The finances of an anesthesia practice are dictated primarily by the payment rates and policies of both government and private payors. In recent years, both government and private insurers have focused on reducing the costs of individual episodes of care as well as the rate of growth in overall health care spending. As a result, the past decade has undoubtedly seemed quite turbulent to many physicians, particularly in comparison to the relative stability of the health care payment system during the two decades prior. Despite a variety of approaches to managing these costs, the containment strategies to date have not been successful. New approaches designed to value health care differently are being implemented. Most of these changes are based primarily on quality and safety rather than cost alone. Many of the alternative payment models require providers and health systems to assume new financial risks. These approaches represent more sophisticated attempts to manage the costs of care, as well as a transition to value-based care. As a result of these shifts, by 2030 the financial framework of the U.S. health care system will be unrecognizable to those who entered practice in late 20th century.

This article will first review some of the past changes in health care payment methodology and policy experienced since the inception of the Medicare program in 1966. We will then describe the likely path for financing health care in general and anesthesia practices in particular over the next decade. The discussion will emphasize the finances of anesthesia practices as they relate to government payors, including Medicare and Medicaid, as well as describe some of the likely changes being implemented by private payors. Some legislators and public advocacy groups have proposed a transition to a single-payor system. However, in the current legislative climate, neither Medicare for All nor any other public option are likely to be implemented in the next few years. Nonetheless, attempts to expand public options based on the Medicare experience make understanding this system essential as we consider what to expect in the future.

**Table 1: Definitions Medicare Used for Customary, Reasonable, and Prevailing**

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customary</td>
<td>Median of a physician's charges for a specific service for a specific time period</td>
</tr>
<tr>
<td>Reasonable</td>
<td>The 90th percentile of all customary charges of physicians in the same peer group (specialty) in a specific locale</td>
</tr>
<tr>
<td>Prevailing</td>
<td>The lower of the actual payment or the customary charge for a particular service in a defined locale</td>
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*Source: Medicare RBRVS: The Physicians’ Guide 2021, American Medical Association*

**Payment methodologies**

While we often think of Medicare as a slow-moving bureaucracy that is resistant to change, intermittent paradigm shifts are nothing new to the Medicare payment system. A careful review demonstrates that each payment system seems to have a defined life cycle of about two decades. For the first 23 years, Medicare payments were based on the charges submitted by providers. Payments to physicians were based on Customary, Reasonable, and Prevailing (CRP) charges. The definitions Medicare used for these terms are presented in Table 1.

A standardized fee-for-service (FFS), Resource-Based Relative Value Scale was used to determine payments for the next 26 years. In the most recent six years, these FFS payments have been adjusted upward or downward based on scoring systems related to quality of care, overall cost of care, care coordination efforts, and the use of information technology by health care providers.

Shortcomings of the CRP system included variation in payment to physicians of different specialties for the same service as well as regional inconsistencies in how Medicare carriers processed and paid claims. When Medicare implemented mechanisms to control the growth of total spending...
under the CRP system, concerns about accuracy and fairness were magnified. This in turn led to the work of William C. Hsiao, PhD, and his team at Harvard, which developed the Resource-Based Relative Value System (RBRVS). The RBRVS was eventually approved as a replacement for the CRP system and was subsequently phased in over a four-year period (1992-1996).

The RBRVS assigned relative value units (RVUs) to each service or procedure as described by a CPT® code. The ultimate cash payment to a physician for a service was then determined by multiplying the number of RVUs by the dollar value of each unit – known as the conversion factor (CF). Over time, there have been many changes to how the CF is determined (Table 2), much of it based on budget neutrality.

