American Society of Anesthesiologists®

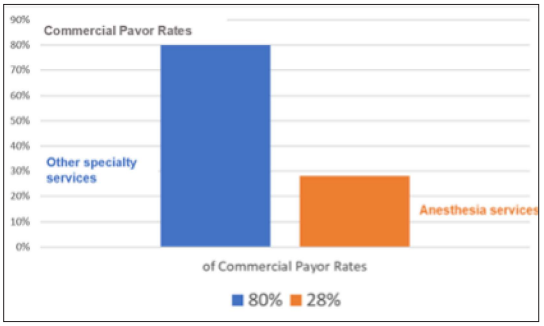
ASA® Supports an Annual Inflation Adjustment to Medicare Payments for Physicians

ISSUE

The Medicare physician payment system is broken and represents a threat to the viability of physician practices. Unlike other Medicare payment systems, Congress has no inflation adjustment or other mechanism in the Medicare physician payment formula to reflect the increasing costs of providing services.

BACKGROUND

- As a result of Congressional and regulatory actions, Medicare payments to physicians now lack any relationship to the actual cost of providing services and are insufficient.
- According to the Medicare Payment Advisory Commission (MedPAC), on average, Medicare physician payment rates represent approximately 80% of commercial payment rates. However, there is significant variability among different physician specialties with some specialties' Medicare rates well less than the MedPAC average. **Medicare rates for anesthesia services represent less than a third of commercial insurance payments**, according to a recent study by the Government Accountability Office (GAO).
- Physician payment rates have been subject to a six-year payment freeze that will last until 2026, and even experienced a 2% across-the-board cut effective January 2023. Medicare payments to physicians have been further eroded by spiking inflation, COVID-19, and the rising costs of running a practice.
- Medicare rates have consistently undervalued physicians' services. With the recent inflation, the problem has become more acute, with rates now unsustainable for many practices – especially anesthesiology.



REQUEST:

Congress is urged to support and pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act. This bipartisan legislation seeks to add a mandatory annual inflation update to Medicare physician payments. While other sectors of Medicare, including hospitals and ambulatory surgical centers, have long enjoyed annual inflation adjustments, Medicare payments for physicians have lacked a similar mandatory update. As a result, Medicare physician payments have continued to fall behind, especially in periods of high inflation.

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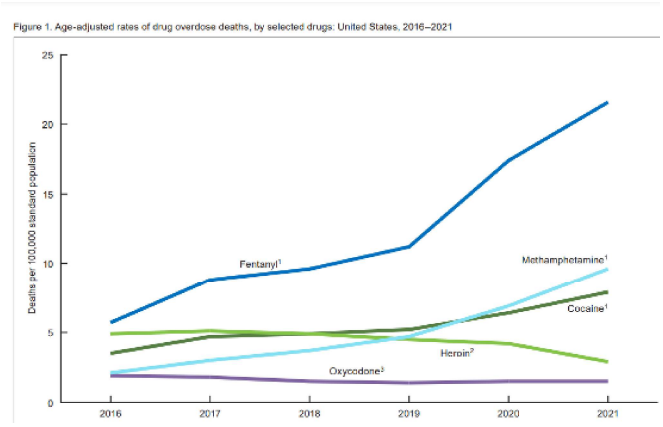
ASA® Supports Expanded Access to Naloxone to Reverse Illicit Fentanyl Overdoses

ISSUE

The opioid crisis has ravaged the United States, claimed lives, and devastated many families and communities. In recent years, deaths from illicit fentanyl have grown dramatically. Naloxone is a life-saving medication that can reverse the effects of an illicit fentanyl overdose and prevent deaths when delivered in a timely manner.

BACKGROUND

- There are two types of fentanyl: medical-use fentanyl and illicit fentanyl. Both are considered synthetic opioids.
- Medical-use fentanyl has been safely used for over 50 years by medically-trained anesthesiologists as part of anesthesia for surgery and for the treatment of pain.
- Illicit fentanyl is a synthetic opioid that is up to 50 times stronger than heroin and 100 times stronger than morphine. It is now a major contributor to fatal and nonfatal overdoses in the U.S.
- A recently released Centers for Disease Control (CDC) report noted the surge in illicit fentanyl deaths when compared to methamphetamine, cocaine, heroin, and oxycodone.
- ASA has long supported equitable community to naloxone as a nonprescription treatment.
- ASA pioneered REVIVEme, a program that members of the public as well as federal, state, and stakeholders on how to recognize, react to, and individuals suffering an illicit opioid overdose.
- More recently, ASA worked with stakeholders to encourage the Food and Drug Administration (FDA) to approve the over-the-counter (OTC) access to Narcan, a brand of naloxone. ASA applauds the FDA subsequent decision to approve OTC naloxone and believes naloxone should be available in all communities across our nation, including schools.



