Commission Report: August 2008

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Commission on
Anesthesia
Economics & Reimbursement

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Preface

As required by the American Association of Nurse Anesthetists (AANA) Board of Directors (Board), the Commission on Anesthesia Economics and Reimbursement (Commission) examined current and projected health economic trends that are having or may have an impact on the delivery of anesthesia services. Based on its findings, the Commission formulated recommendations for the Board to consider. Throughout the course of its work, the Commission was mindful of the role of the anesthesia profession in the changing healthcare marketplace, and the anesthesia professional's interest in safe patient care and fostering appropriate incentives for effective utilization of anesthesia services.

The Commission's work has more breadth, depth and balance due to the exemplary group of experts the Board appointed as commissioners. These commissioners, all experts in their fields, consisted of AANA members from around the country as well as national healthcare policy and system experts. They contributed a diversity of skills and knowledge to the Commission, and exhibited a willingness to share their expertise with and learn from their fellow commissioners.

The commissioners are confident in the report that was presented to the Board on May 29, 2008. The Commission discussed in great detail a broad range of topics and ideas, from the status quo to outside-the-box thinking, from high-risk to low-risk concepts. However, given the broad nature of its objectives and the complexity of the current healthcare and payment system, the Commission recognizes that additional work may be required to fully address the objectives. The Commission welcomes the Board's direction on whether the Commission should continue its work beyond its one-year charter. Many of the Commission's recommendations are ready for further action and possible implementation by the AANA. If the Board decides that the Commission's work should continue, the Board could, for example, direct the Commission to refine its current recommendations, conduct additional research, or take a new path and explore additional areas of anesthesia economics and reimbursement. It is conceivable that further work by the Commission might be more task-oriented than work typically done by commissions.

This report is organized into three main sections: Commission Objectives, Commission Findings, and Commission Recommendations.

The Commission Objectives section identifies the objectives the Board charged the Commission with accomplishing and details how the Commission addressed these objectives. In its deliberations, the Commission found that the objectives inherently shared many of the same themes, required the same background information, and raised similar questions and issues. Therefore, to streamline the report and limit redundancy, a conscious decision was made to organize the report around topics rather than individual objectives.

The Commission Findings section includes background information related to the status of anesthesia payment, practice and policy that was brought to light as the Commission addressed its objectives. To effectively develop recommendations for the Board, the commissioners had to collectively

understand the status of anesthesia payment and practice. They achieved this understanding by reading numerous academic articles and reports, researching specific aspects of anesthesia practice, and presenting their findings and sharing their expertise during Commission meetings. (See Appendix A for a list of documents reviewed by the commissioners.) The Commission also gathered information about anesthesia payment and practice environments from AANA members during the Commission Open Forum at the November 2007 AANA Fall Assembly of States, and from comments emailed to the Commission's dedicated email address accessible through the Commission webpage. To collect in one comprehensive document this active exchange of knowledge on anesthesia practice is unique in itself. Most information about anesthesia practice and payment exists in bits and pieces, making a comprehensive understanding very difficult to attain for anesthesia professionals, their employers, administrators, insurers, billing entities and policy makers.

The recommendations in the Commission Recommendations section are based on the Commission's findings. These recommendations are built upon a conceptual framework of advancing the nurse anesthesia profession's goals of quality, safety and efficiency at a lower or neutral cost to the healthcare system. The Commission has not established a value for or prioritized its recommendations. The Board could choose to move forward with none, one, or many of the recommendations. Regardless, altering the state of anesthesia practice and payment on a large scale, given its complexity and vast number of stakeholders, would require a comprehensive plan driven by dedicated anesthesia professionals, substantial manpower and financial resources, and support from a broad-based coalition of stakeholders.

The commissioners thank the AANA Board of Directors and AANA membership for the opportunity to work on this Commission.

Executive Summary

Each year throughout the United States, Certified Registered Nurse Anesthetists (CRNAs) use their skills, intelligence and commitment to make a positive difference in the health of millions of patients. Although the charge given to the Commission on Anesthesia Economics and Reimbursement (Commission) was broad, the Commission's objectives could be summarized by answering the following question: How can CRNAs best position themselves to continue contributing to the health and well-being of their patients, maintaining and building their practice, and being a valuable part of the healthcare system?

To answer this question it was important for the Commission to not only understand nurse anesthesia payment and practice, but to also understand the current healthcare system at the national level and the role of CRNAs in that system. While CRNAs make a necessary contribution to the nation's healthcare system, the practice of nurse anesthesia is just one part of a large and growing healthcare industry that includes millions of stakeholders, each with their own agendas that compete for attention and funding from both the private and public sectors.

CRNAs face an evolving political landscape and ever-changing rules, regulations and laws that can both free and bind practice; proposals for sweeping changes to the current healthcare system; drastic reductions in payment; competing providers; and technological advances that may alter the nature of anesthesia practice. Such sweeping changes are difficult if not impossible for any one group to control. However, with the commitment of its members and the right tools in place, one group can effectively shape any changes in its favor. The Commission recognized that an effective way for CRNAs to face these mounting challenges is to utilize one of nurse anesthesia's greatest strengths: The ability of CRNAs to successfully advocate for themselves and their profession. For decades, CRNAs have played a vital role in shaping rules, regulations and laws that have an impact on their practice and ultimately their patients. To continue in this role, CRNAs must be equipped with additional tools and resources that bolster their ability to advocate for themselves and their profession.

The Commission has therefore made recommendations in the area of practice management education. These recommendations propose that the American Association of Nurse Anesthetists (AANA) expand its current educational efforts to not only provide CRNAs with the tools and resources they need to understand the complex payment and practice rules affecting them on a daily basis, but also to ensure that CRNAs know how to apply what they learn. With tools and resources that focus on the business and financial aspects of anesthesia practice, CRNAs will be able to more effectively advocate for themselves, their profession and their patients. But becoming knowledgeable about the business aspects of anesthesia may require a cultural shift for many nurse anesthetists, because seemingly few CRNAs are well-versed in this area. To best position nurse anesthesia practice for the future, the AANA's practice management education initiatives should assist CRNAs in presenting themselves as providers who add value to their workplace. CRNAs have a growing need for this type of business and financial information, and these

recommendations, if implemented, could help to address that need. Should large-scale changes to the healthcare system occur, CRNAs would be better equipped to shape these changes in their favor and adapt their practices accordingly.

The tools and resources CRNAs need in the area of practice management may include additional information about the various payment and practice models available to CRNAs, as well as the financial and practice implications of each model. This information could assist CRNAs in determining which payment model would work best in their practice environment. Analysis of cost-shifting between public and private payers and patients due to payer coverage decisions or other factors might also be useful. Further discussion on these topics can be found in the Commission Recommendations section of this report under "Alternative Anesthesia Payment and Practice Models." Should the AANA Board of Directors (Board) decide to have the Commission continue its work, one area of focus may be alternative anesthesia payment and practice models.

Measuring the financial and practice benefits of various payment models requires that the AANA and its members be able to accurately measure and establish benchmarks for the cost of anesthesia practice. For this reason, under "Studies, Surveys and Data Collection" in the Commission Recommendations section of this report, the Commission has proposed that the AANA explore the feasibility of enhancing the Medical Group Management Association (MGMA) anesthesia cost report survey to incorporate CRNA data and promote CRNA participation in this survey. The current MGMA anesthesia cost report survey does not accurately reflect the cost of CRNA practice but is used by hospital administrators when negotiating contracts for anesthesia services, including contracts for CRNA services. This section of the Commission's report also includes recommendations that the AANA gather information from the Centers for Medicare & Medicaid Services on CRNA reimbursement under Medicare's payment models, and that the AANA encourage CRNAs to conduct research in the area of practice management and quality measures.

Under "Patient Safety and Quality" in the Commission Recommendations section, the Commission recommends that the AANA, using an evidence-based focus, increase CRNA involvement and contributions in quality measurement development and pay-for-performance initiatives. Similarly, in the area of technology the Commission recommends that the AANA continue to enhance current strategies and assess current and emerging technologies that may affect the economics and efficiency of anesthesia practice and improve patient safety. These recommendations are consistent with CRNAs' long-standing commitment to safe, high-quality anesthesia care.

Under "Building Relationships and Alliances" in the Commission Recommendations section, the Commission recognized that to best position nurse anesthesia practice for the future, additional work in the areas of public relations (PR) and education may need to be done to emphasize that CRNAs are safe and effective providers, and that there are alternative anesthesia payment models that are also profitable. PR efforts would be directed at CRNAs and other healthcare stakeholders including patients, hospitals, administrators, anesthesiologists, surgeons and other providers, as well as insurers and legislative and regulatory decision makers. With nursing in its ascendancy as an influential profession, the Commission recommended that the AANA take the lead in cultivating stronger relationships with advanced practice nursing organizations and seek opportunities to align efforts. The Commission agreed that collaborating with multiple stakeholders and other providers with similar interests would be a very effective way for CRNAs to address healthcare system changes and challenges that have an impact on CRNA practice.

One of the benefits of creating the Commission was that it allowed the opportunity for CRNAs, national policy experts, and others from across the United States to blend their experience and knowledge in order to learn from each other and, in so doing, build trust and relationships that otherwise might not have been built. Should the AANA Board decide to have the Commission continue its work, the AANA might consider adding additional experts to the Commission to serve as members or advisors, or to testify to the Commission. These experts could include a large

self-insured employer, a small employer, an insurance carrier, a surgeon, and additional consumer or patient advocates. Additional experts could help contribute to and round out the overall knowledge of the entire Commission, as well as help build relationships with experts who have experience in other areas of the healthcare system affecting CRNA practice. This recommendation can be found under “Commission Membership” in the Commission Recommendations section of this report.

As stated in the Preface, the Commission’s work and recommendations are built upon a conceptual framework of advancing the nurse anesthesia profession’s goals of quality, safety and efficiency at a lower or neutral cost to the healthcare system. The Commission has not established a value for or prioritized the recommendations. The Board could choose to move forward with none, one, or many of the Commissions’s recommendations. However, altering the state of anesthesia practice and payment on a large scale, given its complexity and vast number of stakeholders, would require a comprehensive plan driven by dedicated anesthesia professionals and involving substantial manpower and financial resources, and where possible, support from a broad-based coalition of stakeholders.

About the Commission

Background and Authority

At the American Association of Nurse Anesthetists (AANA) Annual Business Meeting on August 5, 2007, five AANA members presented a resolution to create a commission to study reimbursement methodologies for anesthesia services. AANA members approved the resolution. Four days later, the FY2008 AANA Board of Directors (Board) created the Commission on Anesthesia Economics and Reimbursement (Commission) based on this resolution, and developed and adopted the Commission's purpose, composition, and objectives. (The objectives are discussed in the next section, beginning on page 11.)

Purpose

Examine current and projected future health economic trends that are having or will have an impact on the delivery of anesthesia services and formulate recommendations, mindful of the antitrust laws, to best position the anesthesia profession in this changing market while maintaining an interest in sound patient care and fostering appropriate incentives for effective utilization of anesthesia professionals.

Composition

The Commission is comprised of 13 members including a chair (see page 10). The Commission chair and members are appointed by the AANA president in conjunction with the AANA Board. The president may add additional Commission members at his or her discretion. The AANA intends for Commission membership to be diverse and interdisciplinary. Commission members and those called upon to provide input as Commission experts include members of the AANA, physicians, hospital and ambulatory surgery center administrators, payers, employers, and patients. The Commission is staffed by designated AANA executive and administrative staff members.

Meetings

The Commission met in Washington, D.C., for two days each in February and March 2008. The Commission scheduled conference calls as necessary.

The Commission also hosted an open forum for AANA members titled "Anesthesia Payment and You" during the AANA Fall Assembly of States in November 2007. At the forum, AANA members provided the Commission with insight into their anesthesia payment and practice environments.

