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Statement of The New York State Society of Anesthesiologists
At the Joint Hearing of the Senate Standing Committee on Finance
&
Assembly Standing Committee on Ways and Means
Concerning the SFY 2020-21 Executive Budget Proposal
Relating to Health
Albany, NY
1/28/2020

Chairwoman Krueger, Chairwoman Weinstein, Assemblyman Gottfried, Senator Rivera we are submitting testimony as part of the formal record of the Joint Legislative Hearing on the 2020-21 Legislative Budget Proposal.

The Executive Budget estimates a $2.5 billion Medicaid Gap and proposes a Medicaid Redesign Task Force develop a plan to address the Medicaid Deficit. We are presenting testimony here consistent with the Governor's message to ensure there will be zero impact on the anesthesia care for Medicaid recipients. We reject a two-tier system of anesthesia care, and we are concerned that the redesign of Medicaid in New York state may lead to the following situation: one tier for the poor and disabled wherein the physician anesthesiologist is eliminated as the anesthesia care provider or direct supervisor of a nurse anesthetist, and another tier for everyone else with the physician anesthesiologist as the anesthesia care provider or supervisor. We do not support any fiscal or policy proposal that would sacrifice patient safety, especially when it is likely to have an unequal impact on our most vulnerable patients. On the basis of education and training, physicians are the most capable

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health care professionals for providing rapid diagnoses and decisive actions when adverse events arise during the perioperative period.

Past proposals to weaken the supervisory link between physicians and nurse anesthetists have been repeatedly defeated in both houses of the New York State Legislature as well as by the Obama Administration in Washington D.C. before the Veteran's Health Administration.

In addition to the patient safety and justice concerns, we want to submit facts that demonstrate that weakening immediate physician supervision of nurse anesthetists will not result in savings for Medicaid.

Medicaid Rates

First and foremost, it is important to understand that Medicaid pays just 13% of what private insurers pay for anesthesia services, and Medicare pays approximately 30% of what private insurance pays. In comparison, other medical and surgical specialties average approximately 85% of what private insurance pays according to CMS information.

Conversion Factor RATES

Medicaid pays $10 per unit
Medicare pays $22 per unit
Commercial pays $75 per unit

Anesthesia Billings

An anesthesia bill for services provided by a Physician Anesthesiologist (Medical Doctor) and/or a nurse anesthetist, is broken into three parts. Each part is assigned a unit value. Base units are assigned based on the complexity of the procedure, followed by Time units, and Modifier base units for additional procedures performed (i.e. postoperative nerve block). 42 CFR 414.46 is the federal payment rule for anesthesiologists, which states that if a case is performed solely by the anesthesiologist, the reimbursement is total base units plus time units multiplied by a conversion factor (the "Physician Fee Schedule Amount"). That regulation also states that if the anesthesiologist medically directs a

nurse anesthetist, the anesthesiologist receives 50% of the Physician Fee Schedule Amount, and the nurse anesthetist receives 50%. **So, whether performed solely by a physician anesthesiologist, or while the physician anesthesiologist is medically directing a nurse anesthetist, the fee paid by Medicaid in New York State is $10.00 per unit.**

In addition, federal regulation 42 CFR 414.60 which governs nurse anesthetist reimbursement contains the same reimbursement language. In cases supervised by a physician anesthesiologist, the nurse anesthetist receives 50% of the unit rate and the anesthesiologist receives the other 50% of the unit rate. Nurse anesthesia rates are based on the amount paid to a physician for a service, thus reimbursement is set to the anesthesia unit rate. This mean that any arguments based on type of anesthesia provider would result in a state discount under Medicaid are **incorrect**. The federal regulation also makes provisions for those state's that allow a nurse anesthetist to perform a case without a direct physician supervisor. In those situations, the nurse anesthetist is paid the same fee as a physician anesthesiologist would be paid if they were performing the case alone.

So again, whether an anesthesia service is performed solely by a physician anesthesiologist, or by a physician anesthesiologist medically directing a nurse anesthetist, or performed solely by a nurse anesthetist, the net fee is the same pursuant to federal regulation.

Also, we would note here that the rate of payment for the anesthesia team under Medicaid is abysmally low in New York State relative to other payors and other state's rates of payment.

As detailed below, under no circumstances will physician anesthesiologist anesthesia services cost more than nurse anesthetist anesthesia services under the Medicaid system. In fact, a recent study found that "surgery procedures with nurse anesthesia providers working without physician supervision have worse surgery outcomes in terms of

complications requiring additional treatment. Clearly surgical procedures with these complications are likely to entail higher overall costs than procedures without complications." (Health Economics Review: 2017; 7:10. Published Feb. 27, 2017)

We have detailed below anesthesia care from Pre-Op Evaluation to Post-Operative Care to further demonstrate the savings physician-led anesthesia care provides to Medicaid together with some billing examples.

