ASA: Working for You

Patrick Giam, MD, FASA | Speaker, House of Delegates

July 16, 2022

American Society of Anesthesiologists®

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Disclosures & Objectives

- Nothing to disclose

- Objectives: Participants will learn
  - How ASA is working nationally and in the states to address current challenges
  - Key trends facing the specialty in the marketplace, legislative, and regulatory arenas
  - ASA's increased focus on delivering value for members

Special "Thank you" to...

ASA Director & Alternate Director

Timothy N. Beeson, MD
Director, Georgia Society of Anesthesiologists

Matthew Klopman, MD, FASA
Alternate Director, Georgia Society of Anesthesiologists

ASA Past Presidents

1999 – John B. Neeld, Jr., MD, FACA
1970 – John E. Steinhaus, MD, FACA
1965 – Perry P. Volpitto, MD

Anesthesiologists of Note

Michelle Au, MD, Georgia State Senator

Steve Sween, MD, FASA
Former ASA Speaker of the HOD

ASA Committee Chair

Grant C. Lynde, MD, MBA, Chair,
Committee on Quality Management & Departmental Administration

Special "Thank you" to...

State Component Officers

Julius Hamilton, MD, President

Keith Johnson, MD, FASA, President-Elect

Korrin Scott Ford, MD, FASA, Vice President

Rachel Steckelberg, MD, Secretary/Treasurer

Jennifer Scaljon, MD, Immediate Past President

We are ASA: Leaders in Patient Safety

Mission: Advancing the practice and securing the future

Vision: A world leader improving health through innovation in quality and safety

Values: Patient safety, physician-led care and scientific discovery

Strategic Pillars

1. Advocacy
2. Quality & Practice Advancement
3. Educational Resources
4. Member Growth & Experience
5. Leadership & Professional Development
6. Scientific Discovery
7. Financial Performance and Operational Excellence

Membership

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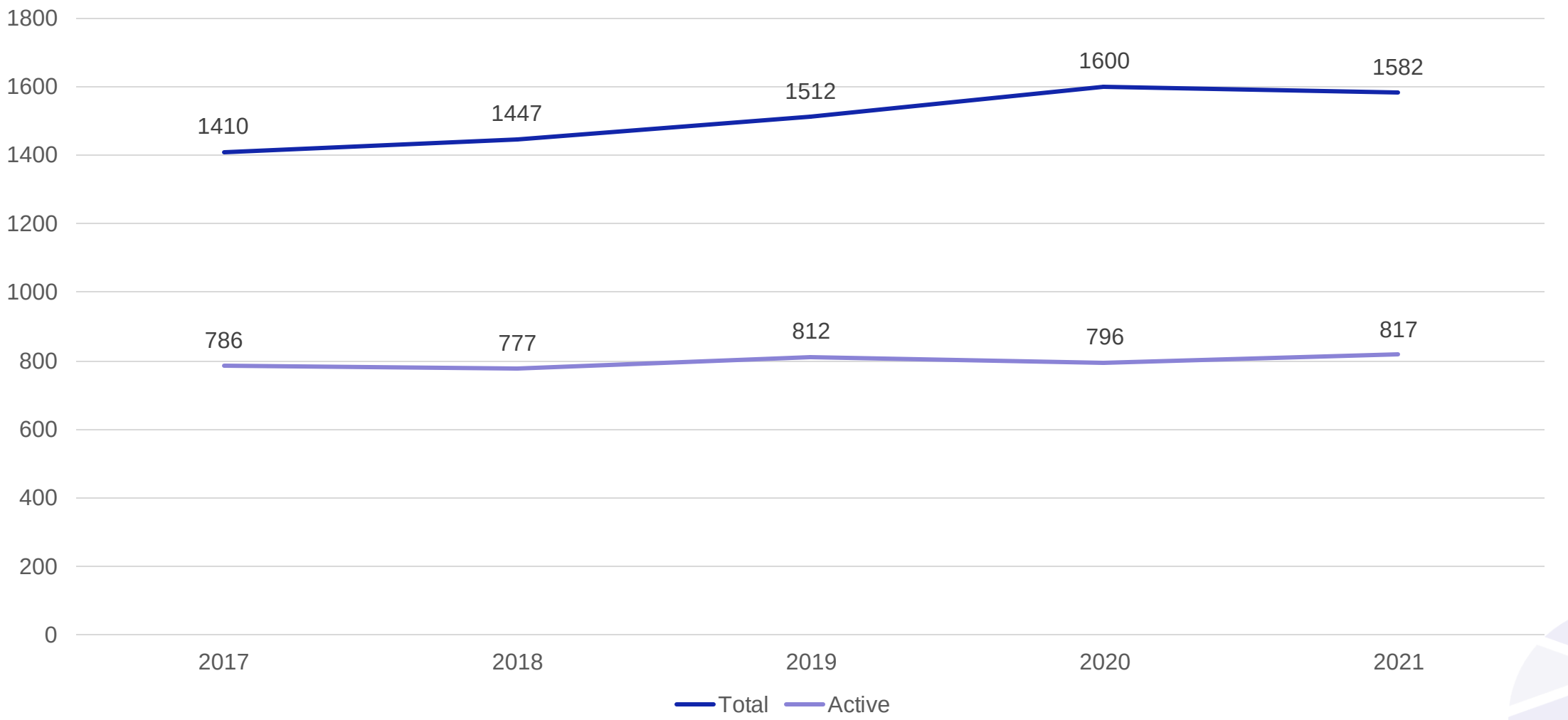
Georgia Society 5-Year Member Count Trend



