Payment Progress Series, Part 1: ASA Initiatives to Secure Your Economic Future

The 33% Problem: Why It Matters and What We Can Do About It

Catlin Nalley

In this series, the ASA Monitor *investigates the unique circumstances surrounding the financial valuation of anesthesiologists by the health care industry. Learn how anesthesiologists are paid, what needs to change, and how you can join the ASA Economic Strategic Plan Initiative to achieve a more stable and equitable future.*

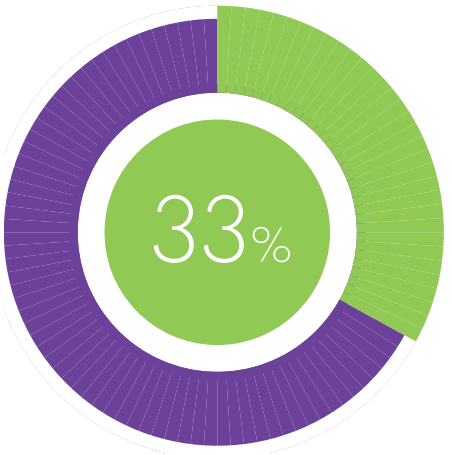
Anesthesia services are an integral component of the practice of medicine and span the continuum of care, within both the OR and encompassing perioperative care field. Because of its importance and the need to ensure availability of skilled anesthesiologists, anesthesia services must be valued appropriately.

Payment for most anesthesia services is somewhat unique, based on an anesthesia relative value system with payment based on a conversion factor determined by the commercial payor or Medicare. While payment for anesthesia services vary by payor, for anesthesia services paid by Medicare, Medicare payments represent approximately 33% of average commercial payments for anesthesia services compared with about 80% for other medical specialties.

What led to this discrepancy? The issue — known as the 33% Problem — arose when the Resource-based Relative Value Scale (RBRVS) was established in 1992. This shift sought to base Medicare payment on resources required to provide care and to establish relativity across specialties; however, the methodology used to value clinical services led to a 29% decrease in Medicare payment for anesthesia services (*ASA Monitor* 2020;84:28–33).

This reduction was a result of the formula used in the original study, led by Hsiao et al., to create the RBRVS system, including payment for work, practice expense, and professional liability insurance. Linkages were established to compare work efforts across specialties; however, only three were used for anesthesia (D&C, Cesarean section, and repair of AAA), significantly less than for other specialties.

ASA sought to correct this methodologic error on a number of occasions, primarily through the Five-Year Review



process used by the Relative Value Update Committee, which took place in 1995, 2000, and 2005. These three efforts did increase payment for anesthesia services by 16%, 1.6%, and 23% respectively, in the Medicare anesthesia conversion factor. Despite these successes, Medicare still undervalues anesthesia services.

"Corrections have been made, but over time, we haven't kept up with inflation," explained Christopher Troianos, MD, FASE, FASA, Chair of the ASA's Committee on Economics. "The 2021 national average Medicare anesthesia conversion factor is $21.56. To be equivalent to the 1991 rate, we would have to be at $36.77 today, just based upon inflation alone."

Recognition of value

Ensuring anesthesiologists receive appropriate compensation for their services is vital not only for the specialty, but also for patients and the medical profession as a whole.

"We want physician anesthesiologists to be available to participate in and provide the high level of services often required for these patients," said Neal Cohen, MD, MPH, MS, Professor, Anesthesia and Perioperative Care and Medicine, and Vice Dean, UCSF School of Medicine. "To do this, we need equity with the other physician practices when it comes to how our specialty is valued."

While the 33% Problem has been a concern for a number of years, there are several factors that make addressing it especially important today. These include an aging population and ongoing discussions around health care reform, both of which have an impact on the percentage of patients covered by Medicare.

"If we have any health care reform mechanisms that increase the number of patients covered by government payment models and, payment is based on the same system that is currently in use, it will devastate anesthesia practices," noted Dr. Cohen. "Secondly, if there is a Medicare for All or another public option that results in decreased payment to physicians in general, including anesthesiologists as well as hospitals, all physicians who receive support from hospitals will be affected, including anesthesia practices that receive support from the hospitals to ensure continuous availability of anesthesia services."

Another important consideration is the continued growth of the specialty particularly related to perioperative care. The ongoing success and availability of anesthesiologists depend on recruitment of the next generation of physician anesthesiologists. Recruitment could become a challenge if the work of anesthesiologists is not valued at the appropriate level.