Commission Members and Staff (See Appendix B for commissioner biographies.)

Members

Larry Hornsby, CRNA, BSN
Commission Chair
Business Owner – Anesthesia billing company, consulting services, recruitment/placement company, education seminar business
Moody, AL

Lee Broadston
President & CEO, BCS, Incorporated—Healthcare practice management and consulting services
Waconia, MN

Linda F. Golodner
President Emeritus, National Consumers League
Principal, Consumer Initiatives
Washington, DC

Michael Hash
Principal, Health Policy Alternatives, Inc.
Washington, DC

Jim Henderson, CRNA
President, Riverview Anesthesia Associates
LaGrange, GA

Paul Henderson, CRNA, MS
Great Lakes Anesthesia, P.C.
Elkhard, IN

Kathleen P. Kinslow, CRNA, EdD, MBA
Executive Director, Pennsylvania Hospital, University of Pennsylvania Healthcare System
Philadelphia, PA

Tim Nelson, MBA
Corporate Director of Physician Services, Forum Health
Youngstown, OH

Ken Plitt, CRNA, MBA
Mill Creek, WA

Sara Rosenbaum, JD
Chair, Department of Health Policy—George Washington University School of Public Health & Health Services
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Kay K. Sanders, CRNA, MHS
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Commission Objectives

To most effectively address the broad objectives charged to the Commission on Anesthesia Economics and Reimbursement (Commission) by the AANA Board of Directors (Board), the chair assigned the commissioners to research each of the objectives and present their findings to the entire Commission. These presentations set the stage for the active and candid sharing of knowledge and experience among commissioners. The Commission developed its recommendations after evaluating the complex information before them.

The dialogue between the commissioners who are national policy experts and the other commissioners revealed that policy makers sometimes do not have a clear understanding of (1) anesthesia practice in the public and private payer sectors, (2) anesthesia payment methodologies, (3) CRNA scope of practice, and (4) cultural aspects of anesthesia practice. These dialogues also revealed that CRNAs and others sometimes do not have a clear understanding of the broader, highly complex healthcare system and the demands being placed on policy makers and others by multiple stakeholders with competing interests. Likewise, commissioners with seemingly similar backgrounds brought to light aspects of their practice and expertise that were previously unfamiliar to their fellow commissioners. This sharing of expertise allowed for the Commission's work to maintain an overall balance that represented CRNA views and the role of CRNAs in the context of the wider national healthcare system.

Objectives

1. ***Identify and evaluate payment/reimbursement methodologies for existing anesthesia practice models.***
2. ***To the degree possible, describe the positive and negative impacts of these existing anesthesia payment models on patients, anesthesia providers, healthcare organizations, society at large, payers and other stakeholders, and on the output and quality of anesthesia services.***

Presentations by Pamela Blackwell, JD, and Jim Henderson, CRNA, set the stage for addressing Objectives 1 and 2. Blackwell's presentation, "Medicare (and Anesthesia) as a Second Language: Payment and Policy Issues for CRNAs," gave the commissioners an overview of the status of the healthcare system, Medicare funding, and the rules and regulations that have a direct impact on CRNA payment and practice. Henderson's presentation, with contributions from Lee Broadston and Larry Hornsby, CRNA, BSN, addressed payment/reimbursement methodologies in the public and private sectors and provided insights on the positive and negative impacts of these methodologies on various stakeholders. Because the commissioners had different levels of understanding about Medicare, the national healthcare system, and the role of CRNAs in that system, these presentations helped the commissioners get up to date on the status of anesthesia payment and practice in

various healthcare settings. Information from these presentations, as well as related insights and evaluations shared by the commissioners, are incorporated into the Commission Findings section of this report.

3. ***Identify current payment/reimbursement methodologies for physicians and healthcare facilities, such as hospitals and ambulatory surgical centers, and evaluate how these methodologies affect the demand for and output of anesthesia services.***

Paul Santoro, CRNA, MS, and Kate Kinslow CRNA, EdD, MBA, set the stage for addressing Objective 3 in their presentation to the Commission. Information from this presentation, as well as related commissioner insights and evaluations that provided perspective from healthcare administrators, are incorporated into the Commission Findings section of this report.

4. ***To the degree possible, describe the degree (frequency and/or amount) of cost-shifting related to current anesthesia reimbursement/payment methodologies. In this context, "cost-shifting" refers to the practice of healthcare providers increasing billing rates to some patients or payers to cover for those patients or payers who pay less than what would be usual or customary. In addition, it also refers to payers such as Medicare or Medicaid that set their payments at below-market levels, leading to cost-shifting by providers. This also refers to direct and indirect facility subsidization of anesthesia group services. (This objective is based on the reality that these figures may not be available to the general public and accessing this information may either be impossible or not feasible. Therefore, members of the Commission may need to further assess the feasibility of pursuing this objective, based on both financial and time constraints. This may lead to a recommendation of what types of future research may be required in this area if the Commission believes this information may be helpful.)***

Tim Nelson, MBA, addressed Objective 4 in his presentation. The existence of cost-shifting from providers to patients and payers, cost-shifting from providers to providers, and hospital subsidies was addressed in Nelson's presentation (as well as previous presentations) and included in the Commission findings. However, the ability to measure cost-shifting is unique to Objective 4. The Commission determined that to accurately measure cost-shifting it would first have to be able to accurately measure the cost of anesthesia services in various settings. Each year the Medical Group Management Association (MGMA) administers a survey which includes data on the cost of anesthesia practice. However, this survey does not accurately reflect the cost of CRNA practice. Nelson explained this limitation by demonstrating the data inconsistencies and small CRNA sample sizes in the MGMA survey. Broadston also contributed his expert analysis of the MGMA study and developed initial cost estimates for CRNAs under various payment models. The Commission decided that the most feasible way to achieve Objective 4 would be to work with the MGMA to collect accurate data about CRNAs by expanding CRNA participation, an idea that was incorporated into the Commission recommendations.

5. ***Identify/describe current and future healthcare economic, demographic and policy trends and the potential/real impact on nurse anesthesia practice models, including quality, practice patterns/models, employment arrangements, statutory requirements, output, patient access and costs.***

To address Objective 5, the commissioners who are experts in national healthcare policy, Michael Hash, Sara Rosenbaum, JD, and Tom Scully, JD, shared with the Commission their insights on the short- and long-term legislative, regulatory and financial pictures of U.S. healthcare. This presentation provided the commissioners with a broader perspective on how anesthesia and CRNAs fit into the changing and complex healthcare system and suggestions on how CRNAs could better position themselves for the future.

6. ***Based on current and future healthcare economic, demographic and policy trends, characterize the relative strengths and weaknesses of anesthesia payment methodology alternatives.***

Throughout the deliberative Commission process, the commissioners measured the strengths and weaknesses of various proposals and their potential impact on the stakeholders listed in Objective 5. The Commission recommendations were developed based on these strengths and weaknesses and their impact on the various stakeholders.

7. ***Budget for Commission not to exceed $32,500 without Board approval.***

It was necessary for the Board to revisit the Commission budget and approve additional funding beyond the initial budget allocation. As of March 31, 2008, the hard and soft expenditures for the Commission totalled approximately $212,000, with hard costs equalling approximately $84,000. This included but is not limited to travel expenses for all commissioners and one staff liaison, meeting costs, facilitator costs, and staff hours devoted to Commission work.

8. ***A draft report of the Commission to be completed by May 2008, and the final report to be completed by July 2008.***

A preliminary report of the Commission was presented to the Board on May 29, 2008, as part of the process for presenting the final report to the AANA membership at the 2008 AANA Annual Meeting.

Commission Findings

I. Status of U.S. Healthcare System

A. Medicare and Medicaid Face Increasing Financial Strain

Medicare and Medicaid face significant financial challenges that will likely have an impact on the amount of funding available to pay for anesthesia services. As the baby-boom generation reaches retirement, Medicare's healthcare costs will grow exponentially, rendering ineffective many efforts to curb costs and increasing pressure to find ways to contain expenditures. These resulting cost increases make healthcare providers vulnerable to reimbursement cuts.

In 2006, approximately $2.17 trillion was spent on healthcare in the United States, which is approximately 16 percent of the U.S. Gross Domestic Product (GDP).[1] Close to half of all U.S. health expenditures are funded by taxpayer dollars and are paid by public sources such as Medicare, Medicaid, and various state and local programs. Medicare costs equate to 19 percent of the U.S. budget, totaling $420 billion per year. In real everyday terms this is equivalent to every person in the United States contributing $1,375 per year to Medicare.[2] If you add in Medicaid expenditures, the per-person contribution increases to $2,458 per year. Compared to 2004, Americans are now spending $733 more per person for Medicare and Medicaid.

The increased demand for and cost of healthcare has had a direct impact on employers' bottom lines and patients' pocketbooks. More and more employers who provide healthcare benefits are shifting their increased costs to their employees by reducing benefits or dropping coverage altogether. For this and other reasons, patients have experienced a steady increase in out-of-pocket expenses via higher co-pays and deductibles, and having to pay for over-the-counter drugs that used to be covered prescription medications. During this same period, the salaries of CRNAs and other healthcare providers have increased, adding to the financial burden of those responsible for paying for their services.

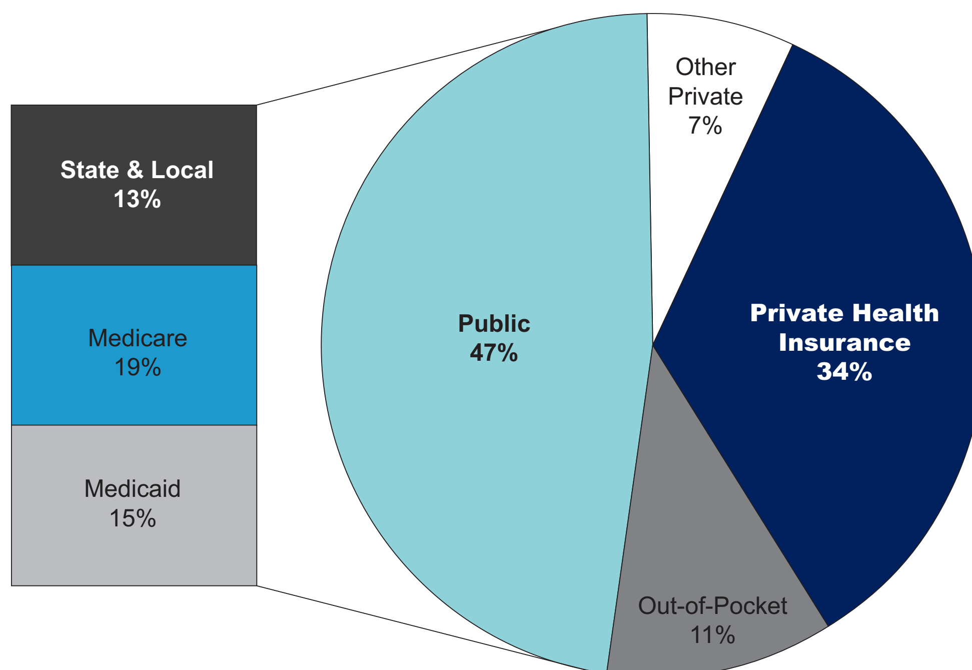
Each year for the past five years physicians and other clinicians have faced cuts in Medicare reimbursement under the Physician Fee Schedule (PFS) as a result of the Sustainable Growth Rate (SGR) formula. Developed by Congress and implemented by Medicare, the SGR is used to contain annual healthcare spending for provider services. One of the problems with the SGR is that it does not accurately account for the real cost of healthcare services in that changes in annual Medicare spending are tied to GDP growth rather than healthcare growth/inflation. From 2007 to 2017, GDP growth is estimated at approximately 4.8 percent per year while healthcare inflation is estimated at 6.7 percent.[3] In recent years, when faced with having to cut provider reimbursement, Congress has decided to override the SGR formula and permit spending above the targeted amount. Providers, including CRNAs, have experienced significant payment cuts, but not as large of cuts as they would have if Congress had not acted. However, as the Commission's report is being finalized for presentation

1 Medicare Payment Advisory Commission (MedPAC). Report to Congress: Medicare Policy. Washington, DC: MedPAC. March 2006:9.