ASA Focus: Strengthen State Component Engagement

- Focused attention to strengthen relationships with components - Component and Intersociety Relations department
- Improved data sharing and access
- Toolkit and resource library for components
- Open Forums for component leadership and staff on relevant topics such as:
  - Membership Renewal and Recruitment
  - Resident and Early Career Engagement
  - Diversity, equity and inclusion issues
- 48 State Components participate in Unified Dues Billing Program for 2023

ASA Tools for Support! State Component Member Recruitment & Renewal Aids

Themes and messaging reinforce ASA+YOU membership campaign, highlighting ASA & state components partnership for every career stage:

- Recruitment/renewal postcards
- Communications calendar with ASA's outreach efforts
- Data to identify/target potential & renewing members
- Customizable email templates

New Early Career Membership Program

- Targets graduating residents and fellows
- Offers simplified no-fuss, highly discounted, three-year membership in ASA
- Wealth of educational and professional development resources designed for the newly minted anesthesiologist

ASAPAC Update

American Society of Anesthesiologists®

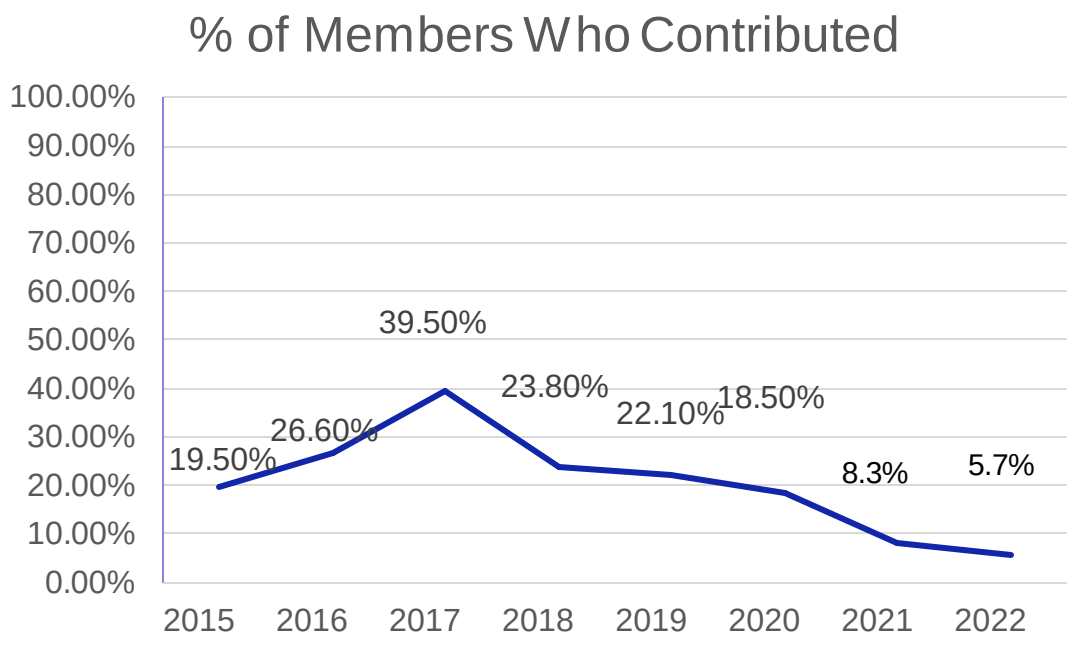
Why Contribute? Our Dollars Make a Real Difference

