From the CEO

Medicare Rates on the Brink– Again

By Barbara Baldwin, CSA Chief Executive Officer

In just under six months a 5.2 percent reduction in physician payment rates under Medicare is scheduled to go into effect unless Congress acts to avert the disaster. The situation is familiar and reminiscent of 2002 when mandatory reductions in Medicare reimbursement of 5.4 percent took place and further reductions would have occurred from 2003-2005 if not for Congressional intervention. The temporary fix bought time to fix the cause of the projected downward adjustments, the Medicare Sustainable Growth Rate (SGR), whose purpose is to control the rate of increase in physician costs under Medicare. The SGR adjustments are tied to the growth in the use of medical care, and when it exceeds the growth of the Gross Domestic Product, absent intervention, reimbursement rates are cut.

Use of medical services is driven by many factors under which physicians have no control, including patient health needs, new technology, addition of benefits, and the cost of physician administered drugs. The current system takes a fixed income and adds new expenses that must be paid from the same funds. The advisory board to Centers for Medicare and Medicaid Services, the Medicare Payment Advisory Commission, has recommended scrapping the SGR and replacing it with the same approach used for updating payments to hospitals, nursing homes, and other Medicare providers.

The SGR affects all physician specialties treating Medicare patients and correction of it is a priority of the AMA and most specialty societies. At the ASA Legislative Leadership Conference in May, it was the key talking point for delegates meeting with congressional representatives. Without a bill to reference, however, it was difficult to convey the urgency to some legislators.

On May 20, House Ways and Means Committee members Clay Shaw (R-FL) and Ben Cardin (D-MD) introduced H.R. 2356, the "Preserving Patient Access to Physicians Act of 2005," that would replace the Medicare SGR formula with a positive update in 2006 and tie future updates to a weighted average of input prices for physicians' services. This would permanently correct the SGR so that every few years physicians are not subject to payment reductions that would cause them to contemplate how they can continue treating Medicare patients in the face of rising costs. Looking into the not-too-distant future when baby boomers reach

retirement age and begin using Medicare benefits, patient mix could take a disastrous turn for many physicians.

Virtually no bill emerges from Congress in the same form as when introduced. HR 2356 will undoubtedly go through several iterations which will give physicians some measure of financial predictability in Medicare rates.

New Medicare Regulations Assist Anesthesiologists

Within a myriad of changes in Medicare regulations, two in particular will benefit anesthesiologists if adopted as proposed. The first regulation solves a problem the CSA addressed at the state level in 2000 and subsequently submitted a resolution to the ASA for national action. Many will recall that the rule regarding security of medications was strictly interpreted by some hospital surveyors and administrators in a way that could compromise patient safety. Some were citing hospitals for failing to keep medication carts inside operating rooms locked when the room was unattended between cases. Showing that operating rooms themselves are secure areas did not satisfy some surveyors. In turn, hospitals undergoing surveys would be "dinged" if the surveyor interpreted the rule in its strictest sense.

The CSA brought the issue to the Department of Health Services (DHS), which certifies that hospitals are Medicare compliant, and asked for clarification that would lay the issue to rest. In April 2002, DHS Medical Consultant Anthony Way, M.D., issued a letter that stated clearly that carts in secure areas (operating rooms) do not have to be locked when momentarily unattended, such as when a patient is transferred to the recovery room.

The CSA submitted a resolution to the 2003 ASA House of Delegates that called for achieving a national solution to the question. Regulations published in March for a 60-day notice added language to the Medicare rule stating that "482.25(b)(2)(i) all drugs and biologicals must be kept in a secure area, and locked when appropriate. (ii) Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area. (iii) Only authorized personnel may have access to locked areas."

Another rule mandated that the person administering anesthesia to a patient complete and document a post-anesthesia evaluation within 48 hours after surgery. This rule was debated for years as being overly burdensome for hospitals and practitioners. The new rule at section 482.52(b)(3) states "With respect to inpatients, a postanesthesia evaluation must be completed and documented by an

individual qualified to administer anesthesia as specified in Paragraph (a) of this section within 48 hours after surgery." Making this rule consistent with pre-anesthesia evaluation requirements gives greater flexibility in meeting the needs of patients.

The final regulations are expected to be published in the next few months.