Anesthesia: Past

- Anesthesia Practices:
- Hospital Based Academic
- Hospital Based Community
- Private MD & CRNA group
- Anesthesia Management Company
- Locums
- Independent Practice
Anesthesia Changing Trends

- Past:
  - Competition for Anesthesia Services & Contracts based in legacy, traditions & geographical factors
  - Limited Options for Healthcare Organizations

- Present & Future:
  - Competition for Anesthesia Services value based, extremely competitive markets with mergers & acquisitions the norm
  - Numerous Anesthesia Options Local & National
Anesthesia Trends

- Flexibility & Adaptability to meet Organizational needs are invaluable
- Collaboration & Shared Vision with Organization a must for Anesthesia Team
Anesthesia Trends

• Market Trends for CRNA’s, AA, MDA
• Balance of Supply versus Demand: Regionally & Nationally
• Critical Access Areas
• Governmental Providers
Anesthesia Activism

- AANA American Association of Nurse Anesthetist
- PANA Pennsylvania Association Nurse Anesthetist
- Legislators Federal & State
- Stewardship Essential
Anesthesia Professional Citizens

- Anesthesia Providers Professional Citizens versus Inhabitants
- Anesthesia Providers as Business Partners with Healthcare Organizations: Partners in Shared Vision
Anesthesia Professional

- Employment Choices
- Contracts
- Non Compete Clauses
- Geographic Limitations
- Offer Letter
- At Will versus Union
Anesthesia Professional Balance

- Compensation Package
- Scope of Practice & Practice Setting
- Work Life Balance
Anesthesia Business & Practice

- Healthcare Landscape Changes & Anesthesia National Trends
- Affordable Care Act Signed 2010
- Implemented in Stages since 2011
- Healthcare Exchanges Medicaid & Medicare Expansion 2011
New Game Changers

- Landscape & Environment of Healthcare
- Patients as Consumers
- Payers & Payment Innovations
- ACA Impacts
• New England Journal of Medicine projections suggest healthcare costs will encompass 26% of GDP…all disciplines will play a role in the costs
• United States spends approximately $9366 per person on healthcare
• 2015 Healthcare costs increased 3.7%
• $2.9 TRILLION
HealthCare as a Business

- United States spends more money per capital than any other nation!
- Healthcare costs represent 17.8% of Gross Domestic Product!
How Does the Affordable Care Act Cover the Uninsured?

6.6 MILLION YOUNG ADULTS were enrolled in a parent’s health plan in 2011 as a result of the Affordable Care Act’s requirement that employers and insurers that offer dependent coverage INCLUDE ADULT CHILDREN TO AGE 26.

30 MILLION people will gain insurance through the Affordable Care Act by 2020.

2/3 will be covered through the new health insurance exchanges
   These state marketplaces will serve as portals through which small businesses and people who do not have an affordable employer-based health plan can go for coverage starting in 2014.
   Subsidies will be available to:
   - Individuals earning up to $44,680
   - Families of four with incomes up to $92,200

1/3 will be covered through Medicaid expansion
   States will have the option of participating in a Medicaid expansion in 2014.
   Benefits will be available to:
   - Individuals earning up to $14,856
   - Families of four with incomes up to $30,657
Affordable Care Act

- Politically Charged
- National focus on Healthcare requesting better quality for better price since to “To Err is Human” 1999
A CA, SGR, Anesthesia

• Sustainable Growth Rate 1997 “Doc Fix Bill”
• Since 1997 Amended multiple times to avoid reductions in Reimbursements
• Repealed in April 2015 with Bipartisan Support
ACA, SGR, Anesthesia

- SGR Repeal approved April 2015 focus on Value Based Reimbursement
- SGR repeal held off 22-25% payment cuts
- WHY was SGR so easily repealed by a Bipartisan Vote?
Goodbye SGR, ACA Pioneers

Since 2011 Pioneers in Care Models & Payment Models have allowed for feedback & review of successes and failures on revolutionary changes to the healthcare system
Anesthesia Revenue: Metrics