The power of unity and combined resources!

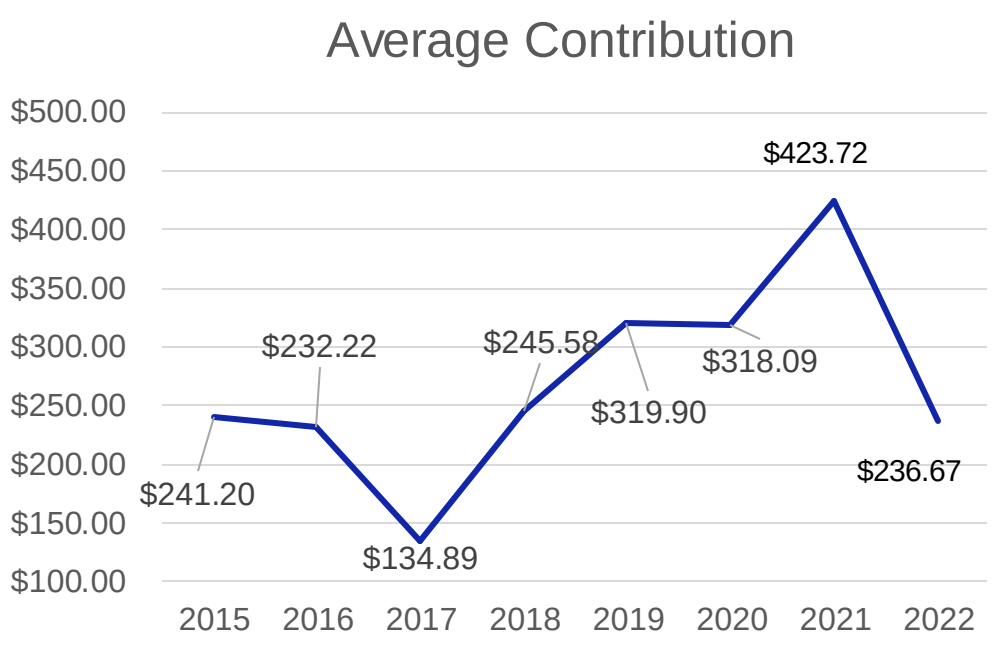
Important at the federal and state level
Powerful tool in ASA's Advocacy for:

- Economically sound practices
- Patient safety and quality of care
- Physician-led, team-based care
- Scientific discovery
- Support for the next generation of anesthesiologists

ASAPAC Activity by Georgia Members



ASAPAC's Fiscal Year 2022 national average participation rate is 4.1%
(Fiscal Year 2022 is October 1, 2021 – September 30, 2022)



ASAPAC's Fiscal Year 2021 national average contribution is $367.12.
(Fiscal Year 2022 is October 1, 2021 – September 30, 2022)

FY 2021 Residency Programs at 100%

- Cleveland Clinic Florida
- Mount Sinai
- Tulane University
- Medical College of Wisconsin
- Mayo Clinic Arizona
- Baylor Scott and White
- Lahey Clinic
- University of Colorado

As a reminder, ASAPAC Fiscal Year 2022 began on October 1, 2021, and ends on September 30, 2022. Encourage your colleagues today to achieve 100% ASAPAC Participation! Once you believe your residency program has reached 100%, contact ASAPAC at ASAPAC@asahq.org to confirm.

