The negative effects of Medicare’s inconsistent and detrimental payment policies for anesthesia services are dealt with in relation to institutions where nursing anesthesia programs exist. Such policies burden CRNAs and nurse anesthesia students with financial disincentives and payment exclusions that could lead to a long-term worsening of the shortage of trained practitioners.

Current federal payment policies and practices that impact on Nurse Anesthesia Educational Programs (NAEPs) will be described. The different types of NAEPs, Medicare and private third-party payments under Medicare Part A and Part B, are contrasted with payments for anesthesia residencies and NAEPs.

Types of payors

There are three primary methods under which anesthesia services are paid through the federal Medicare system. This percentage varies widely from urban to suburban to rural areas as well as by region and state. Generally, rural areas have the highest mix of Medicare patients and services, then urban and, finally, suburban. Regions or states that have high populations of retirees obviously have a greater Medicare mix.

The next most common source of reimbursement for anesthesia services is private payors (e.g., Blue Cross/Blue Shield, Travelers, etc.). These payors are generally not a concern, because they relate to anesthesia services provided in institutions with nurse anesthesia programs. However, many third-party payors follow Medicare’s lead and adopt detrimental payment strategies. The past several years have seen an increase in the number of private payors who pay for CRNA services separately and directly, but some payors continue to foster discriminatory reimbursement policies.

The third most common source of reimbursement for anesthesia services is the consumer—the patient. While the percentage of private paying patients who are primarily responsible for payment is relatively low, some types of anesthesia practices do have a very high percentage of private paying patients (e.g., plastic surgery, dentistry, etc.). Private pay patients are not generally a source of concern for NAEPs, except in those areas where there is a high number of indigent patients and underinsured or uninsured patients without sufficient means to pay for health care services. Some of these patients are covered under a state Medicaid program, which generally reimburses at a rate much lower than cost. State Medicaid programs will often follow the lead of the federal Medicare program.

There are several other health programs that are not discussed individually here, because their funding is derived from sources other than those described. These include the military, Veterans Administration and U.S. Public Health Service. Other non-public systems, such as health maintenance organizations, preferred provider organizations and other managed care systems, are also affected by the inconsistent payment policies and practices of the Medicare system.

Payment categories

There are generally two payment categories used by both public and private payors. They are divided according to types of services: institutional services (hospi-
Medicare and some private payors refer to these two systems as Part A (hospital inpatient) and Part B (clinical providers and outpatient services). Blue Cross is synonymous with Part A services, and Blue Shield is synonymous with Part B services. Therefore institutional services (e.g., pharmacy, nursing, radiology) are reimbursed by the Part A or Blue Cross system and clinical provider services (physicians, CRNAs, podiatrists) are reimbursed by the Part B system for Medicare and the Blue Shield system of private payors in most states. Some private third-party payors still reimburse CRNA services through the hospital under the Part A or Blue Cross system.

Payment methodologies

There are generally three types of payment methodologies utilized by public and non-public payors—prospective payment, usual and customary and pass-through.

A prospective payment system (PPS) is based on historical costs and establishes a fixed prospective payment for a service, regardless of its cost to the institution. A fixed payment is assigned to a specific diagnosis-related group (DRG). Medicare and some private payors utilize this system.

There is one fixed payment for the service and if the cost of providing the service is higher than the DRG payment, then the institution loses money. If the cost is less than the DRG payment, then the institution makes a profit. These payments may be adjusted, based on an urban rural/ and teaching/non-teaching designation. Medicare Part A (institutional services) reimburses on the basis of the prospective payment DRG system.

The second payment system is the usual and customary charge system. Here, the payments are based on historical data on customary charges for similar services. Medicare Part B payment is based on this system for physicians and other limited license providers. CRNAs are now reimbursed from a set fee schedule. Physicians also are allowed to balance bill the Medicare beneficiary for that portion of the charge not covered by Medicare, but these balance billing amounts cannot exceed certain maximum allowable charges set by Medicare. Most private third-party payors also use this system for physicians and CRNAs.

Beginning in 1992, Medicare will limit physician balance billing to 125% of the prevailing charge; this amount will decrease to 115% and 110% in succeeding years. In 1989, Congress enacted legislation that will eliminate the usual and customary charge system for physicians and implement a new resource-based relative value system for all physicians, which includes a national fee schedule.