In 1989, the CF updates were set based on year-to-year changes in the Medicare Economic Index (MEI) and through comparison to an adjustment metric known as the Medicare Volume Performance Standard (MVPS). In 1997, the Sustainable Growth Rate (SGR) formula replaced the MVPS. While MVPS was based on historical growth in Medicare spending patterns, the SGR looked at projected growth in the nation’s gross domestic product. In 2015, MACRA repealed the flawed SGR formula. MACRA initially imposed a CF freeze for several years, then provided for minimal fixed annual increases. For the first time, MACRA also included bonuses or penalties to be applied to physician payments related to assessments of the value or quality of a physician’s overall care.

In addition to understanding the evolution of the RBRVS system, anesthesiologists must be cognizant of the unique system by which government payments are made for anesthesia care. Anesthesia services are valued using a system related to, but distinct from, the RBRVS used by other specialties. The Anesthesia Relative Value guide continues to be the basis upon which anesthesia services are valued using base units for each specific surgical service plus time. Other non-anesthesia services provided by anesthesiologists are valued based on the RBRVS. Such services include pain medicine and critical care. While the system of anesthesia-specific valuation has served the specialty well overall, payments for anesthesia services under Medicare are undervalued. Since the implementation of the RBRVS, Medicare has paid only a fraction relative to commercial payors for anesthesia services (the “33% Problem”). In addition, the separate system for valuing anesthesia services is confusing to other providers and has made it difficult to compare payments and value with other specialties. The pressure for anesthesiologists and all providers to control the escalating costs of health care has thrown some of these misunderstandings into stark relief. All of these factors will continue to impact anesthesia valuation of services and those services paid under the RBRVS system.

If intermittent change is inevitable, the most pressing question is “what comes next?” There will be technical changes to payment mechanisms in the immediate future as well as continuing refinement of the regulations derived from the MACRA legislation for years to come. However, rather than pondering whether physicians will be using CPT-5 and/or ICD-11 for billing purposes in the future, the forward-thinking practitioner and practice will need to ponder issues bigger and of much broader scope.

There are several obvious looming challenges facing both the house of medicine and the specialty of anesthesiology. The trend toward value-based payments is a rational one from the perspective of improving the quality of care. However, the complexities of the current payment methodologies risk smothering the benefits that could otherwise be accrued. The growth rate for the overall cost of health care in the U.S. continues to be unsustainable. Therefore, this trend will slow or be reversed, either by design or by collapse of the underlying financial structures (the housing crisis of 2008 serves as a relevant exemplar). Finally, consumer dissatisfaction with the health care system remains high and will assume increasing importance as patients are required to take ownership of a growing proportion of their health care spending.

### Table 2: Medicare Conversion Factor Update Methods

<table>
<thead>
<tr>
<th>Payment Based on</th>
<th>Update Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRP</td>
<td>1966-1989</td>
</tr>
<tr>
<td>CF updates</td>
<td>Omnibus Budget Reconciliation Act (OBRA) of 1989</td>
</tr>
<tr>
<td>determined by MVPS</td>
<td></td>
</tr>
<tr>
<td>CF updates</td>
<td>Balanced Budget Act (BBA) of 1997</td>
</tr>
<tr>
<td>determined by SGR</td>
<td></td>
</tr>
<tr>
<td>CF updates</td>
<td>Medicare Access and CHIP Reauthorization Act (MACRA) of 2015</td>
</tr>
<tr>
<td>determined by statutorily set amounts</td>
<td></td>
</tr>
</tbody>
</table>

**Integrated delivery systems**

As a result of these ongoing challenges, by 2030 the financial structures underpinning the health care system will have evolved dramatically. Given the competitive advantages of vertical integration within the health care system, the predominant model will bundle physicians, health care institutions, and insurers under a single corporate entity. We are already witnessing this transition as the majority of physicians are now employed by multidisciplinary medical groups or health systems. This integrated model will create cost efficiencies gained by eliminating resource-intensive but low-value care. Savings will then be shared directly with the clinical care delivery systems. This represents the purest expression of the value-based payment concept but eliminates the present-day complexity required by the marketplace of distinct third-party payors and independent health care entities.