"Anesthesia has to receive appropriate compensation for the quality and type of the work that we do," said Johnathan L. Pregler, MD, member of the ASA Committee on Economics and Chair of the Committee's "33% Problem" Workgroup. "In order to continue to attract talented physicians, we need to remain competitive with other specialties, and to do that our specialty must be valued by Medicare equally with the rest of medicine."

Potential avenues to explore

As a part of the ASA's Economic Strategic Plan Initiative, a working group within the Committee on Economics is spearheading efforts to address the 33% Problem. It began with a comprehensive look at the issue and brainstorming new ways to tackle the problem (*ASA Monitor* 2020;84:28–33).

This review led the Committee to suggest four potential actions to improve the problems related to Medicare payment. One option is to repeat the original study with a broader base of cross linkages to allow for a better comparison with other specialties.

Another avenue is an update of the building block approach to recognize how the practice of anesthesiology has evolved since the original study and subsequent reviews. "We used this building block approach in 2005 to help other physicians

understand anesthesiology and provide a better valuation of what the specialty entails," noted Dr. Troianos.

The building block approach involved breaking an anesthesia service down into discrete components, identifying a comparable service performed by other specialties and then adding up the work Relative Value Units assigned to those benchmark services.

A third potential approach is to quantify the gap between Medicare rates and commercial payments over time, while highlighting how this has impacted anesthesiology more than other services that are paid by the RBRVS system.

The last option under discussion is to adjust the formula for calculating anesthesia payments, so it better aligns with the system used for other specialties. This could be accomplished by creating fractional base units, eliminating the anesthesia time component, or incorporating anesthesia services into RBRVS.

Ongoing commitment

To ensure anesthesiologists are valued appropriately, ASA continues to explore a number of economic issues, including, but not limited to, addressing the 33% Problem. The first step included a detailed review of the problem, how it has evolved, and what has been done so far, noted Sharon Merrick, MS, CCS-P, Director of Payment and Practice Management for ASA.

"The 33% Working Group has now turned its focus to taking a closer look at our options and the various avenues we can explore as a Society," she explained. "We are committed to addressing this issue and making sure anesthesia is valued appropriately."

These efforts include an analysis of the various pathways to payment equity

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Brigham and Women's

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James P. Rathmell, MD

Perioperative and Pain Medicine at Brigham and Women's Hospital, "We went from questioning what we should do with elective surgery on a Friday to completely closing down elective surgery on a Monday, staffing up ICUs, and reducing to 30% of our overall surgical volume very quickly." The hospital's ICU capacity jumped to more than twice its usual patient volume as the COVID-19 surge went on, requiring the hospital's anesthesiology team to care for a high number of very sick patients with limited PPE resources.

With a growing number of critically ill patients and very little information on the disease, the hospital deployed its emergency response team. Dr. Rathmell explained that they adopted the same hospital incident command structure that would be used for a natural emergency or terrorism situation. A pre-determined hierarchy with an emergency medicine physician as the hospital commander worked quickly to coordinate staff to serve in various roles by redistributing staff from their usual positions into roles that were more critical at the time.

Within a matter of days, the anesthesiologists with intensive care experience were redeployed to open additional units while a COVID response team joined in a daily conference to plan shifts and ICU coverage, line and intubation teams, and telemedicine, which grew rapidly. Dr. Rathmell said a large number of recent graduates and young faculty members familiar with working in ICUs volunteered to help.

Despite the robust staffing, it became obvious in the first few weeks of the April 2020 surge that critical care teams were overworked, so the hospital created three different intubation and line placement teams to work around the clock, allowing critical care teams with a usual load of 8-10 patients to safely care for 15-20 patients in the same period of time. In addition, transport teams relieved respiratory therapists who were overwhelmed with the number of ventilators in use and could no longer move patients to imaging.

Meaghan Hurley, BSN, RN, a nurse in the emergency department at Brigham and Women's Hospital, greets arriving patients in an outdoor mass-testing facility during the peak of the COVID-19 pandemic in Boston.

A new approach

As the months went on, clinicians at Brigham and Women's became so well-versed at treating COVID-19 patients that when a second surge took hold of the community in December 2020, the ICUs weren't overwhelmed and, in general, patients weren't as sick. By this time, Dr. Rathmell said the hospital's approach to treatment had changed. "We learned with the rest of the world that early intubation was not the best approach and instead found that people are much more comfortable with using medicines such as dexamethasone early," he explained.