![PQRS Timeline Graph](image)

- 2010: +2.0%
- 2011: +1.0%
- 2012: +0.5%
- 2013: +0.5%
- 2014: +0.5%
- 2015: -1.5%
- 2016: -2.0%

Physician Quality Reporting System: PQRS

- Initially incentive based, voluntary
- 2015 Penalty for failure to report
- 2015 Decrease reimbursement for payments in (2017)
- 2015 payment reduction of -1.5%
- Performance Years vs. Payment Years
- MACRA 2015 will be the new focus
- PQRS will evolve
ACA & Payments

Exhibit 5. Accelerating Implementation of Key Payment Reform Provisions

**Hospital Value-Based Purchasing**
- **2010–2012**: Builds on measures used in Inpatient & Quality Reporting (IQR) and Hospital Compare programs.
- **2013**: 1% of hospital payments affected.
- **2014–2017**: Incremental increase to 2% of hospital payments affected in 2017 and beyond.

**Hospital Readmissions Reduction Program**
- **2010–2012**: Builds on the measures used in IQR and Hospital Compare programs.
- **2013**: Up to 1% of hospital payments affected. Based on readmissions for heart attack, heart failure, pneumonia.
- **2014–15**: Incremental increase to 3% of hospital payments affected in 2015 and beyond. Additional conditions included: COPD and elective hip & knee replacements.

**Medicare Shared Savings Program**
- **2012–13**: Initial members join program. Pay-for-reporting in first performance year. Option for shared-savings only in first three years of participation.
- **2014–15**: Measures transitioned to pay-for-performance (shared savings only).
- **2016 and beyond**: Greater incentives for sharing (downside) risk.

---

1 Builds on Physician Group Practice demonstration. Pioneer and Advanced Payment ACOs also launched through the Center for Medicare and Medicaid Innovation in 2012 with more-sophisticated provider organizations.
Two Midnight Rule

- IPPS Inpatient Payment System
- Significant financial impact nationally on Hospital Reimbursements
- Anesthesia Providers must have awareness & insights to navigate with hospitals
Why focus on the IPPS?

- $539 Million
- Anesthesia & Surgical Issues may impact length of stay or Hospital Acquired Conditions (HAC)
Anesthesia & Payment Reform

- Alternative Payment Models:
  - MIPS
  - Bundle Payments
  - ACO
  - Payment Initiatives & Pioneer Projects
New Kid on the Block: MIPS

- Merit based incentive payment system: MIPS
- The roll up of PQRS, Meaningful Use, Value Based Payments
- 2018 Impact Year versus Performance Year: 2 year lag
Anesthesia Metric Reporting

- MIPS: Must report metrics to a qualified clinical data registry (QCDR)
- Benchmarks
- Data Mining
- Quality & Value
MIPS

Timeline

**FEE**
- Schedule Updates
- Quality
- Resource Use
- Clinical Practice Improvement Activities
- Meaningful Use of Certified EHR Technology

**MIPS**
- PQRS, Value Modifier, EHR Incentives
- 4% 5% 7% 9% MIPS Payment Adjustment (+/-)
- Qualifying APM Participant
- 5% Incentive Payment
- Excluded from MIPS

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
MACRA 2015
Benchmarks & Bundles

- Benchmarks for undefined episodes of care to be compared using qualified data registries
- Bundles Payment Model April 2016!
- More Bundles to follow soon!
MACRA December 2015

- Medicare Access & CHIP Reauthorization Act of 2015
- Repeals SGR permanently & allowed input until November 2015 from Payers & Providers
Payer Mix Projection 2017-2022

Payer Mix of Hospitals

- Government Programs: 51%
- Private Health Insurance: 37%
- Miscellaneous Programs: 9%
- Individual Payments: 3%

Source: National Health Expenditure Projections 2012-2022
Healthcare Exchanges & Revenue

HIX
29 million people will be covered by HIXs by 2019
$241 million allocated by Health and Human Services for HIXs

Health Insurance Exchange
Shop and compare!

