Medicare payment reform

By the time this article reaches *AANA Journal* readers, Congress should have acted in Committee regarding its 1986 Medicare amendments. As in past years, these amendments will be part of the annual budget reconciliation legislation required by law to establish reduced deficit levels. Three committees must deal with this Medicare legislation: the Senate Finance Committee, the House Ways and Means Committee and the House Energy and Commerce Committee. By the end of July or early August, these Committees should have acted.

In April and May, hearings were held within these Committees regarding two major areas of concern, capital financing and physician payments. Neither capital payments nor physician payments were included in the original DRG hospital payment system and are major elements in the Medicare financing system. For example, physician payments constitute about $19 billion of Medicare expenditures each year. The Committees also have had hearings on the Administration’s proposals for Medicare payments for the forthcoming fiscal year. Those proposals include limiting the medical economic index used to update physician prevailing rates for next year.

The Administration does not propose to freeze Medicare physician payments for next year. The Administration does propose to reduce Medicare payments for local standby anesthesia provided by anesthesiologists or CRNAs who are their employees. Regulations are not proposed yet to implement the standby proposal. It is expected that the limitations on standby will involve reduced payment rates or revised definitions of standby.

Physician reimbursement reform

The hearings on physician payments have raised many significant options as to how Medicare should pay for physician services. A number of major studies also have been done on the question of physician payment issues by the Congressional Office of Technology Assessment (OTA), the Administration and individual researchers. The Administration study, as of the date of this writing, has not been submitted.

The issues in physician reimbursement payments are numerous, encompassing: (1) geographic variation in physician charges and payments, for example, a surgical or anesthesia physician service in Boston may involve a payment twice as high as one in Des Moines for the same service; (2) procedural services such as surgical or laboratory procedures paid at rates five or six times the payment for similar time spent on a case history and physical examination even though the elements of service, that is, professional time practice costs, are very similar; (3) growth in volume of services where payment is on an item of service basis and there are many individual items of service; (4) generally excessive payments in some areas of physician services relative to the estimated costs of the service or charges for the same service in a different area; (5) higher
payments to specialists—often practicing in urban areas—than to general internists, pediatricians or general practitioners—often practicing in rural areas—for precisely the same service; and (6) the utility of using non-physician personnel in reducing costs.

Anesthesia is certainly a physician payment issue which Congress and the Administration are focusing upon in the context of these hearings. The relationship of CRNA practice to the anesthesia payment issues is well known to the Congress and HCFA. Clearly, the pass through provision and the unbundling exception are related to the physician payment issues.

One major option proposed to Congress by the OTA study and other studies is the creation of a national schedule of fees for all physician services. The national fee schedule would replace the current law which pays on the basis of the lower of a physician's own customary charges or the prevailing charges in the community for the same service. The current system is the opposite of a schedule of national fees; it is theoretically a free market system driven by individual fees. However, the prevailing rates (the 75th percentile of rates used in the locality for the same service) have been indexed since 1972 by the use of a medical economic inflator keyed now to a 1973 base year of practice costs. This index has resulted in the prevailing rates now being the payment amount for a majority of physician payments regardless of customary charges. However, the rate is still far from uniform nationally.

The national fee schedule generally recommended is one which would utilize the Relative Value Scale (RVS), an approach which is generally used by ASA and most anesthesiologists. The RVS being considered most seriously, however, is one which would measure the relative value of physician services by the economic resources utilized in providing the service. Two researchers at Harvard, Dr. Hsiao and Dr. Stason, developed this method in the late 1970's and have continued to work on it. They now have a HCFA contract to fully develop such a method for the payment of all physician services.

The resources to be assessed by the researchers in determining value are physician time, skill, overhead costs of practice, use of non-physician professionals, and lost opportunity costs from training. This is a very different approach than that used in the current RVS for anesthesia services utilized by Medicare. That RVS actually prices services based on the customary or prevailing fees of the physician involved, but varies the price depending upon the relative complexity, time and risk of the case. A national fee schedule for anesthesia based on the Harvard RVS model described above would produce more uniform fees nationally and would base the price per service on the actual economic value of the resources applied to the case.

