ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2010

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As promised in 2009, ASA is pleased to offer the commercial conversion factor survey results on an annual basis. What a difference a year makes – implementation of the teaching rule, health reform legislation, and self-serving, unscientific studies! We even were able to have a team effort on this year's analysis thanks to ASA's Health Policy Analyst Loveleen Singh.

Based on the 2010 survey results, the volume-weighted national average commercial conversion factor ranges between $69.36 and $73.89, while the median ranges between $60.77 and $64. As a reminder, the 2009 survey results showed a conversion factor range between $58.99 and $68.92 and the median between $55.02 and $60. The current Medicare conversion factor for anesthesia services is $21.5696.

We analyzed the survey data similar to our 2009 survey methodology. Table 1 provides the overall survey results broken down by reported managed care contract. As with the 2009 survey, we requested that participants submit data on five commercial contracts. Due to the weighted adjustment, we have elected to report data on all five contracts despite some contracts representing a smaller percentage of a practice's commercial business. Table 2 provides additional survey results broken down by region of the country as identified by the Medical Group Management Association (MGMA). These regions are as follows:

- Eastern: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV
- Midwestern: IL, IN, IA, MI, MN, NE, ND, OH, SD, WI
- Southern: AL, AR, FL, GA, KS, KY, LA, MS, MO, OK, SC, TN, TX
- Western: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

Table 1: National Commerical Contracted Anesthesia Conversion Factors, 2010

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5
Mean	69.36	71.94	72.86	73.89	72.98
Low	30.00	32.00	15.00	16.95	33.66
25th Percentile	55.00	55.00	55.00	56.00	56.00
Median	60.77	63.00	63.00	64.00	64.00
75th Percentile	68.31	74.85	73.50	77.00	76.38
High	143.64	150.75	125.00	125.00	125.00
Number of Responses	233	222	207	183	156

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Table 2: Regional Commercial Contracted Anesthesia Conversion Factors, 2010

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5
Eastern	(n=81)	(n=80)	(n=73)	(n=65)	(n=57)
Mean	67.74	64.47	66.93	70.53	67.61
Low	43.80	43.00	15.00	16.95	42.00
25th Percentile	55.00	55.00	55.52	58.41	56.00
Median	64.00	65.00	64.00	65.00	64.00
75th Percentile	75.00	81.00	78.00	82.00	79.75
High	142.50	125.00	125.00	125.00	125.00
Midwestern	(n=31)	(n=29)	(n=28)	(n=24)	(n=20)
Mean	81.74	85.71	86.12	78.28	83.89
Low	35.00	42.00	38.56	33.58	33.66
25th Percentile	56.50	58.00	59.00	57.50	58.44
Median	60.50	63.00	64.50	64.00	63.95
75th Percentile	65.00	75.00	73.75	69.00	68.25
High	129.00	106.00	109.12	100.00	100.00
Southern	(n=86)	(n=81)	(n=76)	(n=66)	(n=54)
Mean	67.02	75.74	75.40	76.45	75.34
Low	30.00	32.00	39.00	42.00	40.00
25th Percentile	50.00	54.55	52.00	53.50	52.13
Median	57.50	62.00	63.00	63.00	60.62
75th Percentile	65.00	69.57	72.00	73.50	73.69
High	100.00	150.75	120.00	117.00	117.00
Western	(n=35)	(n=32)	(n=30)	(n=28)	(n=25)
Mean	62.13	54.67	63.08	69.86	67.51
Low	45.00	36.00	40.00	36.00	39.00
25th Percentile	54.47	54.75	55.25	55.00	58.00
Median	62.00	60.52	58.25	62.34	65.90
75th Percentile	67.00	69.25	67.88	71.25	75.95
High	108.00	94.00	102.00	105.00	101.00

The survey reflects responses from 235 practices in 44 states plus the District of Columbia. Our results in 2009 included 279 practices from 45 states and the District of Columbia.

Methodology

The survey was disseminated beginning May 26, 2010, and responses were accepted through June 30, 2010. In order to comply with the principles established by the Department of Justice and the Federal Trade Commission in their 1996 Statements of Antitrust Enforcement Policy in Health, the survey requested data from respondents that was at least three months old. In order to comply with the Statement, we are only able to provide aggregated data. Since some states did not respond and other states had insufficient response rates, we are unable to provide data on a state level.

We offered the survey electronically again this year through the website **www.surveymonkey.com**. ASA staff

Continued on page 46

Continued from page 45

urged participation through various electronic mail offerings, including ASA committee list servers, "ASAP" (all-member weekly e-newsletter) and "Vital Signs," which is an electronic newsletter sent to all ASA PAC contributors. In addition, ASA is very appreciative of the MGMA Anesthesia Administrators Assembly (AAA) and its postings to its membership intranet promoting the survey. Special thanks to AAA President Steven Comess, MSHA, for his willingness to aid in the response.