Eligibility
Please key in your personal info

Medicaid
Individuals & families
CHIP
Children
Public Subsidy Options
Individuals
Employer-Based Insurance
Employees

Individual consumers

Small employers

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Payer Mix & Revenues

- Payer mix with exchanges is moving target
- Exchanges had ACA financial incentives to mitigate financial risk but these end in 2017
- Insurers are beginning to limit participation or pull out completely
Anesthesia Practice

Anesthesia Practices as a Business are undergoing dynamic changes nationally:

- Anesthesia Management Companies
- Hospital Practice/Ownership
- Private Anesthesia Groups
- Solo Provider
- Locums
Anesthesia Clinician vs. Business Partner?

- The Affordable Care Act has thrust anesthesia clinicians into a myriad changes in both clinical & business aspects of anesthesia practice!
Anesthesia Clinician: Flexible, Adaptable & Resilient

- Anesthesia Practice have “evolved”
- Anesthesia Providers must increase knowledge of business aspects to remain adaptable & resilient!
Affordable Care Act: Change

- ACA was implemented in phases by year since 2011 to allow for adaptation by providers, payers, organizations & patients
Anesthesia Business & Practice Model

• Flexibility & Awareness of the new Paradigm in Anesthesia Care is extremely important
• Failure could result in Fiscal Insolvency
Evolving Changes & Anesthesia Business

- New Focus
- Pay for Performance (P4P)
- Volume to Value (V2V)
- Models of Care
- Payment Models
Anesthesia as Part of the Healthcare Business

- Healthcare organizations are evaluating the fiscal assets & liabilities. Care Organizations are determining where are the Revenue Streams, Revenue Losses, Models of Care.
Anesthesia: Costs “Big Picture”

- Anesthesia Practices must ensure their business models are sound!
- Anesthesia accounts for 5-6% of perioperative costs in hospital settings—primarily labor costs!
AANA Practice Data

• How are CRNA’s practicing:
  • 80% Team Models
  • 37% physician group
  • 32% hospital employee
  • 16% Independent Contractors
  • 3% Ambulatory Employees

• 36 States that allow Medicare Payment directly to CRNA
• 38 Blue Cross Payers that directly reimburse CRNA
• 22 States that mandate direct CRNA payment
Where is the Money?...Surgical Services

- Perioperative Care represents *over 65%* of most hospital revenue streams
- Significant attention & focus on Perioperative Care due to the large stake of revenue at risk!
Anesthesia Business

- Labor Costs
- Supply Costs
- Stipends
- Services Provided: stipends, coverage contracts (codes, OB, trauma, non elective surgery)
Anesthesia Business

- Productivity of labor
- Labor Models…team models medical direction with 1:4 ratio
- Productivity: mining the data using electronic records for billable minutes per care provider versus hours paid to provider
### Operational Efficiency Goals

#### OR Operational and Organizational Benchmarks

Best practices and performance targets for OR productivity and profitability.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule</td>
<td>8-hour blocks</td>
</tr>
<tr>
<td>Utilization</td>
<td>75% minimum requirement</td>
</tr>
<tr>
<td>Open rooms</td>
<td>20%</td>
</tr>
<tr>
<td>Pre-op prep</td>
<td>Phone screen (3-5 days prior)</td>
</tr>
<tr>
<td>Nursing model</td>
<td>Specialty teams, flexible staffing</td>
</tr>
<tr>
<td>Cancellations</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>On-time starts</td>
<td>≥90% (within 5-7 minutes)</td>
</tr>
<tr>
<td>Turnover time (IP)</td>
<td>20-35 minutes</td>
</tr>
<tr>
<td>Turnover time (OP)</td>
<td>10-20 minutes</td>
</tr>
</tbody>
</table>
Anesthesia Customer Service

- Anesthesia providers should approach both the surgeon & the patient as valued customers in the competitive market for anesthesia service!
Anesthesia Labor Costs