Another method receiving serious consideration by Congress and experts who testify before Congress is a "physician DRG" payment to the hospital. This approach currently applies only to hospital inpatient care and is being seriously considered for the three hospital specialties of anesthesiology, pathology and radiology. Under this approach, past physician charges for hospital inpatients are correlated with hospital DRG payments for the same case. The hospital then receives either one comprehensive DRG payment which would include the physician payments or multiple payments which would include the existing DRG payment and then additional fixed price payments for the hospital based physician services. The amount paid would probably be an amount equal to the average of all charges for such a service in the past increased by an inflator annually, or, it could be an amount equal to the average of charges in that locality or hospital for such services. The hospital would receive the money and distribute it to those service providers it utilized for the service and to pay for overhead costs of its own. Any savings would accrue to the hospital if it used services which cost less than the price paid.

CRNA payment reform

The pass through and unbundling exceptions to the DRG law for CRNA services expire for full hospital fiscal years beginning after September 30, 1987. These exceptions apply to inpatient services only. With respect to outpatient services, all hospital payments are basically either on a cost reimbursement basis under Part B of Medicare for the hospital-employed or self-employed and on a physician charge basis for the physician employed. The Ambulatory Surgery Center is paid a fixed price payment essentially without a CRNA cost built into it. All of the outpatient provisions continue without limitation.

The CRNA reimbursement legislation, S. 1154 and H.R. 2504, would provide a single Part B payment mechanism for all CRNA services, regardless of the setting or employment arrangements. Payments would be made at 80% of the allowable amount. Payment amounts would be established by the Secretary of the Department of Health and Health Care Financing Administration (HCFA). A national schedule of payment amounts would be fixed and would be updated each year to take into account increases or decreases in service costs and the impact of new technology on payments. The total payment could not exceed the payments Medicare would otherwise make for the same number and type of services if the system were entirely on a
cost reimbursement (pass through) basis. This means that the payment schedule, with payments probably varying by procedure, would be based on the costs associated with services provided by CRNAs. This is a similar approach to that being developed by Harvard for all physician payments.

States laws, Medicare hospital regulations and legally binding hospital rules regarding the scope of practice of CRNAs and physician supervision would be unaffected by this legislation. The legislation relates only to payment for services, not the conditions under which services are provided.

Payment rights of CRNAs would be assignable to the employer so that physician employed CRNAs could assign their rights to the physician practice or to a hospital employer.

The rights of physicians to bill for directing a CRNA service would remain as under current law. If the CRNA were hospital-employed or self-employed, the physician would bill the service of direction as he or she does now. Where the CRNA is physician-employed the physician practice would submit the CRNA bill and a physician bill for direction. In the latter case, there would have to be at least a time unit adjustment for the physician service of direction because the physician practice would also have billed for the CRNA service separately.

The Congressional Budget Office has determined that this legislation will not increase Medicare costs so it has no budgetary problems.

The AANA hopes that this Part B approach to paying for CRNA services will be adopted. It is our preferred position and we urge you to contact your Senators and Congressmen to urge their support for S. 1154 and H.R. 2504. Congressmen and Senators should be in their home districts from June 27 to July 14 during a Congressional recess. See your members of Congress at home in that period, particularly those on the three relevant Committees.

AANA Journal Course

Test Yourself Answers
(Questions appeared on page 271.)

1. The 1985 standard calls for continuous monitoring and evaluation of all departmental activities. The 1979 mandate which called only for generalized monitoring and evaluation was much more diffuse.

2. Critical indicators are key aspects of care which, as a group, are representative of the department's entire range of services. Critical indicators are monitored periodically to determine quality of care within the department and, thus, become the focal point of a unit-based plan.

3. Goals are broad, loosely structured statements which give a general sense of direction to the overall QA plan. Objectives are derived from the program's goals and address their eventual achievement. Objectives are explicit written statements which are concrete, measurable, and pertinent to the setting.

4. Both semi-structured and unstructured interviewing is extremely helpful in eliciting subjective information.

5. Internalization, the third and final phase of peer review implementation, is marked by complete actualization of the entire peer review process. Constructive criticism is freely exchanged among department members. Objectives are well-defined. Both direct clinical observation and chart audits are discussed in peer review conferences. Suggestions to improve care are acted upon.

CRNA – KENTUCKY

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