2 Blackwell PK. Medicare Latte Factor, Medicare as a Second Language. AANA Mid-Year Assembly, Washington, DC. Spring 2005.

3 Centers for Medicare & Medicaid Services. Office of the Actuary, National Health Expenditures Projections 2007-2017. Forecast summary and selected tables. Washington, DC: CMS.

2006 National Health Expenditures



National Health Expenditures = $2.17 Trillion

Source: CMS Office of the Actuary, National Healthcare Expenditures 2005-2015 [4]

to the membership at the AANA Annual Meeting, it appears that the actions taken by Congress to override the SGR may be short-lived. In July 2008, all Medicare Part B providers, including CRNAs, face a 10.6 percent cut in their payments and an additional 5 percent each year for the next seven years to make up for overspending that occurred from 2004-2008. Unless Congress acts, Medicare Part B payment for anesthesia, pain management, line insertions, and all CRNA and physician services will be cut in July 2008, with an additional 5 percent cut looming in January 2009. Over time, this could amount to an approximate reduction in anesthesia payments of 35 percent by 2012.

At the beginning of 2008, anesthesia providers did receive some relief from pending cuts. In 2007, the Centers for Medicare & Medicaid Services (CMS) determined that the Medicare fee schedule undervalued anesthesia work. Medicare was paying anesthesia only 34 percent of what private payers paid for the same anesthesia services, a fact known by anesthesia practice managers for many years.[5] The anesthesia profession successfully won a 34 percent increase in the value of anesthesia services, resulting in a 25 percent increase in the anesthesia conversion factor. The Medicare anesthesia conversion factor takes the value of an anesthesia service and converts it into the actual dollar amount that a CRNA or anesthesiologist can bill for that service. In 2007 the average national conversion factor was $16.23; for January-July 2008 the average conversion factor increased to $19.96. Medicare is now paying 20 percent more for anesthesia care in 2008 than in 2007.

[4] Centers for Medicare & Medicaid Services (CMS) Actuary. National Healthcare Expenditures Projections 2005-2015. Washington, DC: CMS.

[5] Medicare Program. Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008. 72 *Fed.Regist*. 66222. November 27, 2007:66363.

Despite annual cuts in Medicare reimbursement in recent years, the Medicare Payment Advisory Commission (MedPAC), which advises Congress, has consistently maintained that while payment for Medicare Part B practitioner services should be positively updated each year, overall payment is generally adequate to assure Medicare beneficiaries access to healthcare services. In its annual assessment of payment adequacy for provider services, MedPAC has found that Medicare beneficiaries generally have appropriate access to provider services and that the number of providers who become and remain participating Medicare practitioners continues to increase.[6] Given MedPAC's analysis, Congress may be less apt to increase provider payments. MedPAC has, however, expressed concerns that consecutive annual cuts could over time threaten beneficiary access to provider services.[7]

B. Uninsured and Underinsured Patients Remain an Increasing Challenge

Hospitals and providers continue to face an increasing number of uninsured and underinsured patients—including uninsured illegal immigrants—causing further financial strain on the healthcare system. For this reason all state governors and legislators are receptive to solutions that would help finance Medicaid and support care for uninsured patients.

Many uninsured patients do not seek medical care until it is an emergency and then present at hospital emergency departments where care typically costs more. The Emergency Medical Treatment and Labor Act requires that anyone who comes to an emergency room must receive necessary services, regardless of ability to pay. Many times a hospital will cover the cost of these services by increasing the cost of services for insured patients to offset the difference. For nonemergency patients, many healthcare systems establish policies whereby patients are not seen until payment is made.

At the same time, some nonprofit hospitals risk losing their nonprofit status because they are under increased scrutiny due to the proportionately small amount they spend on charity care relative to the billions of dollars in net income they have earned in recent years.[8] The benefit of retaining nonprofit status for these hospitals is that they will have more funds available to make necessary capital improvements, hire staff and/or healthcare providers, increase employee benefits and salaries, and subsidize hospital departments such as anesthesia. However, many nonprofit hospitals spend less on charity care than they receive in tax breaks.[9] The combined net income of the 50 largest nonprofit hospitals jumped nearly eight-fold to $4.27 billion between 2001 and 2006, with 77 percent of nonprofit hospitals reporting profits compared to only 61 percent of for-profit hospitals.[10] Charging uninsured patients at the highest rates or using funds derived from tax breaks for items unrelated to charity care puts a hospital's nonprofit tax status at risk.

Regarding charges, hospitals and providers should instead establish a prepayment discount pricing policy in which reasonable charges are established by taking into account the patient's ability to pay, and then strictly apply these discounts to all eligible patients. New Internal Revenue Service standards require that nonprofit hospitals break out the specifics of their community-benefit contributions, but do not yet require hospitals to provide a minimum amount of charity care.[11]

C. Payment Rules Create Volume Incentives that Increase Costs without Improving Care

In general, public and private payer rules often create incentives to increase the volume of services provided without regard for increasing the quality or value of the services. For example, for chronically ill patients in their last two years of life, Medicare spends an average

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6 Medicare Payment Advisory Commission (MedPAC). Report to Congress: Medicare Payment Policy. March 2008.
7 Medicare Payment Advisory Commission (MedPAC). Report to Congress: Medicare Payment Policy. March 2008.
8 Carreyrou J, Martinez B. Nonprofit Hospitals, Once for the Poor, Strike it Rich. *The Wall Street Journal*. April 4, 2008:A1.
9 Id. Carreyrou J, Martinez B. Nonprofit Hospitals, Once for the Poor, Strike it Rich. *The Wall Street Journal*. April 4, 2008:A1.
10 Id. Carreyrou J, Martinez B. Nonprofit Hospitals, Once for the Poor, Strike it Rich. *The Wall Street Journal*. April 4, 2008:A1.
11 Id., A10. Carreyrou J, Martinez B. Nonprofit Hospitals, Once for the Poor, Strike it Rich. *The Wall Street Journal*. April 4, 2008:A10.

of $59,379 in New Jersey, but only $32,523 in North Dakota. The difference is primarily due to patients getting *more* but not necessarily *better* hospital care, according to researchers at Dartmouth Medical School as reported in the Dartmouth Atlas of Health Care 2008 study.[12] It is possible for anesthesia providers to earn more revenue by doing more less-expensive, less-complex procedures than by doing fewer more-complex, more-expensive procedures. However, reimbursement rates for more common procedures can be so low that CRNAs and anesthesiologists choose to provide more highly valued services, thus creating an access problem for some patients. For example, though there is a high demand for labor epidural services, reimbursement rates for these services are highly variable (very high in some areas and very low in others) and dependent on the payer mix in an area. Low reimbursement rates mean there is little or no incentive for CRNAs or anesthesiologists to provide labor epidural services on a straight fee-for-service basis. As a result, some hospitals have considered decreasing or eliminating labor epidural services, which is especially problematic in rural areas. Further, the Medicare Part A Conditions of Participation Interpretive Guidelines exacerbate this access issue and increase costs to hospitals by requiring that a physician be physically present when a CRNA provides a labor epidural. The AANA continues to work with the CMS to resolve this and related interpretive guidelines supervision issues.

Alternatively, many hospitals are adding labor epidural services due to patient demand. In some cases, physician groups have lost their contracts with hospitals because the groups decided not to cover obstetrical services. While payments for labor epidural services are generally not as high as for other anesthesia services, the increased demand and volume for these services could prove a financial and clinical opportunity for CRNAs.

D. Pay for Performance Initiatives Attempt to Increase Quality and Value of Provider Services—CRNAs Continue Contributing to Quality Measures

In addition to encouraging increased volume but not quality of provider services, the SGR and PFS payment rules create a flat payment system in which poor or mediocre providers are reimbursed at the same rate as excellent or above-average providers.[13] MedPAC has found that the increases in healthcare spending each year do not correlate as closely as they should with increased value and improved quality. For many years MedPAC has made recommendations to Congress supporting efforts to tie higher payments to increased value and quality. Programs run by CMS and private payers, known generally as Pay for Performance or Value Based Purchasing, are programs in which Medicare Part B provider payment is made based on the quality of a provider's services. The drive toward establishing Pay for Performance programs is supported by the results of the CMS Premier Hospital Quality Incentive Demonstration project. The Premier project required providers to report whether certain tasks or measures known to improve patient outcomes were done for each patient. Hospitals that achieved specified thresholds or significantly improved their performance with respect to a set of quality improvement measures were rewarded a total of $8.85 million in bonus payments in the first year of the project.

In 2007, CMS established the Physician Quality Reporting Initiative (PQRI). Under the PQRI all Medicare Part B providers who report measures applicable to their practice are eligible for a 1.5 percent increase in payments.[14] This 1.5 percent increase should not necessarily be considered a bonus, however. Due to the annual SGR derived cuts, total payments to providers, including payment to those providers who earn the 1.5 percent bonus, will not be as high as they would have been. Essentially it means that a provider's

12 Wennberg JE, Fisher ES, Goodman DC, Skinner JS. Tracking the Care of Patients with Severe Chronic Illness. *The Dartmouth Atlas of Health Care 2008*. Lebanon, NH: The Dartmouth Institute for Health Policy & Clinical Practice. Executive Summary; April 2008:3.

13 MedPAC. Report to Congress: Medicare Payment Policy. March 2008:81.

14 Medicare Program. Tax Relief and Health Care Act of 2006. 72 *Fed.Registr*. 66222. November 27, 2007:66366. P.L. 109-432, Division B, Title I, Sec.101.

payment will not be cut by 1.5 percent. CRNAs are eligible to report measures as well. There are three anesthesia-related measures in the PQRI program: (1) administration of the antibiotic prophylaxis in a surgical patient, (2) prevention of catheter-related bloodstream infections—catheter insertion protocol/maximum sterile barrier technique, and (3) prevention of ventilator-associated pneumonia—head elevation of 45 degrees post-surgery.[15]

The AANA has directly contributed to the development of these and future measures as members of the American Medical Association Physician Consortium for Performance Improvement Anesthesiology Work Group, which develops measures. These measures are vetted by the National Quality Forum and the Ambulatory Quality Alliance, and many are eventually adopted by CMS and added to the list of PQRI measures.

Pay for Performance programs are here to stay. It is imperative that the AANA and CRNAs participate in the development of anesthesia measures that improve patient safety and quality and that allow CRNAs to practice within their full scope of practice. It is important that the AANA be proactive in informing its membership of the opportunity to develop and report quality measures; further, CRNAs should welcome the responsibility associated with reporting quality measures. This is consistent with the AANA's goal of improving patient safety and quality.

E. Medicare vs. Private Payer Reimbursement

Private payers generally pay considerably more than public payers and reimburse CRNAs at a variety of rates. For the same service for the same patient, Medicare generally pays healthcare providers only 80 percent of the amount a private payer would pay.[16] However, this is not necessarily the case for anesthesia. In general, anesthesia is reimbursed by Medicare at far less than the amount a private payer would pay for the same anesthesia service. According to a 2007 U.S. Government Accountability Office study, CRNAs tend to be used more where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[17] However, CMS data shows that Medicare pays anesthesiologists as a group disproportionately more than CRNAs, even though CRNAs are the predominate anesthesia provider where there are more Medicare beneficiaries. In fact, CRNAs care for a disproportionate share of Medicare beneficiaries. A handful of private payers pay CRNAs at a reduced rate, or not at all. For instance, Blue Cross & Blue Shield (BCBS) of Alabama is both a Medicare payer and a private payer. The BCBS Medicare side pays CRNAs at the full 100 percent rate, but the private BCBS side will not pay CRNAs for services at all. In addition, more private payers are limiting or threatening to eliminate payment for anesthesia for certain gastrointestinal-related services. It may be beneficial for CRNAs to create a comprehensive strategy which focuses on educating private payers or other associations on how to establish reimbursement practices for CRNAs.