Insurance reform will create larger risk pools on a multi-state and national basis, either through stand-alone insurers or

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through the vertically integrated national health care systems described above. Those insurers who remain independent will have shifted nearly all the financial risk for patient care to health care systems and clinicians. As risk is shifted away from insurance companies and toward health care systems, the former will be viewed less as traditional insurers and more appropriately as financial brokers. These entities will collect premiums and bundle patients into tranches for sale to health care systems, similar to the present-day mortgage market.

**Volume vs. value**

The fundamentals of the payment system for health care services in place today will still be evident in 2030, but the emphasis will have shifted. For the past two decades, health care entities have focused on capturing volume to maintain profitability in the face of shrinking margins. This strategy will eventually reach its limit as payment rates are cut further. By 2030, those health care systems that are thriving will have regained their margins by focusing primarily on cost reduction. This strategy will allow the successful systems to achieve increased profitability while simultaneously reducing the proportion of high-cost services that they provide. A number of strategies used to reduce cost will impact anesthesia practices. Further pressures will be placed on reducing lengths of stay to facilitate earlier discharge. Extended care facilities, home care, and other lower-cost services will be integrated under the health system umbrella. The number of services provided outside of the facility will continue to expand. While some of these changes will provide new opportunities to participate in the continuum of care, anesthesia practices will require innovation and adaptation to most effectively deliver value to patients and their health care systems.

Although fee-for-service payments (payment for process) will continue to be available through payors for limited volumes of their business, the rates will not be attractive. Bundled, episodic, and capitated payments (payment for product) will predominate, shifting risk to those providing clinical care. The benefit of this change in compensation will be to unleash clinical entities, allowing them to innovate as to how health care is delivered. Increasingly, value and profitability will be determined at the level of the physician, hospital, or health care system by delivering quality care at a lower cost.

Fortunately, reducing the cost of care will not require significant reduction in compensation rates for health care professionals, nor a wholesale shift to lower standards of care or quality. Many of the changes over the next decade will be shaped by an acceptance of the need to achieve cost reduction and the idea that this goal is frequently most effectively accomplished by eliminating low-value or futile care. Proactive management of patient populations and care delivery systems will reduce the rates of deteriorating health and complications in high-risk patients. Care will increasingly revolve around data-driven process manage-

**Patient-centric care**

Finally, it is important to note that not only is the relationship between physicians and health systems evolving, but the relationship between patients and these systems is also shifting fundamentally. Patients will have vastly improved access to data about their health status and options and, as a result, have a shared role in managing their care.

To effect this transition, transparent pricing will be a necessity in order for health care entities to attract patients in an increasingly competitive marketplace. The need for accurate pricing will force the restructuring of practice and institutional financial accounting systems. The true cost of health care services will become a central issue for most patients as they are required to assume greater financial risk for out-of-pocket or health savings account payments.

By the year 2030, the public reporting of both outcomes and patient experiences will also become seamless, comprehensible, meaningful, and the basis for a significant proportion of patient choice. To defend their market share, successful physicians and health care systems alike will be required to devote an increasing proportion of their resources to patient education, outreach, and active partnership in health management.

Overall, the patient perception of value (expected health benefit versus cost) will become the primary driver of both physician practice and health care system survival. Consumerism will be on the ascendance within the health care marketplace. Behaviors and expectations will have been reshaped as a result, and the ability to deliver truly patient-centric care will become an existential issue for clinical organizations.

Change is inevitable. Potentially dramatic changes in how health care is financed, and their implications for anesthesia practices, are now accelerating. Given the current challenges confronting the U.S. health care system, this pattern will likely extend well beyond 2030. These changes should not cause undue concern for our specialty provided that anesthesiologists understand the goals and are prepared to address them. Periods of change can present enormous opportunity for those with the time to plan, a vision of what is to come, and the resources necessary to capitalize on unmet needs.

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**Practice Finances**

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