

Commission on Anesthesia Economics And Reimbursement

Summary of Activities and Findings

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Commissioner

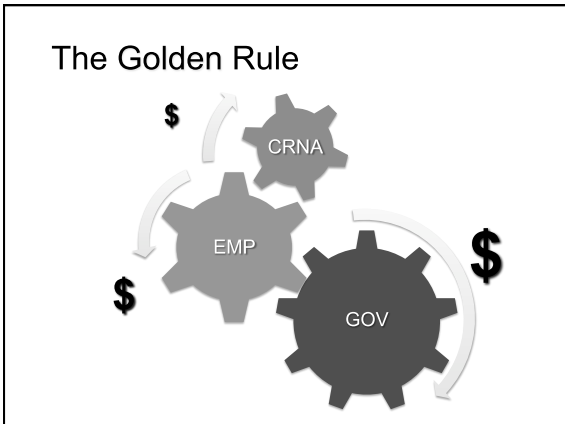
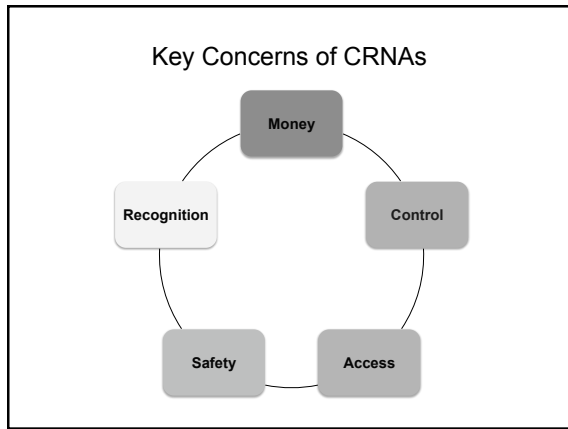
CAER Timeline of Events

And In The Beginning.....

- o August 2007: Member-driven resolution
- o Sep/Oct 2007
 - Core members/chair appointed
 - Washington office participation
 - AANA BOD-developed objectives
- o Nov/Dec 2007
 - Open Forum at AANA Fall Assembly
 - Key experts agree to serve
 - Michael Hash, Tom Scully, Sara Rosenbaum
 - Topic Immersion

CAER Timeline of Events Face To Face Meetings

- o Febuary, 2008 (Washington, DC)
 - President Wilson/President-Elect Rowles Present
- o March, 2008 (Washington, DC)
 - Addition of Linda Goldner, representing consumers
 - Draft recommendations developed
- o June, 2008 (Chicago)
 - Oral presentation to AANA BOD



Medicare Anesthesia Reimbursement

Medicare FFS payment Trends

2004	+1.5%
2005	+1.5%
2006	No change
2007	-8% (not -14% as originally proposed)
2008	-10% (projected, not realized)
2009-12	-25 to -30% (projected)

● ● ● Medicare Part A vs. Medicare Part B for CRNAs

Medicare Part A - Conditions of Participation for Hospitals

- MD "supervision" of CRNAs

Medicare Part B - Conditions of Payment for individual Healthcare Providers

- "Medical direction," non-medically directed payment rules
- Teaching payment rules

● ● ● Medicare Facts for CRNAs

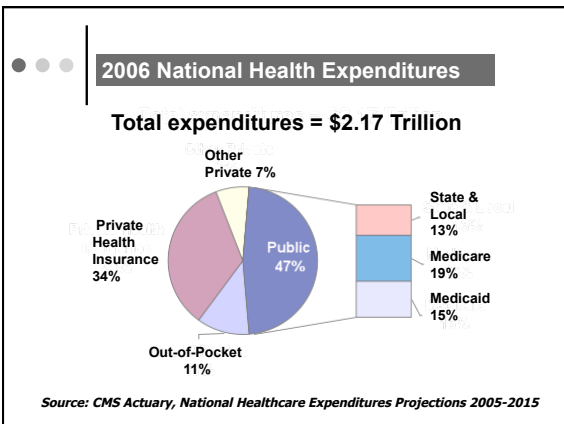
- CRNAs are recognized Medicare Part B providers, 1989
 - Can bill Medicare directly for 100% of the physician fee schedule amount, just as can anesthesiologists
- Medicare reimburses anesthesia professionals \$2.4 billion/year, most of which is for procedural anesthesia services
 - 1.7 billion for physician anesthesia
 - \$657 million for nurse anesthesia
 - Up 25% from 2005 level of \$1.9 million CMS, PFS Final Rule, 11/01/06
- Federal Funding, Education
 - \$3 million for nurse anesthesia education programs
 - *Billions for Graduate Medical Education (GME)*
 - Congress considering cutting GME funding, so CRNAs self-financing their education could be a long-term advantage for the profession.