- Anesthesia Labor costs are a major component of the business overhead variables
- Staffing levels should tightly match case volume trends: Flexibility
Outsourcing Billing

- Internal costs of maintaining a billing office may be economically unfeasible.
- Outsource of billing to 3rd party vendor may provide maximal billing and revenue stream.
Outsourced Billing

- Billing Company fee for services typically are 5-6% of revenues
- Billing company data interface, accounts accrual & receivable must be setup to determine working cash flow.
Billing Data

- Billing company should provide data on:
  - Payer mix
  - Metric compliance
  - Service line revenues
  - Bad Debt Ratio
ICD 10

- ICD 10 in use since October 2015
- Tremendous increase in diagnostic codes that increase specificity of procedural description
- ICD 10 errors may revenue stream due to reprocessing of claims
Anesthesia & “Low Hanging Fruit”

• How many anesthetizing location are in use or dormant?
• Obtain increased locations to include NORA: CVL, EP, IR, MRI, GI*
• Examine the costs of beginning a new site or service line
Once seen as “nuisance sites” have now become areas of significant revenue generation for anesthesia departments $$
NORA & Revenue Streams

• Endoscopy reimbursements for colonoscopy screening for Population Health Initiative

• 100% Reimbursement mandated by ACA for screening—coding can be complex.
Production Pressure versus Productivity

- Efficiency, quality, and productivity initiatives that lack care provider inclusion in systemic or infrastructure changes often result in failure
Productivity in Anesthesia Labor

- Anesthesia Care Provider Time Off
- Paid time off is integrated into labor cost & productivity
- Average CRNA vacation time: 6 weeks (30 days) without producing billable minutes...$**$
Anesthesia Labor & Productivity

- Productivity can be impaired by:
  - Long Turn Over Times (TOT)
  - Case Cancellations or Delays
  - Preop Clinic Delays
Anesthesia Business Basics

- Types of Practice:
  - Hospital Employee
  - CRNA only group
  - MD only group
  - MD/CRNA private group (Blended)

- MD group employee
- Locum Tenens
- Independent Contractor
- AMC- Anesthesia Management Company
Anesthesia Business

- Organizational Type:
  - Hospital (Type)
  - Ambulatory Center
  - Specialty Clinic: Pain, GI, Eye, Plastics

- What types of services are needed?
- What is the overhead? Labor, supply, medication, coverage needs, subsidization, stipends?
Anesthesia Care & Services

- Approximately 96% of Anesthesia groups require a “stipend” to cover cost of required services: airway, obstetrics, trauma, on call services

- MDA Salary ($$$) vs. CRNA Salary ($)

- Overall costs to Healthcare Organization must be considered

- Competition in Anesthesia Services*
Anesthesia Revenue

- What is the payer mix?
- Exchanges:
- Medicaid, Private, Medicare, Commercial, Federal or State Exchanges (ACA)
Anesthesia Professional Fees

- Fee Charged vs. Fee Collected
- Governmental Payers (Tricare, Medicare…)
- Bundles Programs
- Insurance Contracts
- Eligible Providers
ACA The Changing Face of Reimbursements

Value Based Reimbursements: Adjusted Payments anesthesia metrics will promote infrastructure changes
Value Based Payment & MIPS

- Value Based Payments will require provider compliance with Best Practices Processes (Evidence Based)
- Data tracking will promote individual provider accountability.
Anesthesia Practice Model

- Practice Model should fit the organizational needs:
  - Anesthesia Care Team: Supervision or Direction
  - RATIO’s in Team

- Sole Provider: MD, CRNA, Blended.
- Misalignment of needs to care model can result in revenue loss, patient care deficiencies & safety issues!
Anesthesia Payment $$$

- BASE UNITS + TIME UNITS (X) CONVERSION FACTOR = PAYMENT $
- Remember billed versus paid fees
- Value Based Payments
- Metrics: Process and Outcome impact $$$
Anesthesia Payment Complexity