ASAPAC is #1 for 2021

Organization	Dollar Amount
American Society Of Anesthesiologists PAC	$2,411,905
American Association of Orthopaedic Surgeons	$1,829,948
American Dental Association	$1,560,000
American College of Emergency Physicians PAC	$869,635
American College of Dermatology PAC (SKINPAC)	$752,000
American Academy of Ophthalmology	$657,521
American Association of Oral Maxillofacial Surgeons	$381,087
American Academy of Family Physicians	$345,438
American College of Cardiology	$345,019

American Medical Association $1,617,198.05

Advocacy Update

American Society of Anesthesiologists®

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Key Advocacy Initiatives

- State Advocacy
  - Medicare Supervision Rule "opt-outs”
- Federal Advocacy
  - REDI act
  - Medicare payment
  - SafeVACare
  - Surprise Medical Bills
    - No Surprises Act Implementation

2022 State Advocacy Activity

- Nurse anesthetist physician supervision initiatives (10)
- APRN Compact (2)
- State society medical title misappropriation initiatives (5)
- State society anesthesiologist assistant licensure initiatives (4)
- AA practice / supervision ratio modifications (2)

Medicare Supervision Opt-Outs

- Medicare Supervision Rule
  - Trump-era waiver expires at end of Public Health Emergency (PHE)
    - Potential subject of rule-making
  - ASA has initiated discussions with HHS and CMS
    - Office of the HHS Secretary
    - Office of the CMS Administrator
- State Opt-out Risks

ASA Support for State Advocacy

ASA partnership with state components

- ASA financial support
- In-kind support
  - Strategic
  - Professional legal
  - Legislative
  - Grassroot
  - Public Relations and Communications

REDI ACT

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Medicare Payment

- Two Separate Problems

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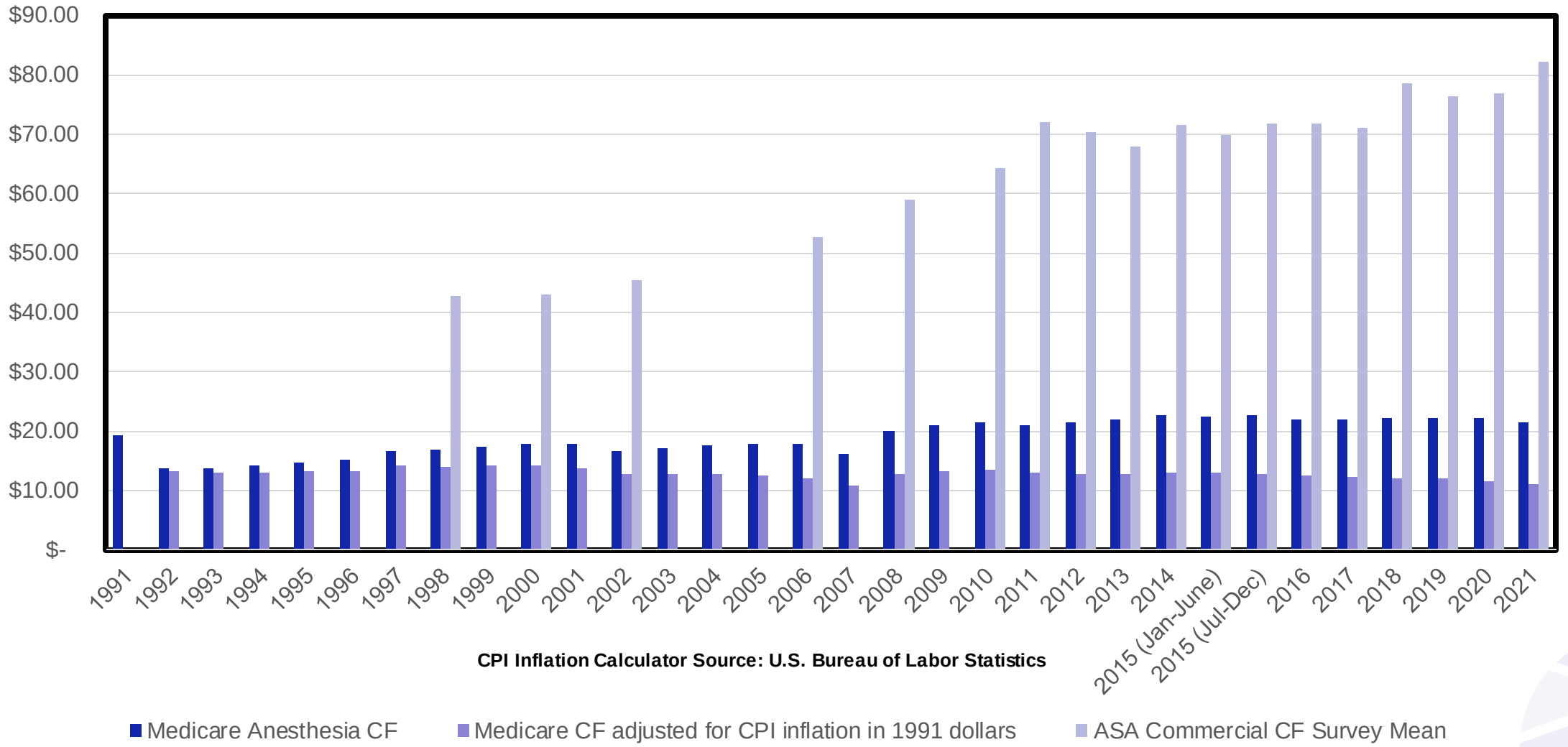
Medicare Conversion Factor – With and Without Inflation Adjustments and Commercial Anesthesia Conversion Factor