In a true market-driven system, the difference between public and private payment would not exist. There is little information as to why private payers have not reduced their payment rates to public payer levels. However, CRNAs should be aware that because of the difference between private and public payment, there remains a risk that private payers could reduce their payments to the public payment level at some point.

For medically directed services, Medicare will write two checks—one for the CRNA for 50 percent of the fee and one for the anesthesiologist for 50 percent of the fee. Private payers on the other hand are increasingly paying only the first provider claim that is received, resulting in a loss of revenue for the other provider or the healthcare facility.

According to hospital administrators and healthcare management companies, obtaining equitable payment for CRNA services from private payers requires a considerable amount of time and negotiation. Despite these extensive efforts on behalf of patients to provide services at a reasonable cost, many patients may have to make up the difference in payment. The current

[15] Medicare Program. 72 *Fed.Registr*. 66222. November 27, 2007:66346-66347.

[16] MedPAC. Report to Congress. March 2008:xiii.

[17] US Government Accountability Office (GAO). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO-07-463. July 2007;15.

payment process with multiple payers is burdensome for hospitals and providers and could eventually put pressure on insurers to cover a minimum standard of procedures. Despite the complexity of the multiple payer system, patients may benefit from a choice of insurers, although the ability of patients to choose benefits or providers is often limited due to the lack of transparency in healthcare benefits.

F. Healthcare System as Viewed by Congress, Regulators and Political Parties in Presidential Election Year

(Following are collective comments by commissioners who are national healthcare policy experts: Michael Hash, Sara Rosebaum, JD, and Tom Scully, JD.)

In the near future a sharply divided Congress and administration will have to address the SGR issue. In the next election, Democrats may retain Congress and may gain some seats, but perhaps not enough in the Senate to create the working majority needed to push through legislation.

Republicans generally believe that (1) healthcare should be more market driven, (2) healthcare should be covered by private insurance plans, and (3) government should have only a peripheral role so that market competition drives rates, quality, and efficiency improvements. Proposals that release employers from paying for insurance would shift more responsibility to consumers and make health insurance more portable from one job to the next. However, this could result in lost efficiencies, thereby requiring more to be spent on system administration and reducing dollars available for actual healthcare services.

Democrats generally struggle with how to make the marketplace both affordable and accountable: If the United States moves away from the current employer-based system, it will have to find something to replace it. Democrats are also generally concerned with the cherry-picking of healthier patients in a private payer driven market. To gain efficiencies and make coverage more affordable, a healthcare system must have a structure that spreads the cost of care across a broad risk pool. The cost of insurance in the individual market (i.e., individuals purchasing insurance on their own without an employer or other contribution) is currently the most expensive, so a reformed system must have incentives or requirements for everyone to purchase coverage. Otherwise, those who are healthier and younger will be less likely to purchase coverage while those with above average health costs will be more likely, driving up the cost of coverage. Individual-participation markets tend to not work well if not everyone is required to have coverage. However, this does not mean that everyone has to pay the same for coverage.

Recently employers have become more interested in reforms. Some viable proposals for healthcare reform in the non-Medicare market could be structured like the Federal Employee Healthcare Benefit Plan, with a large risk pool operating under rating and underwriting rules that spread costs fairly. Medicare as a social insurance program does a good job of spreading the risk, but its role as a price setter is more controversial. Legislators and regulatory agencies are actively looking for areas to cut costs; however, any system-wide changes in the healthcare system will not happen quickly and are likely to be incremental in approach

G. “Fab 5” Changes CRNAs can Expect in Healthcare

The following list, which represents future policy options for healthcare in the public and private sectors, was provided by Michael Hash. Core to implementing these changes will be determining how to allocate financial responsibility for healthcare services to taxpayers, government, insurers, patients, providers, hospitals, etc.

- Digitize the healthcare system, which would increase efficiency and decrease redundancy and errors. This would require investment in a nation-wide IT infrastructure.
- Create value-based purchasing incentives for hospitals and providers, such as Pay for Performance programs and the PQRI which set performance targets. The reward for performance may not be more money; the reward could be not having payments cut.
- Address chronic care management and end-of-life costs which account for most healthcare dollars.
- Conduct comparative effective analysis. The

healthcare system needs better tools and more evidence-based medicine to better determine who gets what services and payment amounts, and to make judgments about best outcomes for the same or less money.
- Move away from fee-for-service to bundled payments. This would address surgical and facility fees for acute and post-acute care to promote efficiencies and avoid disjointed silos of care.

H. Economic Position of CRNAs in Healthcare Marketplace

In the context of increasing healthcare costs, pending payment cuts, and evidence that payments are adequate, anesthesia providers will continually find that their calls for increased payment will be competing with mounting pressure to control healthcare spending. Likewise, with the average anesthesia provider's income substantially higher than the average American household income, arguments that focus on what anesthesia providers earn rather than on what is best for the patient are not likely to be compelling. However, because CRNA salaries are typically lower than anesthesiologist salaries even though CRNAs provide the same quality of care, there is some room for CRNAs to gain an edge in the healthcare marketplace. Currently, most public and private payment mechanisms do not vary based on the quality of services provided, resulting in below-average providers being paid the same as high-quality providers. Looking forward, the challenge for CRNAs is to not focus solely on payment adequacy. Rather, CRNAs should focus on how they can add value or improve the quality of their services and subsequently be rewarded for this increased value.

II. Scope and Status of CRNA Practice

The AANA is the professional association for more than 39,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice nurses who administer approximately 30 million anesthetics given to patients each year in the United States, according to a recent AANA member survey. Nurse anesthetists have provided high-quality, cost-effective anesthesia care to patients in the United States for more than 125 years, and the demand for CRNA services continues to grow. As Medicare Part B providers, CRNAs have billed Medicare directly for 100 percent of the physician fee schedule amount for their services since 1989. In addition, public and private payers reimburse CRNAs for evaluation and management (E/M) services as part of the bundled anesthesia fee. Payment for E/M services in relation to other services is a concern for some CRNAs, and is influenced by both state and federal law.

CRNA services include administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient through surgery and recovery. CRNAs provide assessment and evaluation for acute and chronic pain management services, administer anesthesia for a wide variety of high- and low-acuity surgical cases, and are the sole anesthesia providers in nearly two-thirds of all rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities that might not otherwise be available. CRNAs are predominant in veterans hospitals and in the U.S. Armed Forces, and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units, and the offices of dentists, podiatrists, and specialty surgeons.

A. Supply of Anesthesia Providers Increasing, but More Needed to Meet Future Demand

The number of registered nurses (RNs), the number of nurse anesthesia education programs, and the amount of available federal education funding all have an impact on the supply of CRNAs in the workforce.

The supply of CRNAs is inherently related to the supply of RNs. All CRNAs must first be RNs and must retain their RN license throughout the time they practice as CRNAs. Although studies suggest that the RN shortage has eased since 2000, a shortage of RNs remains.[18] Based on the 12 percent to 13 percent vacancy rate for CRNA positions in hospitals and

[18] US Government Accountability Office (GAO). Nursing Workforce: HHS Needs Methodology to Identify Facilities With a Critical Shortage of Nurses. Report to Committee on Health, Education, Labor & Pensions. US Senate. GAO-07-492R. April 30, 2007:4.

ASCs, the supply of anesthesia providers—whether CRNAs or anesthesiologists—is not meeting demand.[19] This demand will only grow as the baby-boom population ages; in fact, it has been projected that the number of people in older age groups will grow faster than the total U.S. population between 2006 and 2016.[20] However, this demand could be offset by technological advancements that may eliminate the need for a qualified anesthesia provider to be present in some cases.

The number of nurse anesthesia education programs also determines the supply of CRNAs. In 2007, there were 108 nurse anesthesia education programs throughout the country, up from a total of 88 programs in 2003.[21] Additionally, each year—especially since 2002—the number of nurse anesthesia graduates has increased significantly. In 2002 there were approximately 1,330 nurse anesthesia graduates, and in 2008 it is projected that there will be 2,184 nurse anesthesia graduates.[22] Demand for entry into these programs also continues to increase. Many program directors find themselves denying admission to qualified applicants due to the lack of available spots in their programs or because of faculty and program director vacancies. Program director vacancies measured 13 percent in 2007.[23]

While the number of anesthesiologists is not increasing at as fast a rate as CRNAs, the American Society of Anesthesiologists (ASA) reports an overall steady increase in the number of anesthesiology residents.[24] The number of anesthesiologists entering the workforce is limited by the number of residency programs, although currently residency programs are running at near maximum capacity with a match rate close to 100 percent.[25] The ASA has expressed concerns that faculty shortages have contributed to declines in the numbers of anesthesiology programs and residents in previous years.[26]

Federal funding also plays an important role in increasing the supply of CRNAs in the workforce. Each year Congress appropriates millions in funding for healthcare professional education programs. In 2008, Congress provided $156 million for Title VIII nursing programs.[27] Approximately $62 million of this funding is used by advanced practice nursing programs. The federal Health Resources & Services Administration generally allots $3 million of this amount to CRNA programs.[28] Each year Congress also appropriates billions in Medicare Graduate Medical Education (GME) funding for physicians which is used to cover a substantial portion of the cost of educating physician residents.[29] GME funding in 2003 was approximately $8 billion.[30] CRNAs are not eligible for GME funding, but as Congress seeks opportunities to reduce Medicare costs the fact that CRNAs largely self-finance their education could be advantageous to the nurse anesthesia profession.

B. Technology Advances and Demand for Anesthesia Services

Impact on Patient Safety and Quality

Technological advances in the areas of pharmaceuticals and devices have made anesthesia safer and more efficient, and will continue to do so. According to an Institute of Medicine report published in 1999, anesthesia is approximately 50 times safer today than in the mid-1980s.[31] The continued proliferation of

19 AANA Workforce Study. Park Ridge, IL: American Association of Nurse Anesthetists; 2003.

20 US Department of Labor, Bureau of Labor Statistics. *Health Care: Career Guide to Industries*. Collected online March 2008. http://www.bls.gov/oco/cg/cgs035.htm.

21 Information collected by AANA Accreditation and Education Department staff in 2007; staff interviewd by Commission in 2008.

22 Id.

23 Id.

24 Schubert A. 2007 Anesthesiologist Resident Class Sizes and Graduation Rates. *ASA Newsletter*. December 2007;71:24-29.

25 Santoro P, Kinslow K. Presentation to Commission on Anesthesia Economics and Reimbursement, Washington, DC. February 4, 2008.

26 Revisions to Payment Policies Under the Physician Fee Schedule for CY 2006, Proposed Rule. Medicare Program. 70 *Fed. Registr*. 45764. 2005:45789.

27 Consolidated Appropriations Act of 2008. HR 2764. 110th Cong. (2008).

28 Id.

29 Bruccoleri RE, Hexom BJ. Graduate Medical Education Funding. Reston, VA: American Medical Student Association; 2004:1.

30 Id.

e-medicine and distance learning will increase patient access to anesthesia services while providing clinical opportunities for providers to improve the quality of their services. The use of e-medicine and distance learning in light of the healthcare provider shortage, especially in rural areas, will test current rules and regulations that require physicians to be physically present to supervise nonphysician providers.