- QZ: (CRNA modifier – pays 100%) non-medically directed CRNA services; CRNA is either working without medical direction or criteria was not fully met.
- QX: (CRNA modifier – pays 50%) Medically directed CRNA services; the CRNA is being medically directed by an MD, who has met all required steps for medical direction.
- QK: (physician modifier { used in conjunction with QX modifier} - pays 50%) Medical direction of two, three or four concurrent procedures
- QY: (physician modifier { used in conjunction with QX modifier} - pays 50%) MD is medically directing one CRNA
- AD: (physician modifier { used in conjunction with QX modifier} - pays maximum of four units or zero) Medical supervision by a physician of more than four concurrent procedures
- Q6: (physician modifier- doesn’t affect payment) Service furnished by locum tenens “physician”
Review of Billing

- Anesthesiologist must bill under these codes:
  - AA – Anesthesia services personally performed by MDA 100% allowable reimbursement/case
Anesthesia Billing Review

• Medical Supervision:
• AD – medical supervision by MDA concurrent anesthesia services, more than 50% but less than 100% reimbursement
Medical Supervision: does not meet Tefra guidelines, MD is paid 2 or 3 base units. Often avoided due to lost revenue!
Anesthesia Billing Review

- Medical Direction:
- QY – Medical direction of one CRNA one anesthesia service, 100% of allowable reimbursement
TEFRA Guidelines

1. Perform a pre-anesthetic examination and evaluation and document it in the medical record.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures in the anesthesia plan—including induction and emergence, if applicable—and document this.
4. Ensure that any procedures in the anesthesia plan are performed by a qualified anesthetist.
5. Monitor the course of anesthesia administration at frequent intervals and document that they were present during some portion of the anesthesia monitoring.
7. Provide indicated-post-anesthesia care and document it.
Anesthesia Billing Review

- Medical Direction:
- QK – Medical direction of 2, 3, 4 CRNA’s concurrent procedures, 50% of allowable reimbursement per case. $$$$
<table>
<thead>
<tr>
<th>Anesthesia Billing: Complexities</th>
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</thead>
<tbody>
<tr>
<td><strong>Billing documents:</strong></td>
</tr>
<tr>
<td>• Accuracy of Times</td>
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<tr>
<td>• Metric Compliance Process or</td>
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<tr>
<td>Outcomes Penalty for</td>
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<tr>
<td>fallouts...lost</td>
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<tr>
<td>revenue.</td>
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<tr>
<td><strong>Billing Process in place:</strong></td>
</tr>
<tr>
<td>• Outsourced versus Internal</td>
</tr>
<tr>
<td>Billing</td>
</tr>
<tr>
<td>• Collections</td>
</tr>
<tr>
<td>• Accounts Receivable for</td>
</tr>
<tr>
<td>Anesthesia</td>
</tr>
</tbody>
</table>
Anesthesia Billing

• Internal Billing Cons:
  • Costs of maintaining billing office & employees
  • Mining the metrics internally difficult to provide provider dashboards

• Pro:
  • Able to retain all revenues without billing fees typically 5-6% of total fees billed
  • Interface of data from medical records simplified. Unified infrastructure
Anesthesia Billing

- Maximizing revenues is essential in the face of decreased reimbursements
- Documentation deficiencies result in delayed payments & are often rejected
- Provider documentation compliance
Point of Care Collections

- Point of care collections—collecting money at the time of service or prior to initiation of service
- Now becoming the standard within the healthcare industry
Point of Care Collections

- Anesthesia Point of Care Collections:
- Collection of payments may be bundled or itemized
- Ethical challenge for care providers
- Patient education, planning and resource assistance essential.
Paradigm shift in revenue cycles for healthcare. Education & clear communication to patient essential to ensure NO same day cancellation of cases!

