nonparticipating provider must do so during the Medicare open enrollment period. Physicians should write each Medicare carrier to which they submit claims before the end of the year to inform them that they are terminating their participation agreement effective at the end of the current term. Physicians who are currently nonparticipating need not take any action to continue their status.

In making the participation decisions, physicians should keep in mind that some state laws and agreements with hospitals and other facilities either require physicians to take assignment of Medicare claims or restrict or prohibit balance billing. In addition, some states have enacted laws
that prohibit physicians from balance billing their patients**.** Physicians also should know that certain services are only paid on an assigned basis, including services provided to dual Medicare/Medicaid patients and those provided by certain affiliated health care workers, including nurse practitioners, physician's assistants, and clinical psychologists.

3. Private Contracting

Physicians may choose to opt out of Medicare entirely by submitting an affidavit to the Centers for Medicare and Medicaid Services (through their local Medicare Administrative Contractors (MACs)) and entering into private contracts with all their Medicare patients. This opt out applies to traditional Medicare and Medicare managed care.

In the affidavit, the physician agrees not to submit any claims to or receive payment from Medicare for a period of two years. The affidavit will automatically renew for subsequent two-year periods unless the physician notifies Medicare at least 30 days before the end of the two-year period that he/she does not want to renew. A physician who opts out may still bill Medicare for emergency or urgently needed services provided to patients with whom the physician does not have a private contract (subject to Medicare fee limitations). However, the physician may not enter into a private contract with a patient at the time that the patient is in need of emergency or urgent care services.

Non-participating physicians must file the opt-out affidavit with the appropriate Medicare carrier(s) within 10 days after signing the first private contract. Participating physicians must file the opt-out affidavit at least 30 days before the end of the quarter in which the first contract is to become effective. The physician has 90 days

to revoke the affidavit and return to being a participating/nonparticipating provider. A physician or practitioner who fails to comply with the opt-out rules would forfeit the right to enter into any private contract for the remainder of the two- year period and will be subject to the Medicare limiting charge and other Medicare restrictions. The physician might also be subject to liability for submitting false claims, the penalties for which are quite severe.

In the private contract, the patient agrees not to seek reimbursement for the physician's services from Medicare and to pay the physician directly for whatever amount the physician decides to charge for these services (subject to state laws precluding excessive fees). The patient further acknowledges that the physician's charges are not subject to Medicare limits, that Medigap will not pay for the services, and that the patient has had the opportunity to use another physician who has not opted out, but freely chose this one. The contract also must clearly state whether the physician has been excluded from Medicare. The physician must keep copies of all private contracts during the opt-out period and make them available for inspection by the Secretary of HHS upon request.

Physicians in group practices may opt out or become non-participating physicians individually, and it does not affect the ability of the rest of the group members to bill Medicare for services they furnish to Medicare beneficiaries. However, when a group physician has opted out, the group may not bill Medicare in its own name or otherwise receive payment for services provided by the opt- out physician under a private contract. Each physician and group should seek legal counsel if they pursue this option.

Note that private contracts are not required for services that are not covered by Medicare (*e.g*., refractions or conventional eyeglasses). The limiting charge and claim submission requirements also do not apply to non-covered services. Private contracts are also not required for, and the limiting charge does not apply to, covered services that are determined (or likely to be determined) not to be reasonable or medically necessary in the particular case. The physician can still be reimbursed for such services if the beneficiary signs an "Advance Beneficiary Notice" acknowledging that the service may not be covered by Medicare and the beneficiary will have to pay for the service if it is denied by Medicare.

Note also that physicians who opt-out are still able to order tests or make referrals for Medicare beneficiaries and those tests or referral services would be covered. However, physicians are required to register their NPI and other information with the MAC.

To view updates and the latest information about Medicare participation options, or to obtain telephone numbers of the various carrier contacts including the MAC medical directors, please visit the CMS web site at http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/index.html.

Sample Patient Cover Letter for Practices Not Accepting New Medicare Patients

<Your letterhead>

Dear Patient:

Our practice appreciates your loyalty and trust and prides ourselves on providing you with high quality care and personal attention. As you may know, Medicare payments for ophthalmology procedures continue to decline. At the same time, our practice costs and the costs of complying with regulatory requirements continue to increase.