Medicare Cuts for 2022

- Congressional action reduced cuts from -9.75% to -2.75%
- Relief only for 2022
- Cuts "turn back on" January 1, 2023

	Projected Cuts Prior to Congressional Action	S.610, Protecting Medicare and American Farmers from Sequester Cuts Act		
Time period	Jan–Dec 2022	**Phase 1 Cuts** Jan–March 2022	**Phase 2 Cuts** April–June 2022	**Phase 3 Cuts** July–Dec 2022
Medicare Physician Conversion Factor (CF)	**-3.75%**	-0.75% (Jan–Dec 2022)		
Medicare Sequestration	**-2%**	0%	-1%	-2%
PAYGO Sequestration	**-4%**	0% (Jan–Dec 2022)		
TOTAL Cuts	**-9.75%**	**- 0.75%**	**- 1.75%**	**- 2.75%**

Medicare Payment System is Broken

2022 LEGISLATIVE CONFERENCE

- Congress needs to act to prevent the 9% cut effective January 1, 2023.
- Congress is urged to hold hearings to identify reforms…inclusion of a Medicare fee schedule annual inflation adjustment and significant reforms to the "budget neutrality" requirement should be among the first reforms considered and advanced.

American Society of Anesthesiologists

Medicare Payments for Physician Services are Broken

Reforms are Needed to Stabilize the Medicare Physician Payment System

ISSUE

The Medicare physician payment system is broken and represents a threat to the viability of many physician practices. Cuts to Medicare physician payments can cause harm to patient access, especially in underserved communities, will drive increases in economically inefficient cost-shifting in the health care marketplace, and ultimately will decrease the availability of some anesthesiology services.

BACKGROUND

As a result of Congressional and regulatory actions, Medicare payments now lack any basis in the actual cost of providing services and are drastically insufficient.

According to the Medicare Payment Advisory Commission (MedPAC), overall Medicare physician payment rates, on average, represent approximately 80% of commercial payment rates. However, there is significant variability among rates for different physician specialties with some specialties' Medicare rates far less than the MedPAC average. Medicare rates for anesthesia services represent less than a third of commercial insurance payments for the same services, according to a recent study by the Government Accountability Office (GAO).