In addition, establishing nationwide standards for use of e-medicine, electronic medical and health records, and personal health records will likely result in the following: (1) improve the quality and safety of healthcare, (2) raise the level of accountability and competition among providers by measuring provider performance, (3) promote standards for evidence-based medicine and payment of services, and (4) find efficiencies/inefficiencies in the healthcare marketplace. As e-medicine is developed, providers should be wary of efforts to use patient data to provide only the healthiest patients with healthcare services, and alert to heightened sensitivity among providers and patients about privacy and personally identifiable healthcare information. It is important that these types of information systems include CRNAs in all settings so services provided by CRNAs can be clearly identified and their performance tracked, just like the perioperative services of physician providers are identifiable and trackable.

Increased Competition from Other Providers

Technological advances could both increase and decrease the demand for CRNA services. Currently, anesthesia services are essential to the vast majority of surgical and diagnostic services. Each year new life-saving and quality-of-life enhancing procedures that require anesthesia are developed, further fueling the demand for CRNAs.

Alternatively, technological advances in the areas of pharmaceuticals, devices and less invasive surgical or diagnostic procedures could reduce the demand for anesthesia services. For example, the Computer Assisted Personalized Sedation (CAPS) system.[32] currently under review by the Food and Drug Administration monitors and adjusts a patient's level of sedation, a task that typically only CRNAs and anesthesiologists are qualified to do. CAPS could therefore cause CRNAs working in gasterointerological settings to become obsolete. With CAPS or similar technology, RNs rather than CRNAs may be hired to provide patients with conscious sedation or other lower levels of anesthesia for endoscopic procedures.

In addition, the combination of demographic shifts and technological advances that increase demand for anesthesia services and improve safety and efficacy could cultivate competing providers, thereby threatening the once elite position of CRNAs and anesthesiologists. Other types of physicians and RNs, as well as anesthesiologist assistants (AAs), might begin to provide anesthesia services on a wider scale. CRNAs and anesthesiologists could be viewed as superfluous and an additional unnecessary expense. To adjust to a changing marketplace and competing providers, it is important for CRNAs to remain current in all areas of anesthesia practice, from low- to high-acuity cases; seek opportunities to diversify their practice; and be able to realistically quantify the value of their services to their employer. To propose changes in the delivery of anesthesia services based on acuity standards could create a perception that CRNAs are not adequately trained or experienced to handle high-acuity cases.

C. Impact of Rural Area Payment on Anesthesia Practice

CRNAs predominate in rural areas and are the sole anesthesia providers in most rural hospitals.[33] Payment in rural areas, where Medicare patients generally comprise a larger percentage of the patient mix, tends to be lower because it is based on the area wage index. This lower payment creates a disincentive for anesthesiologists to practice in rural areas since anesthesiologists generally demand higher salaries and compensation than rural hospitals can afford. In turn, this creates opportunities for CRNAs to contract with

31 Kohn LT, Corrigan JM, Donaldson MS, eds. Committee on Quality of Health Care in America. Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington DC: The National Academies Press; 2000.

32 Ethicon Endo-Surgery Explores Improved Sedation Practices for Gastroenterology, May 21, 2006. Endonurse. www.endonurse.com/hotnews/6531727241.html.

33 AANA Member Survey. Park Ridge, IL: American Association of Nurse Anesthetists; 1997.

hospitals for salaries and compensation that are less than what anesthesiologists demand. Medicare encourages some rural hospitals to provide surgical and anesthesia services by allowing them to participate in the Critical Access Hospital Rural Pass-Through program, which provides cost-plus-payment for CRNA anesthesia services.[34] However, most hospitals are not eligible for this program.

D. CRNA Malpractice Cost and Access

Cost and availability of malpractice insurance for CRNAs is not a barrier to CRNA practice.[35] CRNA premium rates today are one-third to one-half lower than 1980 rates, in real and inflation-adjusted terms. Much of this decrease is due to technological advances which have improved anesthesia safety. Full- and part-time CRNAs, and recent nurse anesthesia graduates, can readily access insurance coverage. While all provider premiums are increasing, CRNA premium increases are the lowest in "opt-out" states. Opt-out states are the 14 states (Alaska, Idaho, Iowa, Kansas, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington, Wisconsin) that have opted to remove the Medicare Part A physician supervision requirement for CRNAs.[36] While 15 percent to 20 percent of CRNAs pay their own malpractice insurance premiums, most CRNA premiums are paid by their employer. There is no difference in the number of claims between CRNAs and anesthesiologists. Generally, CRNA premiums are lower than those of anesthesiologists.[37]

III. Anesthesia Payment Models

A. Medical Direction

Use of the medical direction payment model in Medicare creates many inefficiencies. CRNAs in all states can work without being medically directed, i.e., they can administer all aspects of anesthesia care without the participation of an anesthesiologist. A nonmedically directed CRNA can bill Medicare directly for 100 percent of the physician fee schedule, the same as a physician can.[38] Under medical direction, the anesthesiologist and CRNA can each bill Medicare for 50 percent of the available physician fee schedule amount; however, the medically directing anesthesiologist must also perform and document a series of seven payment requirements in order to earn his/her 50 percent. The combination of the two payments can equal but not exceed 100 percent of the available Medicare fee schedule. If the anesthesiologist does not perform *and* document all seven steps, then medical direction has not occurred and the case can be billed by the CRNA as nonmedically directed.[39] An anesthesiologist can medically direct up to a maximum of four concurrent cases.

Considering the broad scope of CRNA practice, one might conclude that under medical direction the medically directing anesthesiologist could be viewed as a superfluous provider and added expense to the hospital or ASC since CRNAs can perform an entire case on their own and bill for 100 percent of the physician fee schedule. For example, using the medical direction model, up to four CRNAs can each perfom an anesthesia case under one medically directing anesthesiologist. The hospital can bill for four cases, and must compensate the four CRNAs and one anesthesiologist. However, in a nonmedical direction model, the hospital can still bill the full physician fee schedule for the four cases performed by the CRNAs and must compensate the CRNAs, but the hospital no longer has to compensate the anesthesiologist like it would if using the medical direction model. The anesthesiologist in a medical direction model does not bring in additional revenue to the hospital and in fact costs the hospital more in compensation costs.

[34] Code of Federal Regulations (CFR), 42 CFR §412.113(c).
[35] AANA Insurance Services. Interview with staff, January 2008.
[36] 42 CFR §482.52.
[37] Pine MD, Holt KD, Loy YB. Surgical mortality and type of anesthesia provider. *AANA J*. 2003;71(2)109-116. (Similar conclusions have been reached by the National Academy of Sciences in 1977, Forrest in 1980, Bechtholdt in 1981, the Minnesota Department of Health in 1994 and others.)
[38] 42 CFR §414.60.
[39] 42 CFR §415.110; CMS. Medicare Claims Processing Manual. Chapter 12. Physician/Nonphysician Practitioners. Rev. 1473, 03-07-08) Sections 50, 140.

Additionally, the anesthesiologist increases the hospital's burden of having to enforce the anesthesiologist's compliance with completing and documenting the medical direction steps.

Since there is no available anesthesia clinical outcome data that outlines an evidence-based methodology to define a set of case circumstances that would require the medical direction practice model, the medical staffs at many facilities may unknowingly endorse an anesthesia delivery model that includes duplicate and overlapping services. Facilities that require the medical direction model have to pay for additional anesthesiologists whose average compensation is typically much higher than CRNAs' compensation, leading to increased anesthesia delivery costs and possibly impairing the ability of the operating rooms to function at optimum efficiency. The end result is increased costs to the hospital and its patients. Medical direction has not been linked to evidenced-based medicine nor is it based on improved clinical outcomes and patient acuity. Anesthesiologists' average salaries tend to be higher than CRNAs' salaries and their education track is longer and more costly than the education track for CRNAs. This increases costs to the hospital, to patients, and ultimately to the healthcare system.

There is no correlation between medical direction and quality of patient care, nor is there evidence of a difference in the quality of care between a medically directed anesthetic performed by a CRNA, a nonmedically directed anesthetic performed by a CRNA, or an anesthetic personally performed/administered by an anesthesiologist. CMS has established that the medical direction steps are payment requirements and not quality of care standards.[40]

The proliferation of medical direction across all types of surgical procedures is one example of how payment drives practice, rather than patient care driving payment. The use of the medical direction payment model creates an inaccurate perception of medical direction being a "standard of care."

From a practice perspective, when all first procedures of the day begin at the same time it is impossible to comply with the medical direction steps and maintain an orderly, efficient flow in the operating room. Yet same start times in the morning for multiple cases is common in most facilities. For facilities that use a medical direction model, the facility or facility's billing entity must spend time and resources on the increased paperwork required to comply with the seven medical direction payment requirements for anesthesiologists, which increases the risk of fraud if done improperly. Additionally, the medical direction model restricts the facility's case-scheduling flexibility, resulting in delayed start times and idle operating room staff and resources, and ultimately reducing patient access to services.

A considerable number of healthcare facilities, physicians, and CRNAs are *unaware* that CRNAs do not have to be medically directed by anesthesiologists, and that facilities can instead use a nonmedical direction model. Many of these same stakeholders, including CRNAs, do not know that since 1989 CRNAs in all states have been able to bill Medicare directly and receive 100 percent of the available Medicare fee schedule for their services.[41] CRNAs and their employers commonly confuse the Medicare Part A physician "supervision" requirement for CRNAs with payment for "medical direction" under Medicare Part B. Under Part A, *any* physician, not just an anesthesiologist, can "supervise" a CRNA.[42] The supervision rule does not require the supervising physician to be specially trained in anesthesia or specifically privileged to supervise CRNAs. To comply with Part A, the surgeon who the CRNA works with is frequently the "supervising practitioner." There is no payment associated with Medicare Part A supervision. The principles which determine the liability of a

[40] Medicare Program. Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1999. Final Rule and Notice. 63 *Fed Regist*. 58814. November 2, 1998:58843.

[41] 42 CFR §415.110.

[42] 42 CFR 482.52; 42 USC 1895(u), 1861(r).

surgeon for negligence associated with the anesthesia portion of a surgical case are the same whether the surgeon works with a CRNA or an anesthesiologist.[43] Facilities that confuse Part A supervision with payment for medical direction inaccurately conclude that "CRNAs must be medically directed," and therefore may incur unnecessary costs, increased paperwork, and compliance risks.

In addition, employers of CRNAs sometimes miss out on private payer revenue they should be earning because many CRNAs and their employers do not understand how to develop their own CRNA professional fees based on accurate and reasonable charges for their services. Professional fees created by a facility or billing entity are used by private payers to determine the amount they will pay for CRNA services in that facility. Failure to establish accurate fees means that instead of the facility being reimbursed for CRNA services at the facility's set rate, the CRNAs are reimbursed at a rate chosen by the private payer. Many times this rate is much lower than 100 percent of the charges determined by the facility's CRNA fee schedule. The problem is compounded if the facility erroneously concludes that it can no longer cover the costs of CRNAs, when in actuality it is merely failing to collect revenue it could be generating if it had properly established accurate and reasonable fees for CRNA services.

Based on anecdotal evidence, some AANA members have expressed a desire to see medical direction abolished, while other members have stated they are satisfied with maintaining the status quo. In reality, medical direction as the dominant payment model is slowly dying out. Since October 2003, private payers have been better able to identify the role and financial value of CRNA services due to the implementation of the Health Insurance Portability and Accountability Act transaction code sets and the utilization of the Healthcare Common Procedure Code System modifiers that identify medical direction and nonmedical direction of CRNAs. Since then, many commercial payers have begun refusing to pay for medically directed services and in turn will pay only the provider who administers the anesthesia. Often when hospital administrators learn that their facility can provide nonmedically directed anesthesia services, the facility will change to a nonmedical direction payment model to reduce costs and simplify compliance with payment rules. Facilities that continue to require medical direction may lose revenue when payers will only pay for one claim.