For these reasons, our practice is no longer accepting new Medicare patients. We will be happy to assist you in finding a practice that does accept such patients.

We regret any inconvenience this change in policy may cause you. If you have any questions, please call us at [insert number].

Sincerely,
[Insert signature and printed name]

Sample Patient Cover Letter for Practices Opting Out of Medicare

<Your letterhead>

Dear Patient:

Our practice appreciates your loyalty and trust, and prides ourselves on providing you and our other Medicare patients with high quality care and personal attention. As you may know, Medicare payments for ophthalmology procedures continue to decline. At the same time, our practice costs and the costs of complying with regulatory requirements continue to increase.

For these reasons, we have made the difficult decision to "opt out" of Medicare. This means that, as of January 1, 2025, our practice will no longer be filing claims with or receiving reimbursement from Medicare. It also means that any Medicare patients who we continue to treat cannot file claims with Medicare or receive reimbursement from Medicare for our services. Instead, you will be required to pay our offices in full at the time our services are provided and will not be eligible for reimbursement from Medicare for those services. The Medicare rules also require us to enter into "private contracts" with our Medicare patients that will outline these new practices, as well as our patients' rights and responsibilities. A copy of our private contract is attached for your review and signature.

You also have the option to seek care from a physician who does participate in Medicare. Should you decide to switch to such a physician, our office will be happy to assist you in the transfer of care.

We regret any inconvenience this change in policy may cause you. If you have any questions, please call us at [insert number].

Sincerely,
[Insert signature and printed name]

Sample Medicare Private Contract

This Agreement is entered into by and between _____, M.D. ("Physician"), whose principal medical office is located at_____and_____("Patient."), who resides at _____.

WHEREAS, Physician is licensed to practice medicine in the State of_____and has properly opted out of Medicare;

WHEREAS, Patient is currently a Medicare beneficiary;

WHEREAS, Patient wishes to obtain the services of Physician under the terms of this private contract ("the Agreement");

NOW, THEREFORE, in consideration of the mutual promises and conditions contained herein, and for other good and valuable consideration, the sufficiency of which is acknowledged, the parties agree as follows:

1. ***Covered Services***. This Agreement covers the following items and services ("the items and services") to be provided by Physician: _____ _____.

2. ***No Submission of Claims.*** Patient agrees not to submit a claim for any of the items or services even if such items or services are otherwise covered under Medicare; nor will patient request that Physician do so on Patient's behalf.

3. ***Payment for Services.*** Patient further agrees to be responsible, whether through insurance or otherwise, for payments of such items and services. Patient understands that no Medicare reimbursement for items or services will be provided; that the items and services would have otherwise been covered by Medicare if there were not a private contract and a proper Medicare claim had been filed; and that other patients may be reimbursed by Medicare for the same items or services provided by other physicians or practitioners who have not opted out of Medicare. Patient understands that the Medicare charge limits do not apply, and that Physician's charges may be higher than the fee limits set under the Medicare program for the services. Patient acknowledges that Medigap plans do not make payments for such items and services. Patient further understands that other supplemental insurance plans may elect not to make payments for such items and services.

4. ***Other Patient Acknowledgments.*** Patient understands that he/she has the right to have the items or services specified in this agreement provided by other physicians or practitioners for whom Medicare payment would be made and that 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. Patient certifies that this agreement is

made freely and without duress, and is not made during an emergency or urgent health care situation. Patient acknowledges that the size of the print of this Agreement is sufficiently large to enable him or her to read the Agreement.

5. ***Physician Representations***. Physician will not file a claim with or accept reimbursement from Medicare for the services provided under this Agreement; nor will physician seek reimbursement from any organization that receives such reimbursement from Medicare. Physician further represents and warrants that he/she has/has not been excluded from Medicare and is duly licensed to practice medicine in the State of_____. Physician makes no express or implied warranties or guarantees regarding the items or services to be provided under this Agreement.