Source: Estimates of Drug Overdose Deaths Involving Fentanyl, Methamphetamine, Cocaine, Heroin, and Oxycodone: United States, 2021, Centers for Disease Control. Report No. 27 – May 2023 https://www.cdc.gov/nchs/data/vsrr/vsrr027.pdf

REQUEST:

ASA urges Congress to continue to support widespread community access to naloxone, a lifesaving medication that can rapidly reverse the effects of an illicit fentanyl overdose.

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ASA® Supports the Highest Standard of Care for Veterans

ISSUE

The U.S. Department of Veterans Affairs (VA) is proposing to lower the anesthesia standard of care for VA facilities. A proposed revision to the current standard will put the health and lives of Veterans at risk.

As part of an internal VA program known as the Federal Supremacy Initiative/National Standards of Practice project, the VA Office of Nursing Services (VA ONS) is seeking to dismantle the current team-based standard of surgical anesthesia care. VA's current standard endorses the Anesthesia Team, an anesthesiologist and certified registered nurse anesthetists (CRNA) team-based model of care. Under the nurses' initiative, the only medical doctors with expertise in anesthesia will be removed from Veterans' care. VA will move to a nurse-only model of anesthesia care – a model inconsistent with the highest standards of care recognized by the nation's top civilian hospitals.

Rep. David Scott (D-GA-13), has introduced the Protect Lifesaving Anesthesia Care for Veterans Act, a bill to block the VA proposal and to preserve VA's existing physician-led Anesthesia Team model.

BACKGROUND

- The VA ONS proposal would expose Veterans to a lower standard of care than the civilian population. The Anesthesia Team is widely recognized as the gold standard of care. It is the model used in the nation's top hospitals. The "CRNA-only" model is rarely used and is prohibited in all but a few states.
- VA previously considered a similar proposal from the nurses starting in 2013 and after 6 years of review and study, including two public comment periods generating over 200,000 comments, rejected "CRNA-only" care. VA explicitly noted there was no shortage of anesthesiologists in VA.
- Anesthesiologists are not interchangeable with CRNAs. Anesthesiologists have 12 to 14 years of education and 14,000 to 16,000 hours of clinical training. In contrast, CRNAs have 6-7 years of education and 2,500 hours of clinical training.
- Only anesthesiologists have completed both medical education and training in anesthesia to allow them to safely lead and deliver anesthesia care. ASA has nearly 100 physician-members who previously trained and practiced as CRNAs, but who subsequently went to medical school and completed a rigorous anesthesiology residency curriculum to be licensed as physicians and practice as anesthesiologists.
- Independent studies over a twenty-year period confirm better patient outcomes with the involvement of an anesthesiologist.
- PACT Act Veterans and many other Veterans have underlying health conditions that increase the risks of serious complications during surgery. The care of Veterans requires the clinical knowledge and experience of anesthesiologists.
- With a national nursing shortage, the nurse's proposal for a CRNA-only model is impractical and unworkable.

REQUEST:

Cosponsor the Protect Lifesaving Anesthesia Care for Veterans Act, and urge VA to maintain the standard of care consistent with the nation's top hospitals.

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ASA® Supports Fixes to the No Surprises Act (NSA) Implementation

ISSUE

The American Society of Anesthesiologists® supports protecting patients from surprise medical bills and applauds Congress for their action in 2020. However, key parts of the implementation of the NSA are badly flawed and not in alignment with Congressional intent. As Congress intended, the NSA protects patients from surprise medical bills and improves transparency within the health care system. However, the agencies have fallen short of Congress' intent to create an unbiased, independent dispute resolution (IDR) process to efficiently resolve payment disputes. The current dispute resolution system is unreasonably slow, extremely expensive and highly inefficient. The system benefits insurance companies at the expense of small and medium-sized community-based physician practices.