Should the AANA seek to eliminate medical direction as a payment option, it would risk raising the ire of some of its members as well as anesthesiologists. A campaign to eliminate medical direction from Medicare and other payers' rules would probably be a costly effort and would also create a substantial risk that the final outcome would not be in favor of CRNAs. Recently, ASA leaders recognized that CRNAs will remain strong competitors and that anesthesiologists may have to lessen their reliance on medical direction.[44] A growing awareness by CRNAs, other providers, facilities and billing entities of the waste in manpower and financial resources associated with maintaining medically directed facilities continues to shed light on the inherent inefficiency of the medical direction model. Efforts to increase this awareness would cause more facilities to reject the medical direction model in favor of nonmedical direction models that could benefit the facilities, their patients, CRNAs, and the healthcare system. Establishing education programs to increase awareness of the nonmedical direction model and other models would help push medical direction down the road it is already traveling—one that favors CRNAs—but is likely to be less costly and incur less risk. By establishing practice management-oriented education programs, CRNAs could maintain a strong and balanced stance in favor of cost-effective anesthesia delivery.

As the use of medical direction payment models fades, it is important to monitor any efforts by the anesthesiologists or AAs to allow AAs to be able to work without the direction of anesthesiologists.

From the perspective of CRNA education programs, some nurse anesthesia students are only familiar with

[43] Blumenreich GA. Another article on surgeon's liability for anesthesia negligence. *AANA J*. 2007;75(2)89-93.

[44] Lema MJ. President-Elect's Address to the House of Delegates, October 15, 2006. *ASA Newsletter*. January 2007;71:9-11.

the medical direction model and may not be trained to practice in a nonmedical direction model. Upon graduation, many of these students may assume that the only way to practice is in a medical direction model. Preparing students to work without medical direction could mean altering the current teaching environment in clinical settings to incorporate more exposure to nonmedically directed cases. This does not mean, however, that only CRNAs should teach student nurse anesthetists. The contributions of anesthesiologists as teachers of student nurse anesthetists are important in that they provide the students with access to more clinical sites and clinical experiences in which to learn.

Medicare, but not necessarily all commercial payers, will pay CRNAs or anesthesiologists to teach up to two student nurse anesthetists concurrently, with each student nurse anesthetist in a different room.[45] However, unless the teacher is continuously with the student nurse anesthetist, the teacher can only bill for approximately 50 percent of the value of each case even though each patient is receiving full anesthesia service. Therefore there is a financial disincentive for teachers and healthcare facilities to allow student nurse anesthetists the opportunity to practice without the teacher in the room. Medicare's anesthesia payment rules in the teaching setting remain very complicated and difficult to apply.

In recent years the ASA has requested that CMS and Congress change the payment rules so that when anesthesiologists are teaching anesthesiology residents the teaching anesthesiologists can be reimbursed 100 percent for each of two cases. The AANA recognized that allowing anesthesiologists to bill 100 percent for each of two residents in concurrent cases would create a bias in favor of anesthesiologists that does not currently exist under Medicare. This bias could lead to hospitals choosing to work with anesthesiologists and residents over CRNAs and student nurse anesthetists because the anesthesiologist-only model would be more profitable. Also, under the ASA's proposed model, student nurse anesthetists might have fewer opportunities to provide anesthesia for more complex cases that are required for student nurse anesthetists to graduate because these more financially lucrative cases would be given to anesthesiology residents. To date, based on the strength of the AANA's comments to CMS, the ASA's requests have been denied. Additionally, the AANA has proposed legislation that would treat teaching CRNAs and anesthesiologists equitably by allowing both to be paid 100 percent for each case regardless of the type of "student."[46] This would apply only to Medicare cases.

B. Medical Supervision Payment Model

Using a medical supervision model in which one anesthesiologist supervises more than four CRNAs may help to address perceived liability concerns by surgeons or others. Under Medicare Part B payment for medical supervision, a CRNA can bill for 50 percent of the physician fee schedule but an anesthesiologist can bill for only three to four units per case.[47] There is a considerable disincentive to anesthesiologists to use a medical supervision payment model because anesthesiologists are paid less than under a medical direction model. For CRNAs, however, medical supervision models could present enhanced employment and payment opportunities as payment models shift away from medical direction.

Hypothetically, under a modified medical supervision model anesthesiologists could be treated as "consultants," with the anesthesiologist billing for only a small portion of a case and the CRNA billing for between 50 percent and 100 percent of the case, which is more than the CRNA could bill for if medically directed. However, for the CRNA it is still preferable to bill as nonmedically directed at 100 percent of the physician fee schedule. For the hospital, the cost of hiring a consulting anesthesiologist might be viewed as unnecessarily increasing costs. Anesthesiologists who would like to move into a consulting role may find themselves inadvertently considered obsolete since CRNAs can provide anesthesia for all cases and at all levels of acuity without an anesthesiologist. Hospitals

[45] 42 CFR §414.46. Transmittal 1766, §1600J. Anesthesia Services and Teaching CRNA, Medicare Carriers Manual. Part 3 Claims Process. August 29, 2002.
[46] HR 1932. Medicare Academic Anesthesiology and CRNA Payment Improvement Act of 2007. Introduced April 18, 2007.
[47] Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual. Chapter 12. Physician/Nonphysician Practitioner. Rev. 1473, 03-07-08, §50.

and other facilities might therefore determine that there is no financial benefit to having an anesthesiologist consultant.

C. Payment/Practice Models: Hybrids and Variations

Throughout the United States there are other payment models which may provide CRNAs and their employers with financially beneficial payment model alternatives. One option is to set up a parallel practice model in which CRNAs and anesthesiologists are working in the same department but independently of each other, with both providers administering anesthesia for low- and high-acuity cases. This model could work well in states or facilities that require an anesthesiologist to be present.

Another payment option could include paying anesthesia providers for their services up front. In this scenario, the providers might prefer to be paid up front at a discounted rate rather than wait an average of 50 days on accounts receivable. The providers would also eliminate the risk of nonpayment.[48] Such an arrangement could occur under contracts that establish flat, up-front payment rates.

D. Locum Tenens Practice and Payment Model

Due to the demand for anesthesia providers, many healthcare facilities look to locum tenens providers to temporarily fill their vacancies. Contracting with these providers can be an efficient alternative in that it allows a hospital or ASC to continue providing high-value surgical and diagnostic services to its patients. With locum tenens providers, facilities usually do not incur the same direct costs of salary, benefits, and malpractice insurance that they would if the providers were employees.

However, contracting with locum tenens providers can also be viewed as an inefficient alternative. Due to the demand for anesthesia services and the existing vacancy rate, locum tenens providers frequently contract for more than the cost of actually employing a CRNA. Facilities that use locum tenens providers may also find themselves devoting significant resources to establish their credentials and chase payments. Additionally, some hospital administrators have reported that some locum tenens providers are not as vested in the facility or patient care and tend to have a short-timer or revolving-door mentality.

E. Bundling of Services Payment Model

Congress, Medicare and private payers continue to actively seek opportunities to reduce the cost of healthcare provider services. Policy makers are increasingly drawn to payment models that combine multiple services which are normally paid separately into a single payment which encompasses an entire episode of care. This is referred to as “bundling.” Many healthcare policy experts, including MedPAC and CMS, believe that the bundling of services into one payment instead of multiple payments could yield a reduction in the total amount paid. At the request of Congress, MedPAC is actively investigating ways to shave healthcare costs by bundling Part A hospital services with Part B provider services.[49] This move toward bundling could directly affect how CRNAs are paid for their services. Currently, in a surgical setting for a single case, payers make a payment to the surgeon for surgical services and a separate payment to the anesthesia provider for anesthesia services. It is possible that public and private payers, in an effort to cut costs, could change this separate payment practice and instead combine the surgical and anesthesia service into one bundle and make only one payment. Such a practice could provide savings to the healthcare system but poses many risks for CRNAs. For example, by combining the surgical and anesthesia payments, CRNAs could lose their identity and negotiating leverage as individual providers. The value that a CRNA provides to a surgical case, which currently can be easily measured in dollars, could become diluted. CRNAs also risk losing control of what they earn for their services. If only one payment is made, the question arises, “Who does that payment go to and who decides

[48] Medical Group Management Association (MGMA) Cost Survey for Single Specialty Practices, 2007. Denver, CO.
[49] MedPAC. Report to Congress. Promoting Greater Efficiency in Medicare. June 2007:105.

how much of that payment goes to whom?" Providers other than the CRNA might determine what portion the CRNA receives. It is important for CRNAs to be aware of the trend toward bundling so they can influence payment policies to their advantage and best position themselves in the marketplace should the bundling of anesthesia services occur.

IV. Hospital Subsidies

As the demand for surgical services increases, hospitals continue to provide subsidies to pay for anesthesia services. For many hospitals, these subsidies are not sustainable in the long term. Anesthesia providers with higher-than-average incomes might not be able to generate enough income from anesthesia cases to cover their salaries. Many anesthesiologists make up the gap between the number of cases they personally perform and their accustomed high salary by medically directing CRNAs and getting paid 50 percent for each case. For example, an anesthesiologist may prefer to medically direct multiple cases rather than personally perform one anesthesia case because the anesthesiologist can generate more revenue in this manner.

Without anesthesia services, hospitals cannot generate revenue they rely on from surgical cases. If subsidies become too costly, some facilities may choose to reduce their number of surgical cases. This in turn would reduce demand for CRNA services and patient access to anesthesia services, and would threaten the relationships hospitals have with their communities. Meeting surgeons' needs is a high priority for hospital adminstrators since surgical cases bring in substantial, essential revenue for hospitals. Therefore, hospitals are highly motivated to keep their surgeons happy. Efforts to retain surgeons often include providing subsidized anesthesia providers. However, CRNAs should recognize that when competing with surgeons for a hospital's favor, CRNAs can lose based on the hierarchy of a hospital's needs and the relationship between fellow physicians such as surgeons and anesthesiologists. Therefore, anesthesia providers need to work with hospital administrators and other providers to align incentives over the long-run. For example, operating rooms are generally not efficiently used. Most are used in the morning and empty in the afternoon. One option that anesthesia providers could promote would be running fewer operating rooms throughout the day rather than running multiple rooms in the morning and none in the afternoon. Of course, surgeons generally control start times and often have considerable leverage in supporting or defeating this type of proposal.

In addition, as hospital subsidies to anesthesiologist groups continue to increase, hospital administrators will be looking for ways to cut costs and renegotiate contracts at a lower cost to the hospital. CRNAs can readily demonstrate that they are high-quality but lower-cost providers, creating a unique opportunity to compete for these contracts. This is one example of how CRNAs can be viable competitors in the healthcare marketplace.

Most importantly, CRNAs should keep in mind that while hospitals are obligated and motivated to provide jobs and quality healthcare services in their communities, remaining financially viable is their highest priority.

V. Defining the Future for CRNAs

A. Success for CRNAs

Success for CRNAs in the short- and long-term future includes the following principles:

- The ability of CRNAs to work within the full scope of their practice in all states.
- Real voting representation for CRNAs on payment and practice decision-making bodies.
- Continued contributions by CRNAs to the improvement of patient care and safety.
- Continued active and positive working relationships for CRNAs and the AANA with legislators, regulatory decision makers, hospitals and surgery centers and their trade associations, patients and their advocacy groups (such as the National Consumers League and American Association of Retired Persons), healthcare quality and access councils and agencies (such as the National Council on Quality Healthcare and the Council for Affordable and Quality Healthcare),

and other healthcare providers and their professional associations.
- Transparency in understanding and applying regulations that have an impact on CRNA practice.