6. ***Effective Date***. This Agreement will become effective on [insert date] and shallexpire on or about [insert date] (the "opt-out period").

7. ***Miscellaneous.*** This is the entire agreement between the parties. It may not be modified except by a writing signed by both parties. Neither party may assign his/her rights or obligations under this Agreement without the written consent of the otherparty.

_____
Patient Name

_____
Patient Signature

_____
Date

_____
Physician Name

_____
Physician Signature

_____
Date

For Beneficiary's Legal Representative:

I am the legal representative of the patient whose name appears in the above Agreement. I have read and fully understand the foregoing information and have discussed this information and its terms with the patient to the extent of the patient's understanding. Due to the patient's inability to sign this form, I am entering into this Agreement on the patient's behalf.

_____
Name of Legal Representative

_____ _____
Signature Date

_____
Nature of Relationship to Patient

Note:

Patient or his/her legal representative must be provided with a copy of this Agreement (a photocopy is permissible) before items or services are furnished to the Patient under the terms of the Agreement. Physician must retain the Agreement with original signatures of both parties for the duration of the opt-out period. A copy of this Agreement must be made available to the Centers for Medicare and Medicaid Services upon request.

Disclaimer:

This sample private contract is provided for informational purposes only and is not intended to provide legal advice, guarantee compliance with the legal requirements for opting out of Medicare or entering into Medicare private contracts, or encourage physicians to opt out of Medicare. Physicians are encouraged to consult with legal counsel for guidance on the Medicare opt-out/private contracting process.

Sample Affidavit For Medicare Private Contract Opt-Out
**Please note: Some Medicare Administrative Contractors (MACs) have their own affidavit that they require be used.*

I,_____, have read the following statements and attest that theyare accurate and true to the best of my knowledge, information, andbelief:

1. Except for emergency or urgent care services, during the opt-out period defined below, I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of paragraph 42 C.F.R. § 405.415 for services that, but for their provision under a private contract, would have been Medicare-covered services.

2. Except for emergency or urgent care services, I agree not to submit any claims to Medicare for any item or service provided to any Medicare beneficiary. Nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 405.440.

3. I understand that during the opt-out period, I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, apartner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage (formerly called Medicare+Choice) plan.

4. I acknowledge that, during the opt-out period, my services are not covered under Medicare and no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

5. I promise that, during the opt-out period, I will be bound by the termsof both this affidavit and the private contract(s) into which I have entered with a Medicare beneficiary.

6. I recognize and acknowledge that the terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by me during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

7. I have signed a Part B participation agreement, and I acknowledge that such agreement terminates on the effective date of this affidavit. [This provision is not required for physicians who have not signed a Medicare Part B participation agreement.]

8. I understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of 42 C.F.R. § 405.440 apply if I furnish such services.

9. I understand that these restrictions will remain in effect for a period of two years from the date of this affidavit ("the opt-out period") and that this affidavit will renew automatically for successive two-year periods unless I provide notice that I do not wish to renew.

_____
Signature of Physician

Physician information:

Physician name (print): _____

NPI/UPIN or TIN (if no NPI or UPIN has been assigned): _____

Billing Address: _____

_____

Telephone: _____

Fax: _____

Note:
Non-participating Medicare physicians must file this affidavit with all MACs who have jurisdiction over claims that the physician would otherwise file with Medicare. The affidavit must be filed no later than 10 days after the first private contract to which this affidavit applies is entered into.

Participating Medicare physicians must file this affidavit with all MACs who have jurisdiction over claims that the physician would otherwise file with Medicare. The affidavit must be filed with all such MACs at least 30 days before the beginning of the selected calendar quarter. The furnishing of any items or services to a Medicare beneficiary under such the private contract to which this affidavit applies before the beginning of the selected calendar quarter is subject to standard Medicare rules.

Disclaimer: This sample affidavit is provided for informational purposes only and is not intended to provide legal advice, guarantee compliance with the legal requirements for opting out of Medicare or entering into Medicare private contracts, or encourage physicians to opt out of Medicare. Physicians are encouraged to consult with legal counsel for guidance on the Medicare opt-out/private contracting process.