Medicare budget physician payment and the CRNA fee schedule

Congress is currently reviewing the methods of reducing the federal deficit including spending cuts, and a "summit" conference between Congress and the White House is taking place. The president proposed $5.5 billion of Medicare cuts as part of his January budget proposal to reduce the deficit to the levels required by the Gramm-Rudman law. The House of Representatives recently passed its budget resolution establishing targets for cuts but proposed only $1.7 billion in Medicare cuts. Any reductions below the annual rate of growth allowed is a "cut." The process is now stalemated as discussions proceed between the White House and Congress over the magnitude of cuts and the potential for tax increases. It appears that more cuts or tax revenues are needed to reduce the deficit than the White House or Congress has assumed. Both fear, however, that greater cuts may stimulate a recession. It does not seem that the low level of domestic program cuts in the House budget can be sustained, however, and the $1.7 billion of Medicare cuts will probably increase.

The Medicare budget proposed by President Bush had many cuts in physician payment. As noted in a prior article, anesthesia bears a substantial burden of the president's physician payment proposals. The proposed cuts affect the conversion factor, which is the dollar amount for services and the medical direction fee amounts.

Physician payment reform

At the same time Medicare budget cuts including physician cuts are being debated, the Physician Payment Review Commission (PPRC) and the Health Care Financing Administration (HCFA) are developing plans for the implementation of the resource based relative value fee schedule (RBRVS) for physician payment, which Congress mandated in the 1989 Omnibus Budget Reconciliation Act (OBRA). These changes also affect physician anesthesia payments and have some indirect effects on CRNA payments. Implementation of the RBRVS will require reductions in the conversion factors of physicians for anesthesia services. According to the Harvard RBRVS study and the PPRC, it will also require a significant reduction in the geographic variations in fees for anesthesiologists. Those fees now range from as low as $15 to more than $30. The relative value measurements for anesthesia services of base and time units will not change, however, according to recommendations of the PPRC.

The PPRC has also been asked by Congress to comment on the president's budget proposals relative to physician payment issues. This is an annual occurrence and Congress has, in the past, followed the PPRC advice closely. The PPRC did not advise making cuts anywhere near as deep as those recommended by the president in any physician payment areas.

Effects on CRNA fee schedule and legislation of physician report

Physician payment has a number of direct and indirect effects on CRNA payments. Changes in physician payment policy can have a direct impact on CRNA payments since CRNA payments cannot exceed the prevailing charge for MD anesthesia payment under current law. Also, the president's budget proposal for medical direction payments to physicians would, if enacted, be dependent on the amount of the CRNA payment. Under that proposal, the payment for medical direction is equal to the payment for doing a case oneself minus the payment made for the CRNA service. If the CRNA payment rises as it would if our legislation were enacted, the physician medical direction payment would decrease.
If the MD anesthesia conversion factor is reduced by 10% in all Medicare regions, as proposed in the president's budget, the CRNA payments under both current law and the fee schedule proposal would be reduced in a number of regions. These regions are those where the CRNA payments are already limited by the prevailing charges or within 10% of being limited by the MD prevailing charges. A large number of regions have MD prevailing charges for anesthesia services which are between $15 and $18 a unit and almost half the regions are between $15 and $21. The PPRC has recommended only a 4% cut and has recommended that the regions with the lowest prevailing charges have a lesser level of cut. The American Society of Anesthesiologists (ASA) has endorsed the PPRC approach. The AANA has urged the PPRC to implement any cuts in such a way as to prevent reductions in the CRNA payments.

Under our legislative proposal to create $21 and $14 rates, the MD prevailing charge would not serve to limit the payment to a CRNA of $21 if no MDs were practicing in the hospital where the CRNA practiced.

With respect to medical direction payments, the PPRC did not endorse the president's proposal. It urged, as a substitute approach, the continuation of current law enacted in 1987 which reduces the base units for medical direction by 10%, 25% and 40% respectively if two, three or four procedures are directed concurrently. That law would expire if not extended by 1991. The reduction in base units is not related directly to the CRNA fee schedule and therefore does not pit anesthesiologists and CRNA payments and politics against one another in 1990.

Should there be a general policy integration of CRNA payment with RBRVS?

Conversion factors. The Congress and PPRC have both concluded that, as between physicians, there should be no differential payment based on specialty certification. General surgeons and orthopedic surgeons receive the same payment for the same service if in the same geographic area. The PPRC has generally seemed to espouse this view as to optometrists and podiatrists who are defined by Medicare law as physicians. This would suggest a policy for anesthesia payments which would equate payment for CRNA nonmedically directed services with payment for anesthesiologists' services. Such a policy seems both reasonable and fair since the work performed is exactly the same. Under the current law CRNA payments range from $10 to $19 per unit for nonmedically directed services but in no case can exceed the physician prevailing charges, which are in some areas less than $19.

Geographic variations. The Physician Payment Reform law enacted in 1989 does not establish a single conversion factor for all anesthesia services but does go a long way toward reducing existing variations. The law establishes a geographic practice cost index (GPCI) which will be used to vary the physician fee schedule by region. The GPCI applies to anesthesia. The RBRVS physician fee schedule was enacted in 1989; and the GPCI would be implemented over four years from 1991 to 1995 and would provide a specific fee variation. The index has three parts: (1) routine practice cost differences by region; (2) malpractice cost differences by region and (3) to a very limited extent, earnings differences which are used to reflect the cost of living differences by region. Each specialty will have its own variations and each of the three factors will be used to vary the fee. Only a portion of the national fee schedule amount is varied by these factors. It is anticipated that the effect of the index will be to allow variations which are far less than the variations under current law in anesthesia. For example, variations might be from $17 to $25 under the RBRVS rather than $15 to $30 as they are now.

The CRNA fee schedule proposal has no geographic variation. It establishes a uniform conversion factor for nonmedically directed and medically directed fees of $21 and $14 a unit. The PPRC and others are already looking at whether there should be a variation in our fee schedule similar to the physician variation. It appears, however, that using a physician index, including physician earnings and malpractice costs, would not fairly reflect CRNA differences with respect to malpractice costs and earnings. CRNA highs and lows in earnings and malpractice premiums are not in the same areas as physician anesthesia highs and lows of earnings and malpractice costs. Use of the physician GPCI would not have the appropriate effects in terms of varying payment in a manner to reflect geographic differences among CRNAs in earnings and malpractice costs.

These are simply a few of the major issues in physician payment which could affect CRNA payment legislation and regulations during this year and in the near future. At the moment, we are encouraged that legislation will be passed to significantly increase the CRNA fee schedule payments, hopefully to $21 and $14 a unit. We do not expect that the anesthesia payment changes will adversely affect our legislative proposal. The cost of our legislative proposal increasing our fees is the major obstacle probably, but Congress seems committed to doing something for us in 1990.

We will keep you informed of these matters regarding physician payment and CRNA payments.