● ● ● What We Learned

Health Policy Experts

When Congress has money, they appropriate. When they don't have money, they make policy.

F. Purcell



● ● ● "Fab 5" Changes to Expect in Healthcare

1. Digitize healthcare system to increase efficiency, decrease redundancy and errors.
 - Requires nation-wide IT infrastructure.
2. Address chronic care management and end-of-life costs, account for most healthcare dollars.
3. Create value-based purchasing incentives for hospitals and providers (e.g. Physician Quality Reporting Initiative PQRI)
 - *The reward for performance may not be more money - the reward could be not having your payments cut.*

Pay for Performance Initiatives

- o CRNAs play an active role in contributing to development of healthcare and payment policies.
 - PQRI, CRNAs are "eligible providers"
 - Member of AMA-Consortium Anesthesiology work group to develop quality anesthesia measures
 - Member of National Quality Forum (NQF)
- o 2008 PQRI Measures
 - Administration of antibiotic prophylaxis prior to surgery
 - Prevention of ventilator-associated pneumonia - Head elevation
 - Prevention of Catheter-related bloodstream Infections CRBSI - Central Venous Catheter Insertion Protocol

Fab 5 cont.

4. Conduct Comparative Effective Analysis
 - More evidence-based medicine to better determine who gets what services and payment amounts,
 - Best outcomes for the same or less cost.
5. Move away from fee-for-service to bundled payments

Reduce Cost / Add Value.

What We Learned

Hospital Administrators

Hospital Subsidies – Anesthesia Services

Real / Growing Issue for Hospitals

- o 2004 Studies from ASA and Advisory Board Indicated:
 - 57% of hospitals are paying some form of subsidy for Anesthesia Services
 - 10% of these subsidies are at least \$3,000,000
 - Most prevalent in larger anesthesia groups (>10 providers)
- o Subsidized Services:
 - Anesthesia administration/oversight
 - On Call Coverage
 - Trauma Services
 - Cardiac Coverage
 - Medical Director / Other Administrative Services

Hospital Subsidies – Anesthesia Services

Real / Growing Issue for Hospitals

- o Types or Basis of Subsidies
 - Income Guarantee
 - Payor Mix
 - OR Inefficiencies
 - Minimum Staffing / Coverage levels
 - "Indirect" Subsidies
 - Recruitment Support
 - Retention Payments / Bonuses
 - Hospital CRNA Employment

Hospital Subsidies – Anesthesia Services

Real / Growing Issue for Hospitals

- o One Example
 - Two hospital, One ASC System
 - Subsidy based on requested OR Rooms/staff needs
 - \$2.4 Million Annual Subsidy...
 - ...plus \$650k for OB Coverage
 - ...plus recruitment bonuses and retention payments
- o Subsidies are not sustainable, so changes are being implemented
 - Reducing Hours of Operation
 - Closing on Weekends
 - Requesting Call Coverage from group versus on site
 - Cardiac Services during off hours limited to one facility

● ● ● | **Real Life Impacts**

- **New orthopedic surgery center:** 5 CRNAs do cases, 2 anesthesiologist medical directors do pain clinic
- **Hospital-owned outpatient surgery center:** Installed all-CRNA practice billing nonmedically directed; anesthesiologist group had demanded large subsidy
- **Large suburban med center:** All-MD group opening up practice to CRNAs rather than adding new MD partners

● ● ● | **Real Life Impacts**

- **Residency program/med center:** CRNAs shifted to independent practice model w/ contracted MD consultation
- **MD/CRNA-owned company:** facility contracts based on projected service needs
 - Staffing model maximizes CRNA scope of practice
 - Financial risk of billing/collections shifted to facility
- **Large MDA-owned Corporation:** AAs recently added to meet clinical demands for unfilled CRNA slots
 - *Temporary solution or part of master plan??*

● ● ● | **Multilevel Ramifications**
Anesthesiologist

- ASA
 - Formal academic transition?
 - Embrace wider ratio for CRNA oversight?
 - AA support??
- Individual/Group Practice
 - Local & regional variation continues
- *but watch for trends!!*