Commercial insurer payment rates have historically been tied to negotiation with payer, relevant local-market forces, and the actual cost of physician professional services. In contrast, Medicare rates are determined by statutes and regulation. For example:

- Depending on who is being paid, Medicare payment as a percentage of the cost of providing the service is highly variable. The American Hospital Association (AHA) reports that hospitals receive, on average, 84 cents for every dollar of care delivered for Medicare recipients. By comparison, anesthesiology payments are now an unacceptably small fraction of the actual cost to provide the professional service, far less than what hospitals and other physician specialties receive.
- Annual updates to the Medicare formulas used for setting payments for physicians, along with sequester and pay-go requirements, consistently result in payment freezes or reductions.
  - April 1, 2022, marked the start of a Medicare physician payment cut of 1%.
  - Effective July 1, 2022, payments will be cut by 2%.
  - January 1, 2023, the cut will increase to 9%.
- Unlike other parts of the Medicare payment system, Congress has included no inflation adjustment or other mechanism in the Medicare physician payment formula to reflect the increasing costs of providing services. Adjusted for inflation, Medicare payments to anesthesiologists are about half of what they were in 1991.
- Under a "Hunger Games"-type mechanism built into the physician payment formula known as "budget neutrality," the Center for Medicare and Medicaid Services' (CMS) decisions to increase payments for certain Medicare services are paid for by cuts to other services. As a result of these and other policies, Medicare rates have consistently undervalued physicians' services. The problem is increasing in severity. Rates are unsustainable for many practices – especially within anesthesiology.

REQUESTS

- Congress needs to act to prevent the 9% cut effective January 1, 2023.
- Congress is urged to hold hearings to identify reforms to the Medicare payment system that will ensure the program works for patients, supports timely access to care, and allows physicians to maintain sustainable practices that can invest in quality improvement and patient safety initiatives. The inclusion of a Medicare fee schedule annual inflation adjustment and significant reforms to the "budget neutrality" requirement should be among the first reforms considered and advanced.

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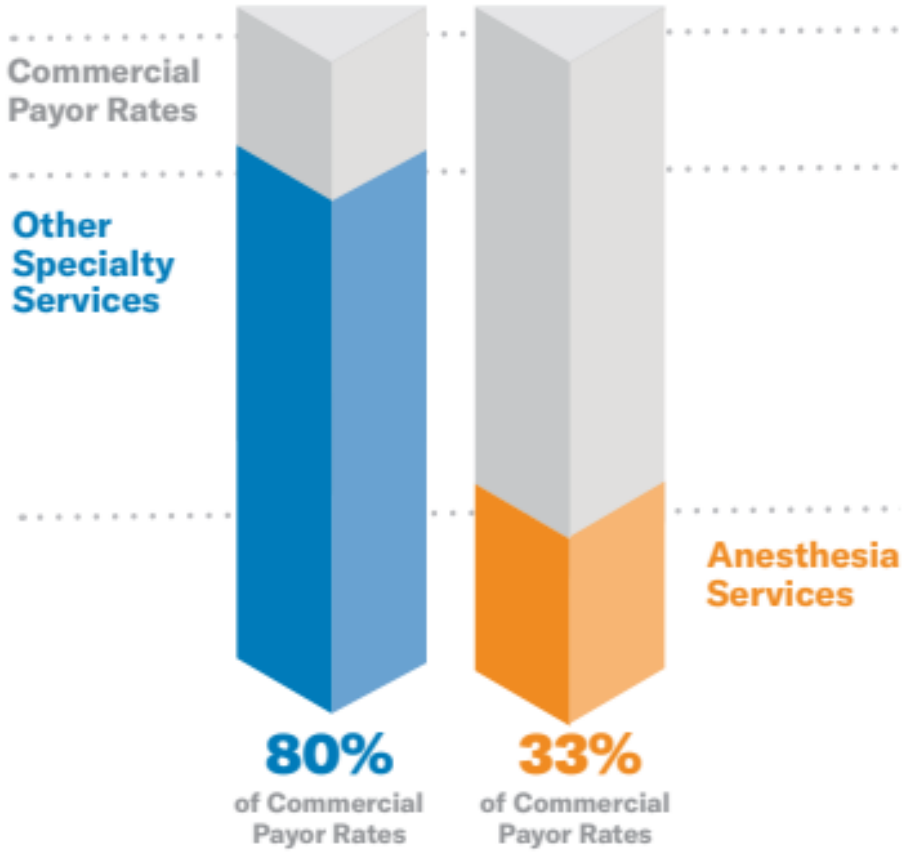
ASA Joined with Medicare Reform Coalitions