B. Redefining the Role of CRNAs in the Healthcare System

To best position themselves in the changing and challenging healthcare marketplace, CRNAs must redefine their role in the healthcare system. They must step away from arguments centered on one provider over another and instead seek opportunities to provide employers and patients with increased value and high-quality services, as well as communicate with them about the enhanced safety and value of CRNA services.

CRNAs should think of themselves as a revenue source, not a cost center. They need to understand the terms, concepts, practice potential, professionalism, and responsibilities that are inherent in being a revenue producer. CRNAs should also think of themselves as healthcare professionals who contribute to the safe, high-quality care patients receive. Without a doubt there is a predisposition for patients and others to favor physicians in all areas of healthcare and this is unlikely to change any time soon. Moreover, the historically acrimonious and competitive relationship between CRNAs and anesthesiologists is also difficult to overcome, but it can be if CRNAs approach their practice as business-minded professionals confident in who they are and what they bring to the healthcare community, and determined to promote themselves as an excellent choice for anesthesia care.

While the perception exists that a hospital with only CRNAs may not have quality anesthesia services, strong financially based arguments in support of the cost-effectiveness of CRNA services can be made that soften this perception and favor the use of CRNAs. Hospital administrators and policy makers are receptive to ideas that rise above politics and turf-related arguments. The financial strain that many hospitals are currently operating under makes for a receptive audience when it comes to reducing healthcare delivery costs. CRNAs should seek out and welcome the opportunity to be contributors on their hospital's financial teams or committees that make financial and practice decisions. For example, hospitals would be receptive to evidence that using only a nonmedical direction model can be cost effective and provide consistently high quality for the hospital.

Currently, CRNAs are in a stronger position to make financially based arguments than their physician counterparts. CRNA salaries and malpractice premiums are considerably lower than those of anesthesiologists, yet CRNAs provide the same quality patient care regardless of acuity level. One of the key elements to this argument is that for decades CRNAs have been educated and trained to manage patients at all acuity levels, and have done so with great success. Allowing this fact to fade could result in reduced recognition and respect for CRNA capabilities.

CRNAs must also overcome the perception by some facility administrators that they are hourly workers rather than highly skilled professionals. Administrators sometimes express concerns that CRNAs have an on-the-clock mentality and resist putting in extra time. In contrast, CRNAs perceive themselves as the providers actually doing the work, compared with anesthesiologists who they perceive as not being actively involved in cases.

With their nursing background, it would seem that CRNAs have the cultural advantage of being more flexible to weather changes as their role in the healthcare system and marketplace is redefined. Many policy makers believe nursing is in a position of ascendancy not only because it is more cost-effective, but also because of its tradition of compassionate patient-centered care. Increasing the number of CRNAs who have a practical knowledge of the business of anesthesia and still embrace their nursing tradition can make CRNAs formidable agents for positive change in the healthcare system.

Commission Recommendations

Following are the recommendations of the Commission on Anesthesia Economics and Reimbursement (Commission) to the AANA Board of Directors (Board) based on the Commission Findings (see previous section). These recommendations are built upon a conceptual framework of advancing the nurse anesthesia profession's goals of quality, safety and efficiency at a lower or neutral cost to the healthcare system. The Commission has not prioritized or established values for the recommendations. The Board could decide to move forward with any number of the recommendations, or with none at all. However, one thing is clear: Altering anesthesia practice and payment on a large scale, given the complexity of such an undertaking and the vast number of stakeholders who would be involved, would require a comprehensive strategic plan developed and implemented by dedicated anesthesia professionals, input from allies in related fields, and considerable staff and financial resources.

Practice Management Education

In the area of practice management education the Commission recommends that the AANA undertake the following actions. Because the current payment and practice rules and regulations are extremely complex, additional education in the area of practice management would allow CRNAs to more effectively advocate for themselves, their profession, and their patients.

- Develop a practice management function within the AANA.
- Develop an education program or track to teach CRNAs about practice management as it relates to public and private payers, and how it enhances their practice and improves patient safety.
- Develop an education program or track on payment and policy that teaches CRNAs about reimbursement rules and regulations that have an impact on CRNA practice and how to effectively navigate through these rules and regulations.
- In practice management-related initiatives, the AANA should showcase the entrepreneurial know-how and current best practices of CRNAs that improve patient safety and quality care.
- Recommend to the Council on Accreditation of Nurse Anesthesia Educational Programs that it consider defining the term "professional aspects" in more detail for anesthesia education curriculum so programs can include coursework on the business of anesthesia and practice management.

Alternative Anesthesia Payment and Practice Models

In the area of alternative anesthesia payment and practice models the Commission recommends that the AANA do the following:

- Further analyze current and alternative practice and collaborative models, including bundling of procedural and anesthesia services.
- Develop a financial analysis for each practice model based on an average patient mix and basic procedure, and provide a graphical representation of these models.
- Develop strategies that focus on outputs rather than inputs, thereby enabling individuals to determine what payment and practice models work best for

their practice environment.
- Identify current policies or practices that put CRNAs at a disadvantage at the national and state levels.
- Further analyze cost-shifting between public and private payers and patients due to payer coverage decisions and other factors.

(NOTE: Should the Board decide to have the Commission continue its work, one area of focus might be alternative anesthesia payment and practice models.)

Studies, Surveys and Data Collection

In the area of studies, surveys and data collection, the Commission recommends that the AANA do the following:

- Explore the feasibility of partnering with the Medical Group Management Association (MGMA) to enhance the MGMA's annual national physician compensation and cost survey by incorporating more detailed CRNA data and promoting CRNA participation. This might best be accomplished through a special CRNA-only survey before including CRNA-specific data in the MGMA survey. In preparation for this, obtain and review current AANA member survey data. There should be clearly defined CRNA data within the MGMA data sets, defined by practice type and employment models. (NOTE: Should the Board decide to have the Commission continue its work, one area of focus might be the MGMA survey.)
- Cultivate CRNA research capabilities and opportunities by working with universities and think tanks, and other research-oriented organizations. Encourage academic research by CRNAs in the areas of quality measure development, practice management, and reimbursement modeling.
- Obtain information from the Centers for Medicare & Medicaid Services (CMS) on reimbursement for nonmedically directed, medically directed and personally performed services.
- Obtain quality data on CRNAs practicing independently.

Patient Safety and Quality

In the area of patient safety and quality the Commission recommends that the AANA do the following with a focus on moving toward evidence-based practice:

- Improve quality and safety standards for anesthesia services.
- Increase CRNA involvement in and contributions to quality measurement development and Pay for Performance initiatives.
- Support efforts to continue the policy of allowing two anesthesia providers to bill for 100 percent of the value in high-acuity cases.

Technology

In the area of technology, the Commission recommends that the AANA do the following:

- Continue to enhance current strategies and focus on ongoing assessment of current and emerging technologies that affect the economics and efficiency of anesthesia practice and improve quality and patient safety.
- Seek opportunities for CRNAs to contribute to the development of electronic health records, perioperative information systems, and other health information management tools so that CRNAs are included in the data collection and their work as a group compared to other provider groups is readily identifiable.

Building Relationships and Alliances

Recommendations in this area may call for additional public relations and education on payment and practice rules directed at CRNAs and other healthcare stakeholders. Efforts should be made to emphasize that CRNAs are safe and effective providers, as well as to identify alternative anesthesia payment models that are profitable. In the area of building relationships and alliances the Commission recommends that the AANA do the following:

- Take the lead in cultivating stronger relationships with advanced practice nursing and seek opportunities to align efforts.
- Continue to build relationships and alliances among anesthesiologists, surgeons, hospital administrators, and professional and trade associations.

- Continue to build relationships with patients and the public at large, including patient advocacy and consumer associations, so they know that CRNAs are valued partners in a team of healthcare providers.
- Continue to build relationships with regulatory and legislative decision makers.
- Seek opportunities for CRNAs to contribute their expertise as representatives on key reimbursement and practice bodies such as private payer provider advisory committees and boards of directors as well as Department of Health and Human Services/CMS committees and boards. Real voting representation should be the ultimate goal.

Commission Membership

Should the Board decide to have the Commission continue its work, in the area of Commission membership the Commission recommends that the AANA do the following:

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

Appendix A: Additional Resource Documents

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Appendix B: Commissioner Biographies and Acknowledgments

Larry Hornsby, CRNA, BSN

Chair, Commission on Anesthesia Economics and Reimbursement
Business Owner – Anesthesia billing company, consulting services, recruitment/placement company, and education seminar business
Moody, AL

Larry Hornsby, CRNA, graduated from the University of Alabama School of Anesthesia for Nurses in Birmingham, Alabama in 1985. He became active in the Alabama Association of Nurse Anesthetists (ALANA) as chair of the ALANA Nominating Committee in 1986 and was elected president in 1991 and again in 1993. He then began actively serving the American Association of Nurse Anesthetists (AANA) as an elected region director (1995-1997), vice president (1998), president-elect (1999-2000), and president (2001). Hornsby successfully established a CRNA group practice in Montgomery, Alabama in 1992 and joined with two other Certified Registered Nurse Anesthetists (CRNAs) in establishing Anesthesia Resources Management, Inc. in Birmingham, Alabama in 1995. Since then they have continued to develop multiple companies spanning all aspects of anesthesia practice and management. Hornsby is a well-known speaker both nationally and internationally and presents on a wide variety of topics. He is a licensed private pilot and enjoys flying, hunting and fishing. He has been married for 25 years to Carol Hornsby and they have two children, Drew (19) and Laura (16).

Lee Broadston

President & CEO, BCS, Incorporated – Healthcare practice management and consulting services
Waconia, MN

Broadston is currently the president and CEO of BCS, Incorporated, a healthcare practice management and consulting firm specializing in the complex arena of anesthesia practice management and reimbursement. BCS manages the business and patient accounting operations, as well as provides consulting services, to CRNA practices and a wide variety of healthcare institutions in more than 40 states across the United States. Practice evaluation, proposal of services, implementation, reimbursement negotiations, operational support, and education account for a significant portion of Broadston's commitment to the success of the nurse anesthesia profession. Broadston brings to the Commission more than 21 years of healthcare practice management experience in which he has provided anesthesia practice consulting and management services to CRNAs in all practice environments including rural, urban, specialty hospital, ambulatory surgical center, and office practices; and in all anesthesia service delivery systems including solo, group, anesthesia care team, and collaborative practices.

Since 1988, Broadston has been successful in breaking through the glass ceiling of many private, public, and managed care organizations to overcome a variety of CRNA reimbursement barriers at local, state, and national levels. Broadston serves as a member of the AANA National Anesthesia Payment and Advisory Panel, has authored publications for the AANA and BCS

on anesthesia reimbursement and practice management, and travels the United States lecturing on a variety of issues and topics that have an impact on CRNA practice. He has also served on several editorial panels for McGraw Hill, Context Publishing, and PMIC in the areas of anesthesia practice management. Broadston and his staff are committed to the success of today's anesthesia providers and/or their employers across the ever-changing anesthesia reimbursement landscape.

Linda F. Golodner

President Emeritus, National Consumers League
Principal, Consumer Initiatives
Washington, DC

Linda F. Golodner is president emeritus of the National Consumers League (NCL), which she joined in 1983. She recently stepped down from the position of president and CEO of NCL, and now serves on its Board of Directors and Executive Committee as well as represents the NCL on a number of boards and advisory committees. Golodner is the principal of Consumer Initiatives, representing nonprofit and for-profit organizations on consumer issues, including healthcare, product safety, and corporate social responsibility.