● ● ● | **Multilevel Ramifications**
Facilities

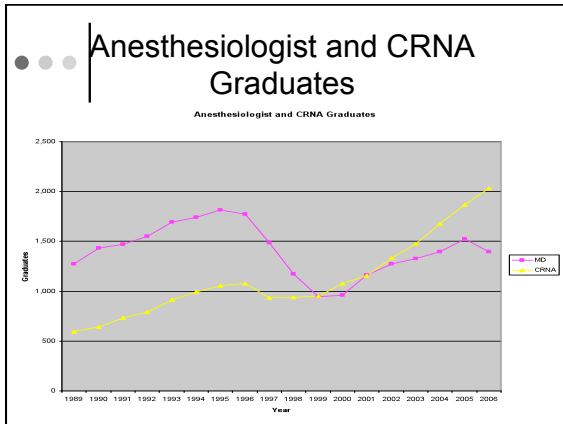
- Hospitals
 - Sickest patients: benefits of hospitalist + true *perioperative team*
- ASCs
 - Difficult to forecast (owner-driven)
 - Expect multiple practice scenarios based on local custom, supply/demand, & competitive business practices

● ● ● | **Multilevel Ramifications**
Non-physicians

- AAs
 - Heavily influenced by ASA/state regulatory environment
- Sedation Nurses
 - Proceduralists + facility + case volume
 - Nature of procedure
 - Evolving technology (CAPS?)
 - Evolving pharmacology (Aquivan?)
 - Insurer policies limiting anesthesia coverage

● ● ● | **Multilevel Ramifications**
Nurse Anesthesia

- AANA (*Considerable growth potential*)
 - Appropriate positioning of CRNAs vis-à-vis other providers?
 - Scope of practice
 - Reimbursement
- CRNAs
 - Expectation shift from medical direction to supervised/consultative models of practice
 - Opportunities for the prepared/threats for the unprepared
 - *Education is key!!!*



CAER Recommendations Acknowledgements

“Altering the state of anesthesia practice and payment on a large scale, given its complexity and vast number of stakeholders, would require a comprehensive strategic plan driven by dedicated anesthesia professionals as well as substantial manpower and financial resources and allies in related fields.”

- ### Practice Management Education
- CAER Recommends That AANA...**
- o Develop a Practice Management Function within AANA
 - o Entrepreneurial Training/Resources
 - o Develop Payment Policy Education
 - o Showcase CRNAs Best Practices and Patient Safety
 - o Encourage CoA to define Professional Aspects to include Business and Practice Management

- ### Alternative Payment and Practice Models
- CAER Recommends That AANA...**
- o AANA analyze current and alternative models
 - o Develop financial analysis for each model
 - o Strategy based on output rather than input
 - o Identify current policy that puts CRNAs at a disadvantage.
 - o Further analyze cost shifting between public and private payers

- ### Studies, Surveys and Data Collection
- CAER Recommends That AANA...**
- o Explore partnering with MGMA to promote CRNA participation and accurate data
 - o Cultivate research opportunities and capabilities of CRNAs. Promote academic research in areas of quality measurement development and practice management and reimbursement modeling.
 - o Obtain CMS information on reimbursement for non-medically directed, medically directed and personally performed services.
 - o Obtain quality data on CRNAs practicing independently

- ### Technology
- CAER Recommends That AANA...**
- o Enhance current strategies and focus on ongoing assessment of current and emerging technologies that effect the economics and efficiency of anesthesia practice and enhance patient safety
 - o Seek opportunities for CRNAs to contribute to the development of EHRs, peri-operative info systems and other health information management tools so that CRNAs are included in the collection of this data and their work is easily identifiable.

● ● ● | Building Relationships and Alliances

CAER Recommends That AANA...

- Take the lead in cultivating stronger relationships with advanced practice nursing and seek opportunities to align efforts.
- Build relationships and alliances among anesthesiologists, surgeons, hospital administrators professional associations and trade associations
- Build relationships with regulatory and legislative decision makers
- Seek opportunities for CRNAs to serve as representatives to key reimbursement and practice bodies.

● ● ● | Commission Participation

CAER Recommends That AANA...

- Add a large self insured employer as a member, advisor or to testify
- Add a small employer as a member, advisor, or to testify
- Add insurer as a member, advisor, or to testify
- Add surgeon as a member, advisor, or to testify
- Obtain further consumer/patient perspective as member, advisor or to testify