Background

- 17+ years healthcare management experience
- Military, academic, tertiary care, community hospitals
- Focused in surgical/periop/anesthesia service lines
- 9+ Years in anesthesia practice management and quality management

Anesthesia Financials: An Unbalanced Equation

Revenues
- Volume
- Payor: Contracts
- Rev. Cycle Mgt.

Costs
- Labor
- Services
- Operations
- Resources
- SUBSIDY/STIPEND
Anesthesia Contributes to OR Backlog

- 75% of hospitals are experiencing an increase in surgery wait times
- 66% of hospitals are limiting access to operating rooms

Anesthesia Contributes to Lost Surgical Business

- 47% of hospital administrators are reducing or re-directing operating room procedures due to anesthesia staffing issues.

Anesthesia Subsidy

- Anesthesia Costs - Revenues = Subsidy/Stipend
  - 2008 National Anesthesia Subsidy Study (Healthcare Performance Strategies)
    - 3% (112 responses) of U.S. hospitals with > 25 beds
    - Avg. Subsidy per anesthetic location: $140k (Regional Range: $100 - $180k)
    - Total estimated U.S. anesthesia subsidy: > $4.2 Billion (2011: > $5 billion)
  - 2009 MGMA Anesthesia Cost Survey
    - Median hospital stipend (11-30 MDs): $1.5 million
    - 75% hospital stipend: $2.2 million
- Ineffective management of anesthesia staffing, costs and/or revenues can grow and increase a subsidy
Anesthesia Financials: The Balanced Equation

Revenues
- Leadership & Management
- Volume
- Payer Contracts
- Rev. Cycle Mgt.

Costs
- Labor
- Services
- Operations
- Resources
- Subsidy/Stipend

Yes, this matters

For Unto Whomsoever Much is Given...

- Anesthesiologists, CRNAs, Anesthesia Assistants
- Perioperative medical leaders
- Life and death responsibility (liability)
- Hospital/ASC-wide “intensivists”
- Litigious medical specialty

Financial Impact of Anesthesia Malpractice

Figure 4. COMPARISON OF AVERAGE INDEMNITY PAYMENTS BY MEDICAL SPECIALTY (1995-2009) - 2009 DOLLAR VALUES -


Source: 2010 Physicians Insurers Assoc. of America, Risk Management Review
Anesthesia: The Hospital-Wide Intensivists

Anesthesia Labor Options

Independent Care
- Anesthesiologist
- CRNA (opt-out states only)

Care Team
- Physicians direct/supervise CRNAs and/or AA’s

CRNA Independent Practice
- State governors grant CRNA independent practice status
- 2011: 16 “opt-out” states (Colorado is latest in September 2010)
- 2010: CMS ruling: CRNA “independent” practice in all states for labor analgesia (epidurals)
Anesthesia Labor Economics Formula

- **2010 RAND Anesthesia Labor Study** (\> 150p. document)
  - Approx. 40k anesthesiologists and 39k CRNAs practicing in U.S.
    - Employment:
      - 40% MDs and CRNAs work for single group
      - 40% MDs and CRNAs work for facility/hospital
      - 20% work for multi-specialty group or locums/agency
    - Average Worked Hours per Week:
      - MDs: 49hrs. v. CRNAs: 37hrs. (12hr. Shifts)
    - National Demand:
      - 54% states have MD shortage v. 60% CRNA shortage
      - 2009 MD deficit: 3,800 v. CRNA deficit: 1,200
    - 2012-2020 Prediction:
      - CRNA supply will continue to out-pace current demand
      - MD demand will continue to out-pace projected supply

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Show Me the Money

CRNA "base": $189k
Family Practice MD: $173k
- 4th year in a row!
Source: 2009 CNN Money Magazine

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Anesthesia Professional Fee Revenue

- Anesthesia pro fees; mostly paid in Relative Value Units (RVUs)

  The Anesthesia Payment Formula

  ![Anesthesia Payment Formula Diagram](image)

  - Procedure “flat” fees: Invasive Lines, Pain Management, Consults, Intubations
Anesthesia’s Unlevel CMS “Paying” Field

Medicare to Commercial Payer Conversion Factor Ratio

Illustrative Example:
Knee Arthroscopy
Commercial: $1,000
------------------------
Medicare:
Surgeon: $800
Anesthesia: $333

