Nurse Anesthesia Reimbursement: Trends and Issues for CRNAs

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Federal Government Affairs

Our Agenda Today

- What is shaping health policy?
- What is shaping health politics?
- Major public benefit programs: Medicare, Medicaid, VHA, ACA
- What do CRNAs have to offer?
- Q&A time

America’s Health Policy Environment

<table>
<thead>
<tr>
<th>Was</th>
<th>Is</th>
<th>Will Be</th>
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<tbody>
<tr>
<td>Baby boom</td>
<td>Boomer retirees</td>
<td>Boomer elderly</td>
</tr>
<tr>
<td>R House, D Senate, D Administration</td>
<td>R House, R Senate, D Administration</td>
<td>? House, ? Senate, ? Administration</td>
</tr>
<tr>
<td>Many uninsured, modest OOPs</td>
<td>Fewer uninsured, higher OOPs</td>
<td>Fewer uninsured, still higher OOPs?</td>
</tr>
<tr>
<td>ACA subsidies, Medicaid expansion</td>
<td>ACA subsidies, more Medicaid @29 states</td>
<td>ACA subsidies?, more Medicaid?</td>
</tr>
<tr>
<td>Fee for service</td>
<td>Health reform</td>
<td>Payment transformation</td>
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</table>

Medicare-eligible Population

Source: US Census, AARP

Annual Per Capita Healthcare Costs by Age

Source: Forbes, Year in healthcare charts 2012, from Meeker, 2011, "USA, Inc."
http://s3.amazonaws.com/kpcbweb/files/USA_Inc.pdf
Public Benefit Programs & CRNAs

- Medicare
- Medicaid
- Veterans Health Administration
- Affordable Care Act

Medicare & CRNAs

**Part A: Hospital insurance**
- Conditions of participation
- Pass-through program

**Part B: Physician services**
- Anesthesia payment
- Teaching rules
- Reimbursement for other services

**Parts C & D: Managed care, prescriptions**
Part A for CRNAs

Conditions of participation & of coverage
- Anesthesia services
- ASC surgical services

Rural reasonable cost pass-through
- Certain qualifying rural and critical access hospitals
- <800 cases or less
- CRNA services as a hospital service, no Part B

Supervision

It is a Medicare requirement, a portion of a regulation, 42 CFR 482.52(a)(4)

Anesthesia must be administered only by … (4) A certified registered nurse anesthetist (CRNA), as defined in 410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed …

In the Day

1997: Proposed to be repealed
1/2001: Repealed in a final rule
2/2001: Suspended
11/2001: Finalized as an opt-out process
11/2001 to today: 17 states have opted out

What is required to opt out?

- Letter from Governor to CMS making the request
- Governor has consulted with boards of nursing and of medicine
- Consistent with state laws
- Opt-out is in the interest of the people of the state
- Effective upon receipt at CMS
A national opt-out?
Would eliminate supervision in those states that could opt out but have not
Would not eliminate supervision in states with requirements
No reversal of opt-out

Part B for CRNAs
Anesthesia payment
- Medical direction
- Pain care
- Teaching rules
Payment for other services
Present and future reforms

Fee-for-service
(Base + time) x ($CF) = anesthesia fee
(Relative value) x ($CF) = physician fee
Pays for a thing
Does not necessarily pay for
- Quality
- The right thing
- Care coordination
- Optimal efficiency

Most common anesthesia services
QZ, CRNA nonmedically directed
QX, CRNA medically directed by an anesthesiologist
QK, anesthesiologist medically directing 2, 3 or 4 concurrent CRNA cases
AA, personally performed by an anesthesiologist

Supervision vs Medical Direction

What are the TEFRA rules?
1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.
TEFRA medical direction rules

Anesthesiologist performs all seven tasks in each of up to four concurrent cases provided by a CRNA
Fee split 50/50 between CRNA and medically directing anesthesiologist
A payment model not a standard of care
Encourages higher-cost anesthesia delivery without demonstrated quality improvement

Medical Direction Undermined

Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics

What This Article Tells Us That Is New
• In a review of 1 yr of data from a tertiary hospital, lapses occurred commonly during first-case starts even with a 1:2 supervision ratio.