Golodner is a member of the Board of Directors of the American National Standards Institute (ANSI) and serves on its Executive Committee. She chairs the ANSI Consumer Interest Forum and represents the institute on the International Standards Organization Consumer Policy Committee. Golodner is a public member of the AANA Council on Public Interest in Anesthesia; serves on the board of Omnimedix and the Steering Committee of the Health Sector Assembly; and has served on the Steering Committee of the Centers for Education and Research in Therapeutics and the IOM Committee on Postmarket Surveillance of Pediatric Medical Devices. While president of NCL, Golodner established the SOS Rx Coalition, a multi-stakeholder initiative focused on safe medication use by seniors in outpatient settings. President Bill Clinton appointed her to the White House Apparel Industry Partnership, which she co-chaired; she now serves on the Board of Directors of its successor organization, the Fair Labor Association.

Golodner received the American Pharmacists Association’s Hugo H. Schaefer Award and the American Council on Consumer Interests recognized her for outstanding contributions to policies that promote consumer interests nationally and internationally. The Food and Drug Administration (FDA) gave her its highest public honor, the FDA Commissioners Special Citation. Golodner was also honored by the United Nations Association/NCA for her work in human rights. The National Consumers League presented her with its Trumpeter Award for her years of consumer advocacy and education of consumers in the United States and abroad. She graduated summa cum laude from the University of Maryland in 1975.

Michael Hash

Principal, Health Policy Alternatives, Inc.
Washington, DC

Michael Hash returned to Health Policy Alternatives, Inc. (HPA) in 2001, after three years of service at the Health Care Financing Administration (HCFA, now CMS), first as deputy administrator from March 1998 through September 2000, then as acting administrator October through December 2000. Prior to his federal appointment, Hash was a principal at HPA for 13 years. Hash also served from 1990-1995 as the senior staff associate of the Subcommittee on Health and the Environment of the House Energy and Commerce Committee, with responsibilities for Medicare legislation and healthcare reform proposals. In addition, he was involved with the development of legislation on quality assurance, health services research, and the healthcare workforce. From 1973-1980, he was employed by the American Hospital Association (AHA), with progressive responsibilities that led to his appointment as deputy director of the Washington office, overseeing the management of the AHA's government relations program. Hash is a graduate of Washington and Lee University, with post-graduate studies in political science at Vanderbilt University. He has held teaching positions at the Johns Hopkins University and Georgetown University. Currently he chairs the board of Providence Hospital in Washington, DC.

Jim Henderson, CRNA
President, Riverview Anesthesia Associates
LaGrange, GA

Jim Henderson, CRNA, co-founded Valley Anesthesia Associates, PC in 1995, an all-CRNA group providing anesthesia services to Lanier Health Services in Valley, Alabama. In 2003, the CRNA group expanded to include an anesthesiologist and was reorganized as Riverview Anesthesia Associates, Inc. As the president of Riverview Anesthesia Associates, Henderson is responsible for all aspects of the clinical and business management of the group. In addition to his professional work, Henderson is active in his state and national professional associations, serving two terms as president of the Alabama Association of Nurse Anesthetists (ALANA) and serving as a member of the AANA Dues Task Force. Since 2001, Henderson has served as the editor of the ALANA NewsBulletin and maintained the state association's official website. Henderson is particularly interested in advocating for the nurse anesthesia profession in matters pertaining to reimbursement for anesthesia services and promoting efforts to permit nurse anesthetists to practice at their full scope of practice. Other interests include educating nurse anesthetists, hospital administrators, and other stakeholders about the details, issues, and options surrounding anesthesia department management and billing for anesthesia services.

Paul Henderson, CRNA, MS
Great Lakes Anesthesia, PC
Elkhart, IN

Paul Henderson, CRNA, MS, graduated from Rush University School for Nurse Anesthetists in Chicago in 1979. Henderson, who recently completed a term on the AANA Council on Accreditation of Nurse Anesthesia Programs, has also been very active in the Indiana Association of Nurse Anesthetists, serving as its president for two years. He has worked since 1984 in Elkhart, Indiana. Henderson recently was elected to chair the Board for Great Lakes Anesthesia in Elkhart, which he founded with another CRNA and one physician in 1999. Great Lakes Anesthesia currently employees 32 CRNAs, 15 physicians, and is the largest employer of CRNAs in Indiana. Henderson has a Master of Science degree in Health Service Administration from the University of St. Frances.

Kathleen P. Kinslow, CRNA, EdD, MBA
Executive Director, Pennsylvania Hospital, University of Pennsylvania Healthcare System
Philadelphia, PA

Since 2006, Kathleen P. Kinslow, CRNA, EdD, MBA, has been the executive director at the Pennsylvania Hospital, University of Pennsylvania Healthcare System in Pittsburgh, Pennsylvania. She is responsible for operational, financial, human resource, quality, physician/board relation, retention, recruitment, and contract management aspects of the hospital. Kinslow manages a $350 million budget and is responsible for the supply chain across the healthcare system. She reports to the system's chief operating officer and the Pennsylvania Hospital Association Board of Directors. Kinslow has served as chair of the AANA Council on Accreditation of Nurse Anesthesia Educational Programs and is a past president of PANA.

Tim Nelson, MBA
Corporate Director of Physician Services, Forum Health
Youngstown, OH

Since 1998, Tim Nelson has served as the corporate director of Physician Services at Forum Health. In his role, he has direct operational responsibility for a hospital-owned, multi-specialty physician network which includes 62 employed physicians on five primary campuses. Significant tasks include: practice management, physician and mid-level provider recruitment, physician benefit design/implementation, physician staffing of hospital-based clinics, development of annual budgets, practice marketing and business development, and new practice start-ups. Nelson also oversees the management of the physician billing company serving both Forum Health and private physicians. He has directed the selection and installation

of an IDX Groupcast Practice Management system, including redesign of front office policies and procedures that reduced outstanding days in A/R from 112 to 47. He led the installation of a Logician Electronic Medical Record system and designed and implemented an incentive-based physician compensation system. He has had involvement with all types of system-wide physician contracting and business plan development. Nelson is licensed as a Certified Managerial Accountant.

Ken Plitt, CRNA, MBA
Mill Creek, WA

Ken Plitt, CRNA, MBA, has practiced as a Certified Registered Nurse Anesthetist for over 27 years in the greater Seattle area since receiving his anesthesia education from the Mayo Clinic. Plitt's clinical practice has focused on ambulatory surgical center and office-based activities, particularly in the areas of plastic surgery and ophthalmology. He holds a clinical faculty appointment and serves as an operations consultant to the Institute for Surgical and Interventional Simulation (ISIS) at the University of Washington in Seattle. His consulting background also includes practice management projects for the AANA and clinical education initiatives for Aspect Medical Systems. Ken has been active in professional association activities at both the national and state level and currently serves as chair-elect of the AANA Foundation.

Sara Rosenbaum, JD
Chair, Department of Health Policy – George Washington University School of Public Health and Health Services
Washington, DC

Sara Rosenbaum, JD, is the Harold and Jane Hirsh professor and chair of the Department of Health Policy at the George Washington University School of Public Health and Health Services. Professor Rosenbaum has devoted her career to issues of health law and policy affecting low income, minority, and medically underserved populations, as well as the healthcare safety net. From 1993-1994 she worked for President Bill Clinton, directing the legislative drafting of the Health Security Act and developing the Vaccines for Children program.

A graduate of Wesleyan University and Boston University School of Law, Professor Rosenbaum is the founding chair of the Department of Health Policy, a unique center for learning, scholarship, and service focusing on all aspects of health policy. Professor Rosenbaum has authored more than 250 articles and studies focusing on all phases of health law and healthcare for medically underserved populations. She is co-author of Law and the American Health Care System (Foundation Press, NY)

Professor Rosenbaum serves on numerous foundation and organizational boards. Named one of the country's 500 most influential health policy makers, she has received many national awards, including the Hansen Award from the University of Iowa, a Department of Health and Human Services award for distinguished national service on behalf of Medicaid beneficiaries, and a Robert Wood Johnson Foundation Investigator Award in Health Policy Research.

Kay K. Sanders, CRNA, MHS
Director, TCU School of Nurse Anesthesia
Fort Worth, TX

Kay K. Sanders, CRNA, MHS, is director of the Texas Christian University (TCU) School of Nurse Anesthesia. She has served as a nurse anesthesia program director for 19 years and was the founding director for the TCU program. Since 1992 she has served as a reviewer for the AANA Council on Accreditation of Nurse Anesthesia Educational Programs. Her anesthesia practice has been in rural and small urban hospitals.

Paul Santoro, CRNA, MS
Principal, Midwest Anesthesia Consultants, Inc.
Principal, Ambulatory Surgery Consultants, Inc.
Bingham Farms, MI

Paul Santoro, CRNA, MS, is the owner and founder of Ambulatory Surgery Consultants, Inc. (ASC), which

employs anesthesiologists and CRNAs in exclusive contracts with 22 centers located in mid- and southeast Michigan.

ASC prides itself on its culture of continuous quality improvement in both its clinical and business practices. Toward achieving its goal of providing efficient and high-quality anesthesia services, ASC has embarked on the development of customized anesthesia practice management software which integrates the critical functions of credentialing, clinical privileging, flexible scheduling, and on-line learning for multi-site anesthesia practice management. ASC is currently accredited by the Joint Commission (formerly The Joint Commission for the Accreditation of Health Organizations, JCAHO), an accreditation very few anesthesia groups have. The ASC culture of continuous improvement extends to individual staff members, both clinical and support staff, who are actively supported in the pursuit of higher education and training through tuition/education reimbursement and flexible work schedules.

Santoro is also an owner of Midwest Anesthesia Consultants, Inc., an anesthesia billing and consulting firm. He has spearheaded favorable CRNA reimbursement with numerous Michigan-based carriers, including Blue Cross/Blue Shield of Michigan, PPOM, HAP, PHP, Health Plus, and M-Care. Santoro currently serves on the AANA Board of Directors as treasurer.

Thomas A. Scully, JD

Senior Counsel , Alston & Bird, LLP
Washington, DC

Thomas A. Scully, JD, is senior counsel in Alston & Bird's Washington, DC office and general partner with Welsh, Carson, Anderson and Stowe (WCAS), a New York Private Equity Firm. His Alston & Bird public policy practice focuses on healthcare regulatory and legislative matters, as well as advising clients on health policy and strategies for healthcare delivery. As general partner at WCAS, Scully supports its existing broad base of health investments, serves on the board of four of its companies, and develops and evaluates new investment opportunities.

Scully's public service includes serving as administrator of the Centers for Medicare & Medicaid Services under President George W. Bush (2001-04), serving as deputy assistant to the president and counselor to the director of the White House Office of Management and Budget under President George H.W. Bush (1989-93), and serving as a legislative aide to former Senator Slade Gorton (R-WA) (1981-85). His previous private sector experience included serving as president and chief executive officer of the Federation of American Hospitals (1995-2001) and partner in the Washington, DC law firm of Patton Boggs, LLP (1993-95). Scully holds a Juris Doctor degree from Catholic University and a bachelor's degree from the University of Virginia.

Scully's most recent government experience is especially noteworthy for his instrumental role in passing Medicare reform and Medicare Rx legislation, as well as for changing the agency's culture and making the vast agency more open and accountable to the public. He serves on the board of Select Medical Corporation, SHPS Inc., Ardent Health Services and Member Health. He previously served on the boards of DaVita and Oxford Healthcare.

Commission Staff

Pamela K. Blackwell, JD

Executive Commission Staff
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Pamela K. Blackwell, JD, joined the AANA Washington, DC staff in September 2003 and is the Associate Director for Federal Regulatory & Payment Policy. Blackwell is responsible for management, strategy, and policy development and implementation relating to federal regulatory and payment policy issues. She works directly with Federal Agencies (Medicare, FDA, DEA, etc.), AANA members and staff, and other organizations to develop and improve federal regulatory proposals and outcomes for AANA members. Blackwell particularly enjoys educating AANA members on

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