Table 5: Commercial Conversion Factors by Anesthesia Provider Relationship, by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Anesthesia Provider Relationship</th>
<th>Conversion Factor - 2010</th>
<th>Conversion Factor - 2010</th>
<th>2010 Payer</th>
<th>2010 Overall Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>Direct Delegated CRNA</td>
<td>$87.23</td>
<td>$87.07</td>
<td>257</td>
<td>(66.4% to 70.5%)</td>
</tr>
<tr>
<td></td>
<td>Indirect CRNA</td>
<td>$11.20</td>
<td>$17.93</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No-ORNA initials</td>
<td>$66.00</td>
<td>$75.11</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Southern</td>
<td>Direct Delegated CRNA</td>
<td>$44.22</td>
<td>$66.72</td>
<td>254</td>
<td>(66.4% to 84.8%)</td>
</tr>
<tr>
<td></td>
<td>Indirect CRNA</td>
<td>$17.41</td>
<td>$34.13</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No-ORNA initials</td>
<td>$76.39</td>
<td>$63.53</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Western</td>
<td>Direct Delegated CRNA</td>
<td>$52.67</td>
<td>$55.33</td>
<td>18</td>
<td>(60.8% to 61.6%)</td>
</tr>
<tr>
<td></td>
<td>Indirect CRNA</td>
<td>$6.87</td>
<td>$29.00</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No-ORNA initials</td>
<td>$64.70</td>
<td>$60.00</td>
<td>121</td>
<td>(60.8% to 61.8%)</td>
</tr>
<tr>
<td>Westroads</td>
<td>Direct Delegated CRNA</td>
<td>$77.59</td>
<td>$62.41</td>
<td>71</td>
<td>(60.8% to 61.8%)</td>
</tr>
<tr>
<td></td>
<td>Indirect CRNA</td>
<td>$61.91</td>
<td>$61.22</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No-ORNA initials</td>
<td>$62.76</td>
<td>$56.37</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>

Source: ASA Newsletter, Jan 2011, Volume 75, no. 1

Anesthesia Revenue Cycle Management Impacts Subsidy

Accountability
Compliant Documentation
Maximized Payer Contracts
Audits
AR Management
Performance Benchmarking (MGMA)
PQI(US) Participation

Transparency
Anesthesia PQRI(S) “Disincentive”?

• CMS incentive reported on at least 80% of eligible Medicare Claims

• Prophylactic Antibiotics
  - Measure #80
  - Must be reported with a 2nd measure

• Periop. Temperature Management
  - Measure #203
  - Must be reported with a 2nd measure

• Prevention of Catheter BSI's
  - Measure #194
  - Can be reported alone, or with a 2nd measure

2010 CMS Participation Report (based on 2009 data)

• Anesthesia participation: Only 41% of eligible physicians reported measures
• Total PQRI incentive payout: $234 million; anesthesia’s take: $6.7 million
• Average anesthesiologist payment: $836; average CRNA payment: $403

Anesthesia’s “Perfect” Storm

- A “full days work” to earn a “full days wage”
- OR management: convenience (subsidy) vs. efficiency (limited/no subsidy)
- Align staffing with utilization not capacity

Scenario: 7 room OR; staffed by 8 F/T anesthesiologists (all MD model)

Daily Surgical Capacity: 4 rms @ 8hrs, 2 rms @ 10hrs, 1 rm @ 12hrs. = 64hrs.

<table>
<thead>
<tr>
<th>OR Utilization</th>
<th>Daily Surgical Cap (hrs.)</th>
<th>Daily Rooms</th>
<th>Avg. Daily Costs per Room</th>
<th>Anes. Revenue per OR Room</th>
<th>Daily Anes. Staffing Costs per Bwr. OR Room</th>
<th>Daily Profit (Loss)</th>
<th>Est. Annual Profit (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>sample 1</td>
<td>80%</td>
<td>51.2</td>
<td>7</td>
<td>$2,341</td>
<td>$1,758</td>
<td>$583</td>
<td>$128,843</td>
</tr>
<tr>
<td>sample 2</td>
<td>70%</td>
<td>44.8</td>
<td>7</td>
<td>$2,048</td>
<td>$1,758</td>
<td>$250</td>
<td>$64,090</td>
</tr>
<tr>
<td>sample 3</td>
<td>60%</td>
<td>38.4</td>
<td>7</td>
<td>$1,755</td>
<td>$1,758</td>
<td>($5)</td>
<td>($5643)</td>
</tr>
<tr>
<td>sample 4</td>
<td>50%</td>
<td>32.7</td>
<td>7</td>
<td>$1,463</td>
<td>$1,758</td>
<td>($295)</td>
<td>($55,195)</td>
</tr>
</tbody>
</table>

*Anesthesia revenue assumes average 12 units per case x $40/unit (government/commercial blended rate)
*Anesthesia staff costs assume average total compensation of $400k per MD including benefits, insurance, etc.
Anesthesia Care Team (CRNA) Profitable Impact

Scenario: 7 room OR; staffed by 4 F/T anesthesiologists and 6 CRNAs
(+ 2 FTEs vs. all MD model)

Medical Direction:
* 2 MDs directs 6 ea. CRNAs in 6 ORs
* 1 MD works independently in 7th OR
* 1 MD off/post call

Daily Surgical Capacity: 4rms @ 8hrs, 2rms @ 10hrs, 1rm @ 12hrs = 64hrs.