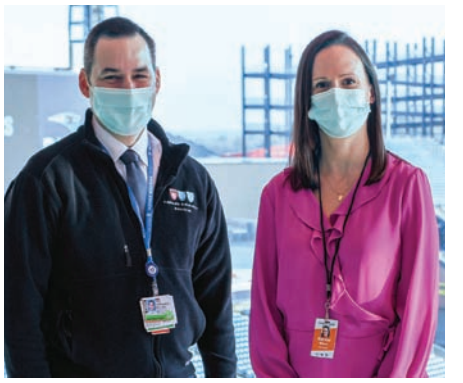
Late in the year, Brigham and Women's COVID-19 program was operating with relative ease. What was once a dramatic shortage of PPE had grown to a healthy supply of resources. Elective surgery returned with some restrictions: patients required a negative COVID-19 test within 48 hours of the surgery and cases were restricted to those that did not require a hospital stay unless postponement would result in probable harm to the patient. Perhaps most important, Brigham and Women's worked closely with other Boston-area hospitals to serve as a transfer destination for other locations that were hit asymmetrically and overwhelmed with patients. Dr. Rathmell explained that comparing notes during the second wave with other hospitals in the health system helped ensure that one location was never overwhelmed by inpatient capacity.

"What was once a dramatic shortage of PPE had grown to a healthy supply of resources."

Community partnership

Over the last year of battling COVID-19, one thing has remained constant: the partnership between Brigham and Women's and the Boston community. "Masks were donated early on," said Dr. Rathmell. "And increased production of N95 has allowed us to now have 90 days of supplies in storage with a robust stockpile of masks, gloves, and surgical gowns." In addition, an outpouring of support from the community allowed the hospital staff to enjoy meals and coffee from local restaurants twice a day for months on end.

In return, the clinicians at Brigham and Women's worked harder than ever to reach out to the community and provide guidance in a time of fear and uncertainty. "People were frightened of coming to the hospital and emergency room, so we stood up mobile testing facilities that went into the community and tested people where they lived," Dr. Rathmell said. "We are working hard to get out into the community to answer questions and reduce hesitancy to take the vaccine so the people of Boston can take advantage of resources such as the mass vaccination site at Gillette Stadium, which can vaccinate as many as 6,000 people a day."



Eric Goralnick, MD, attending physician in emergency medicine at Brigham and Women's Hospital and Incident Commander for the Mass General Brigham Healthcare System, with Rachel Wilson, Chief Operating Officer for CiC (Cambridge Innovation Center) Health. Dr. Goralnick provided medical oversight and CiC Health provided logistical support for Massachusetts' first mass-vaccination site at the New England Patriots' Gillette Stadium in January 2021.

Though the care of COVID-19 patients has stabilized at Brigham and Women's hospital, questions linger about the emergence of disease variants from around the world, such as: Are they more infectious? Are they more deadly? Will the vaccine protect against them? As a slow return to normal lingers on the horizon, with a vaccine promising fewer patients and less severe cases, optimism burns strong. "Like many others," said Dr. Rathmell, "I have some measure of hope that we will find our way through this." ■

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as well as strategies to prevent the 33% Problem from expanding into new payment arrangements. ASA is also committed to creating resources for members to help them discuss this discrepancy and communicate their value effectively.

An additional component of the Economic Strategic Plan Initiative is exploring alternative payment models (APMs). Value-based payment models are another way to help anesthesiologists receive appropriate compensation, and ASA is working to provide tools to help members understand and participate in APMs.

"We are here to advocate for physicians, anesthesia caregivers, and ultimately for patients, to make sure they receive the highest quality anesthesia care that we can provide," concluded Dr. Troianos. ■

Get Involved!

- Participate in the ASA's Annual Conversion Factor Survey. The 2021 survey will launch this June.
- Connect with the public to raise awareness of the important role anesthesiology holds throughout the health care continuum. **www.asahq.org/madeforthismoment**
- Educate yourself on this issue, so you can help others understand the problem.
- Communicate the value of anesthesia — in and out of the OR — with your colleagues in medicine.
- Engage with local lawmakers, and share the **33% Working Group Report**.