- Same day case cancellations result in significant fiscal losses: $ 3900-4300.
- Ensure sound procedures in place, private POC area, credit care agreements & counselors in place.
Anesthesia Revenue

- Anesthesia Revenue:
- Example:
- TAH 65yr. Female
- Medicare
- Length of case 1.5hrs

- 6 Base units +
- 6 Time units =
- 12 Units X $ 22.45 $269.40 per TAH

How many cases per day? 4 x $ 1077.60
Anesthesia Business & Costs

- Time not Billing is lost revenue
- Turn over Time (TOT)
- Lunch, Breaks
- Insufficient case volumes

- Procedures not billed for are lost revenue
- Invasive lines
- Pain Interventions
- Consultations: Airway, Preop, Postoperative
Anesthesia Metrics: Data Driven

- Use of Anesthesia Metrics: Process & Outcome Based
- Quality of Anesthesia Care increases with use of Best Practices
- Evidence Based Anesthesia Care
Anesthesia Evidence in Practice

- Use of Evidence Based Care Practices
- Metrics Tracking
- Anesthesia Provider Education
- Infrastructure Support**
Anesthesia Practice: Metrics

- Infrastructure of metric compliance:
  - Does the “care environment” support compliance?
  - Anesthesia Provider Dashboards?

- Anesthesia equipment in place?
- Medications accessible to comply?
- Anesthesia Provider awareness of metrics?
Anesthesia Practice & Business

- Value NOT Volume
- MACRA 2015
- MIPS
- Alternative Payment Model APM & Bonuses
Anesthesia Metrics & Care Setting

- Anesthesia Practices choose metrics based on:
  - Type of care frequently delivered
  - Setting of Care

- Acuity of Care: Preventative, Routine, Emergent

- Metrics change by year and should be reviewed & revised to meet care setting
Anesthesia Business & Practice

• Volume (of cases, services provided) is a MAJOR driver of a solvent practice!
• Value is the NEW METRIC
• Value added (CRNA cost efficiency) increases job security...key consideration in anesthesia provider competition...MDA, CRNA, AA
Anesthesia Providers: The Evidence

- Cochrane Database: an esteemed internationally recognized database with no political, proprietary, or discipline bias!

- 2014 Study results:
  - No superiority of care noted differentiating one anesthesia provider from another (MDA vs. CRNA)
  - 6000 Literature articles total reviewed
  - Extensive analysis
Cochrane Results: CRNA

- Care provided by CRNA’s represents a cost effective, safe access to quality anesthesia care... recommend CRNA’s practice to the fullest scope of practice!
Anesthesia Business & Practice

- Anesthesia Lean Process Improvements
- Anesthesia Consultants
- Anesthesia Management Companies (AMC)
- Anesthesia Stipend & Contractual Analysis
Anesthesia Practice, Business, Lean

- Consultants, auditors, analysts for process improvement can provide valuable insight for efficiency but engagement, sustainable change are required to ensure fiscal solvency!
Anesthesia & Lean Processes

• Lean processes are patient centered & should ensure quality & safety are maintained or improved

• Lean originated with Toyota yet process improvement knowledge applicable
Anesthesia & Going Lean

- Transforms organizations using 6 main components
- Attitude of continuous process improvement
- Value creation*
- Unity of Purpose
- Respect for frontline workers
- Visual tracking
- Flexible regimentation
The Business – Practice Model

- Anesthesia Providers must increase knowledge of the financial impact of practice choices, PQRS compliance, highest quality documentation, labor utilization & distribution
Lean & Value Stream Map

- Map out the entire care process from Preoperative Visit to Discharge examine areas of inefficiency, redundancy, repetition, replication. Use planned implementation science to impact sustainable change.
Anesthesia Providers: Value Added

- Anesthesia Providers must demonstrate their “value added” benefits to efficient care processes
- Integration of Services to ensure efficiencies between disciplines for the entire continuum of care
Anesthesia a Key Team Member

- Anesthesia team members a problem solvers, collaborators and expert clinicians
- Patient centered processes, reduction of silos, building bridges across disciplines
Summary

- Clinical expertise alone cannot solely guide the practice of anesthesia.
- Integration of sound interdisciplinary team processes &
- Commitment for process improvement as a “lifestyle”
Questions