Value: Increased OR turnover and throughput; regional anesthesiology advantages

<table>
<thead>
<tr>
<th>OR Utilization</th>
<th>Daily Surgical &quot;USE&quot; (hrs.)</th>
<th>OR Rooms</th>
<th>Avg. Daily Cases per Room</th>
<th>Anes. Revenue per OR Room</th>
<th>Daily Anes. Staffing Costs per Bmr. OR Room</th>
<th>Daily Profit (Loss)</th>
<th>Est. Annual Profit (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1</td>
<td>80%</td>
<td>51.2</td>
<td>7</td>
<td>$2,341</td>
<td>$1,472</td>
<td>$869</td>
<td>$192,049</td>
</tr>
<tr>
<td>Example 2</td>
<td>70%</td>
<td>44.8</td>
<td>7</td>
<td>4 $2,048</td>
<td>$1,472</td>
<td>$576</td>
<td>$127,296</td>
</tr>
<tr>
<td>Example 3</td>
<td>60%</td>
<td>38.4</td>
<td>7</td>
<td>4 $1,755</td>
<td>$1,472</td>
<td>$283</td>
<td>$62,543</td>
</tr>
<tr>
<td>Example 4</td>
<td>50%</td>
<td>32</td>
<td>7</td>
<td>3 $1,463</td>
<td>$1,472</td>
<td>($9)</td>
<td>($1,989)</td>
</tr>
</tbody>
</table>

*Anesthesiat revenue assumes average 12 units per case x $40/unit (government/commercial blended rate)
*Anesthesia staff costs assume average total compensation of $400k per MD including benefits, insurance, etc.

2009/10 Case Study: Anesthesia Subsidy Reduction

Situation:
• Nationally recognized tertiary care hospital in upper northwest
• Anesthesia clinically o.k. but significant, growing subsidy; R.O.I. ?
• Anesthesia not leading/managing OR’s and providing limited OB services
• Anesthesia lacks quantifiable QA program

Actions:
• Hospital RFP selects Somnia as transparent, accountable solutions partner
• Effective clinical and administrative leadership manage efficient/productive OR’s
• Anesthesia staffing model converted from MD to Care Team model
• Dedicated OB coverage increases labor epidurals by 200% daily
• Comprehensive QA program implemented
• Expert/experienced revenue cycle management improves revenue capture

Financial Result: Subsidy reduced by over $1.5 million in only 18 months

Anesthesia Subsidy Threat / Risk

- OR’s
  - Inefficient OR Schedules
  - Staff Aligned with Capacity, not Utilization
- Call / "Readiness"
  - Limited Revenue Generating Opportunities to offset Costs
- OB
  - Need "good" payer Volumes
  - Need productive Labor Epidural Service
- Out-of-OR
  - Low volumes don't offset dedicated staffing costs
- Pre-Admission Testing
  - Not a separately billable service unless consulted
Anesthesia Operational Finances

**Fiscal Accountability?**

- **Costs**
  - Gases
  - Drugs
  - Supplies
  - Equipment

- **Revenues**
  - Incremental Charging
  - Bundled Charging

---

Anesthesia Quality Impacts Your Bottom Line

Anesthesia QA Program

- Accreditation (Joint Commission)
- CMS

- * IPPS/VBP (5 of 46 clinical measures; HCAHPS)
- * Compliance: Conditions of Participation
- * Publicly reported (HealthGrades; HospitalCompare)

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Anesthesia Satisfaction Impacts Your Bottom Line

- Patient satisfaction overlooked; global pain question (HCAHPS)
- 2011: HCAHPS piloting a surgery/anesthesia specific survey
- Anesthesia "bookends" of surgical care
- Anesthesia focused survey affords clinician "profiling"
- Satisfied patients = satisfied surgeons
- Satisfied surgeons = increased surgical volumes/revenues
**Keys to Optimal Anesthesia Financial Performance**

- Effective clinical and administrative leadership
- Financial management experience and expertise
- Fiscal accountability (staffing and operations)
- Quantified quality (ACO)
- Market / industry expertise
- Transparency (AAO)

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**Anesthesia Financial Considerations**

- What’s my anesthesia value proposition/ROI?
- Do I really know how my anesthesia service performs?
- Is my anesthesia service transparent and accountable?
- Hospital options and decisions impact anesthesia $$$
- What are my options if not satisfied?

---

**Anesthesia Services Options**

- **Keep Current Group**
  - Pros: “devil known”; politics
  - Cons: change not likely

- **Outsourced Management for Current Group**
  - Pros: clinical stability; improved leadership/management; transparency
  - Cons: group disruption/push-back

- **Replace Group**
  - Pros: new sustainable culture; improved leadership/management; transparency and accountability; achieve desired results
  - Cons: politics; brief transition instability
Thank You!
hmorgan@somniainc.com