- AMA Medicare Reform Workgroup – medical specialty groups and state medical organizations
- Surgical Care Coalition – American College of Surgeons (ACS) and nation's surgical organizations
  - vs. primary care organizations
  - Policy development
  - Focus group – messaging
  - Public engagement
  - Congressional engagement

33% Problem

- Medicare payments for anesthesia services are less than one-third of commercial payments
- MEDPAC report that on average Medicare payments for other medical specialties are 75-80% of commercial insurance payment rates

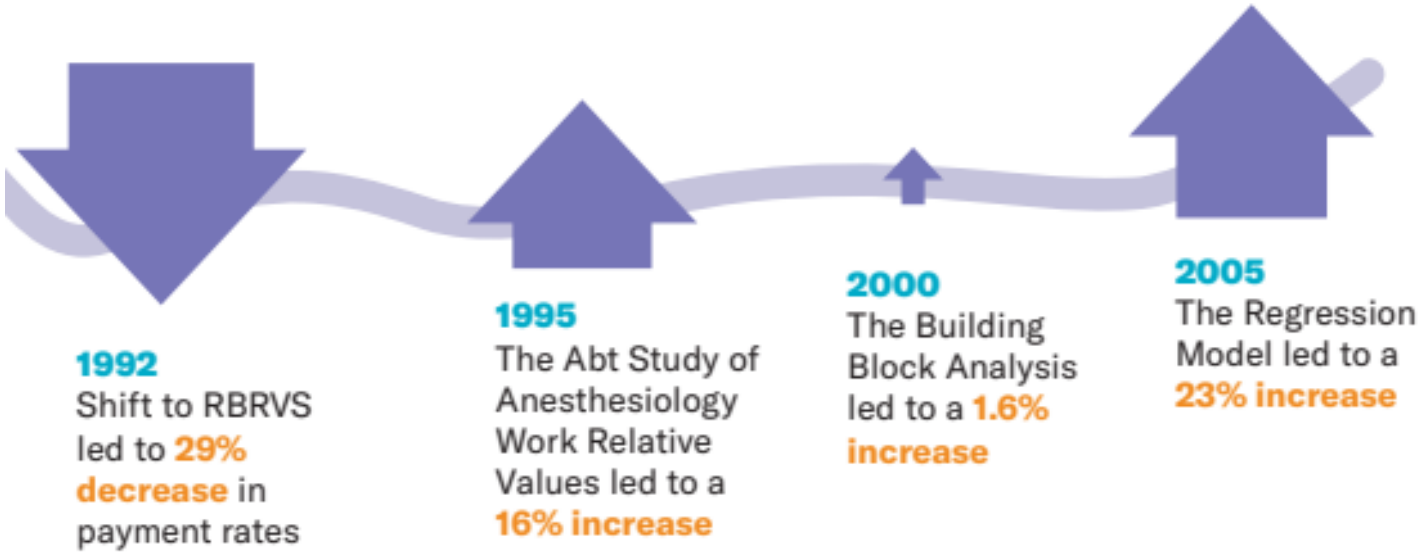


"Workarounds"