The responses to the survey totaled 389 unique practices. However, due to respondents providing incomplete data, we were forced to exclude 154 responses. Of the 154 excluded responses, 124 were excluded because the respondent indicated that they had at least one commercial contract (non-governmental payer) but then failed to provide any data with respect to their conversion factor(s). An additional five responses were excluded because the respondent indicated that the practice did not have any commercial contracts. One response was excluded because the respondent did not indicate the percentage of commercial business each contract represented. We excluded another one response because the responded did not provide practice volume data. Finally, the remaining 23 responses provided information on their commercial contract but were excluded because the respondent failed to identify their state or ZIP code and prevented us from being able to properly categorize them into the appropriate region.

The remaining responses that serve as the basis of this report total 235 practices employing or contracting with 6,144.5 anesthesiologists, 4,571.3 certified registered nurse anesthetists (CRNAs) and 417 anesthesiologist assistants (AAs). The practices also work with an additional 1,670.8 CRNAs and 124.5 AAs for whom the practice does not directly pay compensation (i.e., facility hires or contracts the CRNA or AA). The 235 practices reported on a total of 1,001 managed care contracts. Similar to the 2009 survey analysis, we retained data on all commercial contracts regardless of percentage of business noted since we weighted the conversion factors.

We normalized all contracts with 10- and 12-minute time units to the typical 15-minute time unit using an adjustment factor of 1.26 for 10-minute units and 1.13 for 12-minute units. Similar to the 2009 survey (**http://viewer.zmags.com/publication/d48ed039#/d48ed039/48**), the adjustment factors are calculated as ratios based on the average number of time and base units per case. To make these calculations, we used the national averages published in the MGMA/ASA Cost Survey of Anesthesia Practices: 2009 Report Based on 2008 Data.

We have weight-adjusted all reported conversion factors based on case volume. The intent of the weight-adjustment is to ensure that larger practices with higher case volumes are not treated the same, for the purpose of calculating the overall conversion factor, as a small practice that sees relatively few patients each year.

The weight adjustment is identified through a couple of calculations. First, we multiplied the normalized conversion factor for a particular contract by the number of cases the group reported it perform annually and the percentage of managed care business the contract represents. In a separate calculation, we multiplied the practice's annual case volume by the percentage of managed care business for the contract. The weighted conversion factor is then the sum of the first calculation divided by the second calculation.

In reporting the data, we had to rearrange some of the responses to ensure that Contract 1 reflected the highest percentage of the reported commercial business, Contract 2 reflected the second highest percentage and so on. Thus, when looking at the data, you can see that Contract 1 not only reflects the greatest number of responses (233), but also the highest average percentage of managed care business (32.67 percent). We also reported the number of responses for each contract in both Tables 1 and 2. The intent is to provide the reader with the broadest survey of the available data.

Observations

Here are some of the salient points we found interesting based on our review of the analysis:

- The national average conversion factor increased from a range of $58.99 to $68.92 in 2009 to $69.36 to $73.89 in 2010.
- In general, average conversion factors have increased in the East, Midwest and South, with substantial increases seen in the Midwest.
- The average conversion factors appear to have decreased slightly in the West, but this may be due to the decreased response rate relative to 2009.
- Every region and nearly every contract category had a reported conversion factor high of at least $100. The highest conversion factor reported of $150.75 represents a significant new high for the ASA survey.

Analysis of Opt-Out States

Given a recent pseudoscience paper comparing the cost effectiveness of CRNAs relative to anesthesiologists, we decided to analyze our data comparing opt-out states to non-opt-out states. As a reminder, currently there are 15 states (AK, CA, IA, ID, KS, MN, MT, ND, NE, NH, NM, OR, SD, WA and WI) that have voluntarily opted out of the CMS physician supervision requirements for nurse anesthetists.

We assumed that opt-out states would reflect overall lower conversion factors if CRNAs are truly more cost-effective. However, the results show that opt-out and non-opt-out states have nearly identical conversion factors.

Of the 1,001 commercial contracts reported for this survey, 189 (18.9 percent) came from opt-out states and 812 (81.1 percent) came from non-opt-out states. The median ranges of conversion factors are as follows:

Opt-Out States: $58.75 to $64.45

Non-Opt-Out States: $61 to $64

Considering that Medicare pays the same rate for anesthesia services regardless of whether an anesthesiologist or CRNA provides the care, and given that our survey data indicate that commercial carriers may not be distinguishing in contracted payment rates either, it is a disservice to our patients, the public and policymakers for the AANA to suggest that CRNAs are more cost-effective.

Conclusions

Given that, in general, anesthesiologists continue to be able to increase their contracted commercial conversion factors, coupled with the modest increases in the Medicare conversion factor, this demonstrates that our abysmally low Medicare conversion factor is being subsidized by the commercial payers. However, with the passage of health reform legislation and challenging times ahead for everyone, including commercial payers, whether this trend will continue is anyone's guess. ASA will continue to monitor with our annual commercial conversion factor survey and we hope you will participate in 2011.