Key implementation problems include:

- Insurance companies are leveraging the inefficient IDR process to withhold payments due to physicians for months.
- Insurers are forgoing the NSA's mandated negotiation period to force physicians to utilize the protracted and expensive IDR process.
- The agencies are unable to efficiently manage the resolution of disputes. According to an April 27 Centers for Medicare and Medicaid Services (CMS) report, the IDR backlog currently contains over 250,000 unresolved payment disputes.
- Insurance companies are using their own self-calculated payment amount – the Qualifying Payment Amount (QPA) – as a rationale to reject requests for appropriate payments from physicians and to bias the IDR process. NSA-mandated government audits of the accuracy of QPAs have not been performed.
- Excessive fees impede physicians' ability to resolve payment disputes. For 2023, the agencies unilaterally implemented a 600% increase in the non-refundable "administrative fee" from $50 to $350, in addition to an "IDR" fee of between $200 to $1,200. With total physician outlays at $500 to $1,500, the cost to arbitrate a claim or claims often exceeds the amount in dispute.
- Despite clear Congressional intent, the agencies have severely limited highly-efficient "batched" disputes – the submission of a single, unified collection of similar claims – to the IDR process. As a result, IDR entities must resolve claim disputes one-at-a-time instead of collectively, which exacerbates the massive backlog of payment disputes. Moreover, physicians must pay expensive fees for each individual dispute, instead of a single fee for a "batch."
- The agencies have failed to implement reasonable enforcement mechanisms to ensure that insurers make timely payment to those physicians who prevail in the IDR process. Physicians who have been awarded payments from insurers are not being paid.

REQUEST:

Congress is urged to hold the agencies accountable for implementation of the NSA in a manner consistent with Congressional intent, including pressing the agencies to 1) conduct and make public mandated audits of insurers' QPAs; 2) reverse the imposition of excessive fees; 3) improve IDR efficiency by expanding opportunities for batching, particularly of anesthesia claims; and 4) hold insurance companies accountable for timely payment of amounts determined by the IDR entity to be owed to physicians.

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ASA® Supports A Robust Anesthesiology Workforce

Workforce challenges for anesthesia professionals mirror larger health care workforce trends and have been exacerbated by the national shortage of nurses, including nurse anesthetists. Increasing case volume in the inpatient setting, as well as the migration of surgical procedures to outpatient departments and free-standing ambulatory surgery centers has profound implications for the efficiency of operating rooms and the distribution of workforce.

ASA has submitted formal recommendations to the Senate Health Education Labor and Pensions (HELP) Committee and the House Energy and Commerce Committee. The recommendations include support for:

- federal initiatives to improve the efficient scheduling of operating and procedure rooms;
- expanding funding for anesthesiology residency positions through Medicare graduate medical education (GME) and other mechanisms;
- expanding certified anesthesiologist assistants (CAA) workforce; and
- reforming Medicare payments for anesthesia services.

ASA also supports the following current workforce-related legislation:

Expand Support for Physician Training Programs

The 1997 Balanced Budget Act (BBA) restricted the number of residency slots for which hospitals may receive direct GME funding. It's time for Congress to more fully reform an outdated 26 year-old funding cap on physician training positions.

REQUEST:

Cosponsor H.R. 2389 / S. 1302, the Resident Physician Shortage Reduction Act, which would provide funding for 14,000 additional residency positions.

Ease Resident Physician Financial Burdens

Physicians in residency are often unable to begin repaying student loan debt immediately. Although these residents can qualify to have their payments halted during residency through a deferment or forbearance processes, the loans continue to accrue interest, which accumulates and adds to the overall loan balance. Reforms are necessary to further student loan repayment reform and to provide relief to physicians with high student loan debt as they begin their careers.

REQUEST:

Cosponsor H.R. 1202 / S. 704, the Resident Education Deferred Interest (REDI) Act, which would allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program. The REDI Act will help to address physician workforce needs, make medical education more affordable, and boost health care outcomes across the nation.

Expand Rural Patient Access to Physician Anesthesia Services

ASA is committed to ensuring patients have access to safe, high-quality, physician-led anesthesia care. However, many states face ongoing challenges in assuring access to medical care services for their citizens living in rural areas. Rural patients deserve access to the same level of health care as patients in urban and suburban settings.

REQUEST:

Cosponsor H.R. 2761 / S. 705, the Specialty Physicians Advancing Rural Care (SPARC) Act, which would authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.

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