PRE-OP EVALUATION

An anesthesiologist, since he/she is a physician, can medically assess the patient and determine if specialized medical consultation is required. In most of the cases, the anesthesiologist performs the physical exam, interprets blood gases, evaluates pulmonary function tests, and examines laboratory data at no additional charge to the patient or Medicaid.

PERI-OPERATIVE MANAGEMENT

When anesthesia is delivered by a physician directed anesthesia care team or physician administered anesthetic plan, a patient's medical condition during an operation is constantly monitored and treated by a physician. Should a problem with cardiac, pulmonary, hepatic, neurologic, or renal function develop, appropriate diagnosis and treatment can be instituted promptly by the anesthesiologist. Anesthesiologists are specially trained physicians and have medical training in all those areas (residency is longer than internal medicine, pediatrics, and family practice). During the operation, a patient has the services of a fully qualified anesthesiologist and the need for intra-operative specialty consultation is reduced. This is provided at the standard Medicaid anesthesia reimbursement rate. The additional skills and services that are provided by the anesthesiologists are compensated by Medicaid at the same level as independent nurse anesthesia services.

PERI-OPERATIVE MONITORING

Occasionally, it becomes necessary to insert invasive monitors in a patient in the peri-operative period. If an anesthesiologist does this, he/she will only charge for the procedure of placing the monitor. Most nurse anesthetists are untrained in the insertion of Swan-Ganz catheters and have varying degrees of experience with other monitoring modalities. Using these state of the art technologies would require the use of another physician who, in addition to charging for the procedure, will charge for medical consultation to decide for him/herself if the procedure is medically indicated. If invasive monitors are placed, the monitoring of those lines will be performed by a physician with experience and training in the interpretation of that data such as an anesthesiologist at no extra Medicaid fee. Therefore, the monitoring is more likely to be used to the benefit of the patient. Monitoring of these invasive physiologic hemodynamics intraoperatively is not compensated by Medicaid when provided by the anesthesiologist. Another physician providing this monitoring service would be compensated by Medicaid if the anesthesia service was performed solely by a nurse anesthetist, therefore costing additional Medicaid dollars.

POST OPERATIVE CARE

In the recovery room, the diagnosis and treatment of pain, nausea, vomiting, blood pressure instability, and chest pain can be complex. Most of these services are provided at no extra charge to the patient in the recovery room by the anesthesiologist. No one would expect a nurse to diagnose chest pain as a heart attack or just muscle aches, therefore, a medical consultation would have to be obtained at additional expense to the Medicaid system.

CONCLUSION

This clearly demonstrates that **physician anesthesiologist administered and/or directed anesthesia services will NOT cost Medicaid more dollars than sole nurse anesthetist anesthesia services. It also clearly demonstrates in many cases that the involvement of a physician anesthesiologist in the anesthesia services provided will result in it**

will cost substantially less, than if a sole nurse anesthetist provided the anesthesia services. Therefore, the patient and Medicaid both benefit significantly in value, quality, and cost of care when physician anesthesiologists are directly involved in anesthesia care.

BILLING EXAMPLES

SERVICES PROVIDED by an ANESTHESIOLOGIST:
Colon Resection

Pre-operative physician evaluation of the patient's ability to tolerate anesthesia:	No Additional Charge
Arterial blood gas interpreted pre-operatively:	No Additional Charge
Anesthesia (90 minutes) 6 units + 6 units = 12 units at $10 per unit:	$120
Treatment of intra-operative cardiac failure:	No Additional Charge
Placement of appropriate monitors and continual physician monitoring:	No Additional Charge
Ventilator set-up and physician management in weaning the patient in the recovery room:	No Additional Charge

TOTAL CHARGE: $120

SERVICES PROVIDED by an INDEPENDENT NURSE ANESTHETIST: Colon Resection (complexity = 6 base units)

Pre-operative nursing evaluation of the patient's ability to tolerate anesthesia:	No Additional Charge
Arterial blood gas interpreted pre-operatively by physician who performed pre-op evaluation:	Charge by internist to Medicaid for blood gas interpretation
Anesthesia (90 minutes) 6 base units + 6 time units = 12 total units at $10 per unit:	$120
Treatment of intra-operative cardiac	Cardiology fee for complex

failure requiring medical management. Emergency cardiology consultation called:	visit intra-operatively billed to Medicaid
Placement of appropriate monitors and continual physician monitoring:	Usual fees charged by cardiologist for insertion and monitoring critically ill patients
Ventilator set-up and physician management in weaning the patient in the recovery room:	The physician providing this sick patient with ventilator and hemodynamic interventions will bill Medicare for prolonged intensive care visits.

CHARGE: $120 FOR ANESTHESIA SERVICES ONLY

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Other physician charges for procedures, monitoring, and consultation will add hundreds of dollars to the Medicaid charges that will not be identified as anesthesia services if the anesthesia is performed by a sole nurse anesthetist. These additional charges will be billed as medical or surgical services, and inflate the cost of this bill to Medicaid.