Of the anesthetics you personally administer, how often is an anesthesiologist involved in the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Always</th>
<th>Most of the time</th>
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<tr>
<td>Pre-anesthetic assessment (n=5,764)</td>
<td>42%</td>
<td>23%</td>
</tr>
<tr>
<td>Preclude anesthetic plan (n=5,596)</td>
<td>21%</td>
<td></td>
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<tr>
<td>Present at induction (n=5,564)</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Present for emergency or urgent situations (n=6,796)</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Present for emergence from anesthesia (n=6,796)</td>
<td>28%</td>
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<tr>
<td>Perform post-anesthesia assessment (n=5,712)</td>
<td>17%</td>
<td></td>
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<tr>
<td>Periodically Monitor Anesthetic Course (n=5,791)</td>
<td>18%</td>
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Anesthesiologist Supervision Often Lapses

Medical Direction vs Supervision

<table>
<thead>
<tr>
<th>Medical Direction</th>
<th>Supervision, generally</th>
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<tr>
<td>By an anesthesiologist</td>
<td>By operating practitioner, or by an anesthesiologist who is immediately available if needed</td>
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<tr>
<td>Seven services required in order to claim medical direction reimbursement (50% of a fee, up to 4 concurrent cases (TEFRA rules)</td>
<td>Required as a condition of participation for your hospital, or as a condition of coverage in your CAH or ASC</td>
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<td>Opt-out does not apply</td>
<td>Opt-out does apply; 17 states have opted out</td>
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April 16, 2015: SGR Cuts Permanently Repealed

For Quality & Cost-Efficiency

- By 2016, CMS will make 85% of its payments on the basis of quality or outcomes. – January 2015
- Stable 0.5% positive updates each year 2015-2019
- Medicare has three quality programs now affecting CRNAs: PQRS, VBM, EHR-MU
- By 2019, consolidate these plus “Clinical Improvement Activities” into “Merit-based Incentive Payment System”
- Providers can be exempted from MIPS if they choose reimbursement by Alternative Payment Models (APM)

MIPS
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<th>Quality</th>
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<tr>
<td>Resource use</td>
</tr>
<tr>
<td>Meaningful use of IT</td>
</tr>
<tr>
<td>Clinical practice improvement activities</td>
</tr>
<tr>
<td>Composite performance score</td>
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<tr>
<td>Law scores: 4% 2019 =&gt; 9% 2022</td>
</tr>
<tr>
<td>High scores: Up to 3x the cuts level</td>
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<td>Secretary to issue a plan by May 1, 2016</td>
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APMs
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<th>Quality</th>
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<tr>
<td>Include risk of loss, quality measures</td>
</tr>
<tr>
<td>Medical homes / healthcare homes</td>
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<tr>
<td>Patient centered systems</td>
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<tr>
<td>Bundled payment systems</td>
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<tr>
<td>Testing new specialty models</td>
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<tr>
<td>Technical Advisory Committee to evaluate specialty recommendations</td>
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<td>Identify fraud vulnerabilities</td>
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Veterans Health Administration

- A system, not insurance, that provides health benefits and services to Veterans
- Approx. 900 CRNAs
- Choice Act of 2014 allows some remote Veterans to use their VHA benefits with private healthcare professionals

The Affordable Care Act of 2010

Expansion of coverage
- Medicaid expansion, subsidies in exchanges

Insurance reforms
- State-based exchanges for marketing coverage
- Nondiscrimination, consumer protections

Delivery system reforms
- Accountable Care Organizations
- Innovation Center
- Independent Payment Advisory Board

Financing
Will ACA Last?

- **ACA:** Subsidies may be offered by plans marketed through “Exchange established by the State”
- **King v Burwell case:** May states with federal exchanges subsidize coverage?
  - If yes, nothing changes
  - If no … what disruptions?
  - Decision in June 2015
AANA-Driven Health Policy Change

- **SGR cuts** threatening $15,000 annual CRNA payment reduction – Permanently Repealed
- **Medicare GI screening** endoscopy separate anesthesia service – Covered, no copay
- All Medicare services within CRNA scope of practice in a state, including pain management – Covered
- **Medicare coverage of AA services** – Must have anesthesiologist medical direction

Our 2015 MYA Agenda:

- **For our SENIORS**
- **For our VETERANS**
- **For our FUTURE**

- **Thank you** for permanent SGR repeal! We are your partners in implementation
- **Strengthen Veterans** access to care by supporting full practice authority for VHA’s APRNs
- **Support rural healthcare**, oppose provisions that add to rural anesthesia costs and burden rural hospitals
- **Advance nurse workforce** development funding

We’ve learned about

- Policy, politics and programs shaping CRNA practice and reimbursement
- AANA’s role in shaping the future

Thank You from Your AANA FGA

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