CRNAs services are reimbursed by Medicare Part B under the same relative value guide as that used for physicians. CRNAs have a national fee schedule that is adjusted by differences in state practice costs. This system was implemented in January of 1989, and the fee schedule is 35% to 50% below the cost of providing CRNA services. Medicare is expected to publish a revised final fee schedule by March 1990, which hopefully will be based on the true cost of CRNA services. Current knowledge, however, indicates that the final fee schedule will also be far below cost.

The third payment system is a cost pass-through mechanism. Certain predetermined costs are allowed, including the cost of medical and nursing education. Essentially, a hospital's direct and indirect costs of conducting certain educational programs, including NAEPs, can be passed through outside the Medicare DRG payments. Therefore, the PPS or the DRG payment does not include the costs of these educational programs.

NAEPs: Primary payment sources

Nurse anesthesia programs obtain funding from four sources:

1. Medicare education pass-through. As previously discussed, Medicare allows certain direct and indirect educational costs for CRNA programs to be passed through outside and in addition to the DRG payment. There are two limitations to this system. First, Medicare confines its payment to that portion of the costs which should be allocated to Medicare beneficiaries. In an oversimplified example, if a hospital has a 30% Medicare mix, then 30% of the allowable educational costs may be costs actually incurred by the hospital and not costs of an academic institution transferred to a hospital.

The second limitation results from stringent Medicare requirements and the diversity of NAEP structures within both academic institutions and hospitals. Since NAEPs are generally affiliated with an academic institution that grants a degree at the completion of the program, hospitals often encounter difficulty in utilizing the pass-through for clinical education costs related to NAEPs. This generally is not a problem for physician residency programs, because they are 100% hospital-based, and the residents (unlike nurse anesthesia students) do not pay tuition.

2. Part A private third-party payments: All hospital costs are in some way included or bundled into patient charges. These charges include their portion of all educational and administrative costs. As more private payors move to a DRG prospective payment system, this cost-based reimbursement may be eliminated, and fewer dollars will be available for educational purposes.

3. Part B Medicare payments: The current Medicare regulations do not address how payments should be made for anesthesia services provided by students in NAEPs. However, current Medicare carrier payment practices for services provided by students are not consistent with what is allowed in physician residency programs.
a. Anesthesiologists may supervise up to two anesthesia residents at the same time and charge a full fee on both cases.
b. An anesthesiologist may supervise two nurse anesthesia students, but may only bill for one service.
c. An anesthesiologist may medically direct two CRNAs who are working directly with students, but the anesthesiologist’s fee is significantly less than what would be paid if he or she directed residents. The payment for time is cut in half, and payment for base units (the relative value of a given procedure) is reduced an additional 10%.
d. CRNAs and nurse anesthesia students may provide anesthesia-related services (arterial line insertion, pain management block), but Medicare does not currently pay for these services.
e. Anesthesiologists and residents may provide related services, and Medicare will pay for these services.

4. Part B private third-party payments: When anesthesiologists medically direct CRNAs who directly supervise nurse anesthesia students, the CRNA fee is bundled into hospital payments, but the fee is paid directly to the anesthesiologist. The anesthesiologist may bill for medical direction of multiple procedures.

Secondary payment source
A secondary payment source comes from research funding to hospitals. Some institutions that recently closed NAEPs received hundreds of millions of dollars in federal research grants each year, but claimed that they could not afford a $200,000 nurse anesthesia program. For example, Johns Hopkins recently closed a nurse anesthesia program, although it annually receives in excess of $158 million in Public Health Service grants.

Payment Impact on NAEPs
Medicare has inconsistent and detrimental payment policies for anesthesia services provided in institutions where nurse anesthesia programs exist. These inconsistencies have the following results:

1. Anesthesiologists are discouraged from working within nurse anesthesia programs, because of financial disincentives.
2. Anesthesiologists and hospitals receive financial incentives to conduct physician residencies in anesthesia and financial disincentives to conduct NAEPs.
3. Hospitals are penalized for conducting NAEPs rather than anesthesia residencies.
4. Anesthesiologists can double their income potential by working with residents rather than nurse anesthesia students and can increase their income by 30% over that they would earn working with CRNAs.
5. From a health policy standpoint, health care teaching facilities are given incentives to produce higher cost anesthesia providers and disincentives to produce lower cost providers, even though there is no documented or assumed improvement in the quality of care.
6. These policy disincentives have contributed to the closure of many programs and to the shortage of over 2,000 CRNAs nationwide.
7. This critical shortage will result in the nation’s inability to meet the demand for anesthesia in the very near future.

In summary, federal Medicare payment policies and practices are negatively impacting on NAEPs through financial disincentives and payment exclusions for services provided by CRNAs and nurse anesthesia students.