Anesthesiology Practice Costs, Revenues and Production Survey Data

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ASA and the Medical Group Management Association (MGMA) collaborate on an annual survey of anesthesiology practices, collecting data on revenues, costs, production and staffing. The 2006 Cost Survey for Anesthesia Practices Report (Based on 2005 Data) is an important reference tool. It is available to ASA members at the MGMA "Affiliate" discount rate through www.ASAhq.org/news/mgmacostsurvey.htm. Practices that participated in the 2006 survey have received complimentary copies of the Report — as will all practices that complete the 2007 survey forms that have just been mailed this month and are posted on the "Practice Management" page at www.ASAhq.org. To help you decide whether *purchasing* and *participating* will be of value to your group, an explanation of the data in the 2006 Report follows.

Key Findings

The Report's authors observe that the increase in the number of operating rooms (O.R.s) that groups are being asked to staff — as well as imaging and endoscopy suites, cardiac cath labs and other hospital anesthetizing locations outside of the O.R. — has caused a decline in net medical revenues. Between 2004 and 2006, the annual number of cases per anesthetizing location dropped by about 8 percent, from 1,096 to 1,013. Net medical revenue per full-time equivalent (FTE) physician declined by more than 11 percent, from $559,524 to $495,766.

Hospital compensation for anesthesiologists' services — usually if imperfectly called "stipends," which hints at unearned payments — is now very common. Seventy-eight (78.08) percent of responding practices reported that they received stipends from at least one hospital. Another 20 percent of respondents were compensated by three, four or five of the hospitals their groups covered. Of those responding to the survey question on the dollar amount of stipends, 25 percent reported receiving amounts exceeding $1 million from at least one hospital. Without compensation from the hospitals, many groups would be operating in the red. Across anesthesiology practices, total costs exceed total net revenues by $20,000. (The standard deviation is nearly five times that figure, however.)

The study authors also point out that the data indicate that smaller practices consisting of 10 or fewer anesthesiologists bill considerably higher total numbers of units, per FTE physician (17,792), than do larger groups — almost twice as many. One reason is the higher ratio of nurse anesthetists in smaller practices.

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Using the Data to Benchmark Your Practice

It is important to note that the statistics vary considerably with the size of the practice, payer mix, use of the care team model and the number of trauma centers covered, among other factors. Unadjusted averages or medians paint a general picture of the specialty. To benchmark your own practice, you will need the statistics for groups of your own size and situation.

For example if there are 22 FTE anesthesiologists, the appropriate benchmark for the cost of employed nurse anesthetists would probably be closer to the median for groups of 11-30 anesthesiologists ($162,951) than the median for practices of all sizes ($148,247). There might alternatively be reasons why the 90th percentile would be the better benchmark: perhaps the group's net fee-for-service medical revenues are at the 90th percentile, $85.43, rather than at the median level of $35.96. The Report does not contain geographic breakdowns, but if the practice is in New York City, higher revenues and higher costs would be expected.

Where median values appear similar across the various group sizes, those values may inspire the greatest confidence. The median number of FTE anesthesiologists needed to generate 10,000 ASA units (base + time + modifying units) is broken down by group size:

10 or fewer FTE physicians:	.54
11-30	.80
31 or more	.87
All	.80

Thus a 22-FTE group that produced 275,000 units in a

year would be right at the median. If instead it produced 366,667 units, it would be using only .60 FTEs per 10,000 units. In other words, it would be one-third more productive than a same-sized group producing 275,000 units. The fact that the medians for all but the groups with fewer than 10 anesthesiologists cluster around .80 tends to validate this figure, especially when we already know that smaller groups make greater use of nurse anesthetists, thus boosting productivity.

Customizing Information Through Many New Data Cuts and Cross-Tabs

The 2006 Report is organized into multiple sections so as to display information that will be meaningful for your particular practice. For the first time, pain medicine practices appear separately from "anesthesia-only" practices, which provide a minimum of pain management services. Pain medicine operating costs such as personnel, drug, equipment and building expenses are far more similar to the expenses of other office-based specialties than they are to those of the traditional anesthesiology group. The median total support staff costs per FTE physician in an anesthesia-only practice are $15,725, in contrast to a median of $86,042 for pain medicine practices. On the production side, there are tables showing the numbers of evaluation and management services, nerve blocks and other procedures performed by physician, by provider, by the number of pain facilities staffed and as a percent of total medical revenues.

Data for anesthesia-only practices are subdivided into sets of tables for groups with one to 10, 11-30 and 31 or more FTE anesthesiologists; for groups by care team staffing levels; by payer mix; and by number of trauma centers served, level of nurse anesthetist and anesthesiologist assistant staffing and for academic practices. To permit credible comparisons, the tables contain not just absolute dollar or FTE values but include normalizing information showing values per FTE physician, per anesthetizing location, per unit billed and as a percent of total medical revenues.

For these diverse practices, the best approximation of anesthesiologist compensation, median total physician cost (including benefits) per FTE physician, is as follows:

10 or fewer FTE physicians	$383,882
11-30	$389,572
31 or more	$381,230
One or more nurse anesthetist or anesthesiologist assistant per physician	$399,354
50 percent or more government payer	$375,669
One or more trauma centers	$414,704
Academic	$308,067

It should be obvious that most users will need to look at several tables in order to draw conclusions about the most accurate benchmark levels for groups of their size, staffing model, payer mix and other variations. The wealth of cross-tabs facilitates true comparisons. In addition to the statistics cited above, the 2006 Cost Survey Report contains data on ASA units per anesthesiologist, revenues per unit, revenues and costs per anesthetizing location — and much more.

Conclusion

The MGMA-ASA Cost Survey of Anesthesia Practices: 2006 Report (Based on 2005 Data) is a source of management information that may be critical to your hospital and managed care negotiations. The survey data come from more than 224 practices, a 36.19-percent response rate, in a broad geographic distribution. Payers and consultants increasingly rely on MGMA reports, including this one, which represents many hours of work by anesthesiologists, administrators and staff of the two associations. The Cost Survey also represents many hours of effort on the part of anesthesiology practice staff. ASA is pleased to acknowledge this important contribution through the offer of complimentary copies of the report. We encourage you to participate in the new Survey that, together with MGMA, we launch this month.

In Memoriam: Thomas A. Hurrell

The anesthesiology community in Illinois and around the country lost a valued friend and practice management expert upon the untimely death of Tom Hurrell on January 20, 2007. Tom managed a number of anesthesiology groups and was a member of the MGMA Anesthesia Administration Assembly for 22 of his 48 years. Many, many of us will remember and miss Tom's sagacity, insight, energy, devotion to his family and his wonderful sense of humor. Our deepest sympathies go to Tom's wife and three children, for whom a memorial fund has been established Contributions may be made to the Thomas A. Hurrell Memorial Fund and mailed to Holy Angels Church, 180 South Russell Ave., Aurora, IL 60506; telephone (630) 897-1194.