- Subsidies to Practices
- Commercial Insurance

ASA Efforts to Fix 33% Problem

- 1995 16% increase
- 2000 1.6% increase
- 2005 23% increase
- Next ??
  - Committee on Economics reviewing alternatives, including RURAL PASSTHROUGH (RPT)
  - Funded study underway to examine anesthesia payment rates of other federal payers



asahq.org/advocating-for-you/payment-progress/medicare-payment-reform

Department of Veterans Affairs

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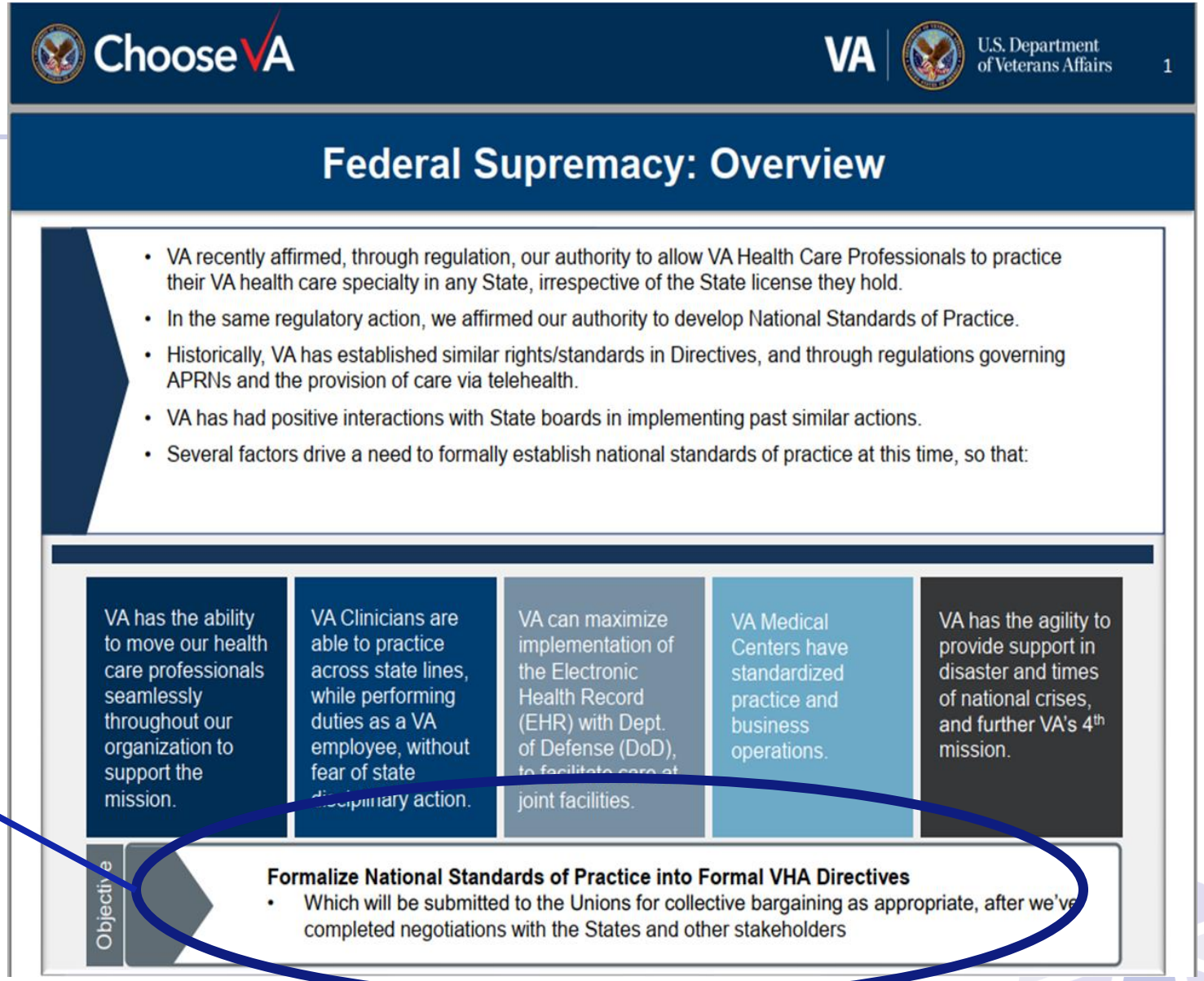
"Federal Supremacy" Initiative

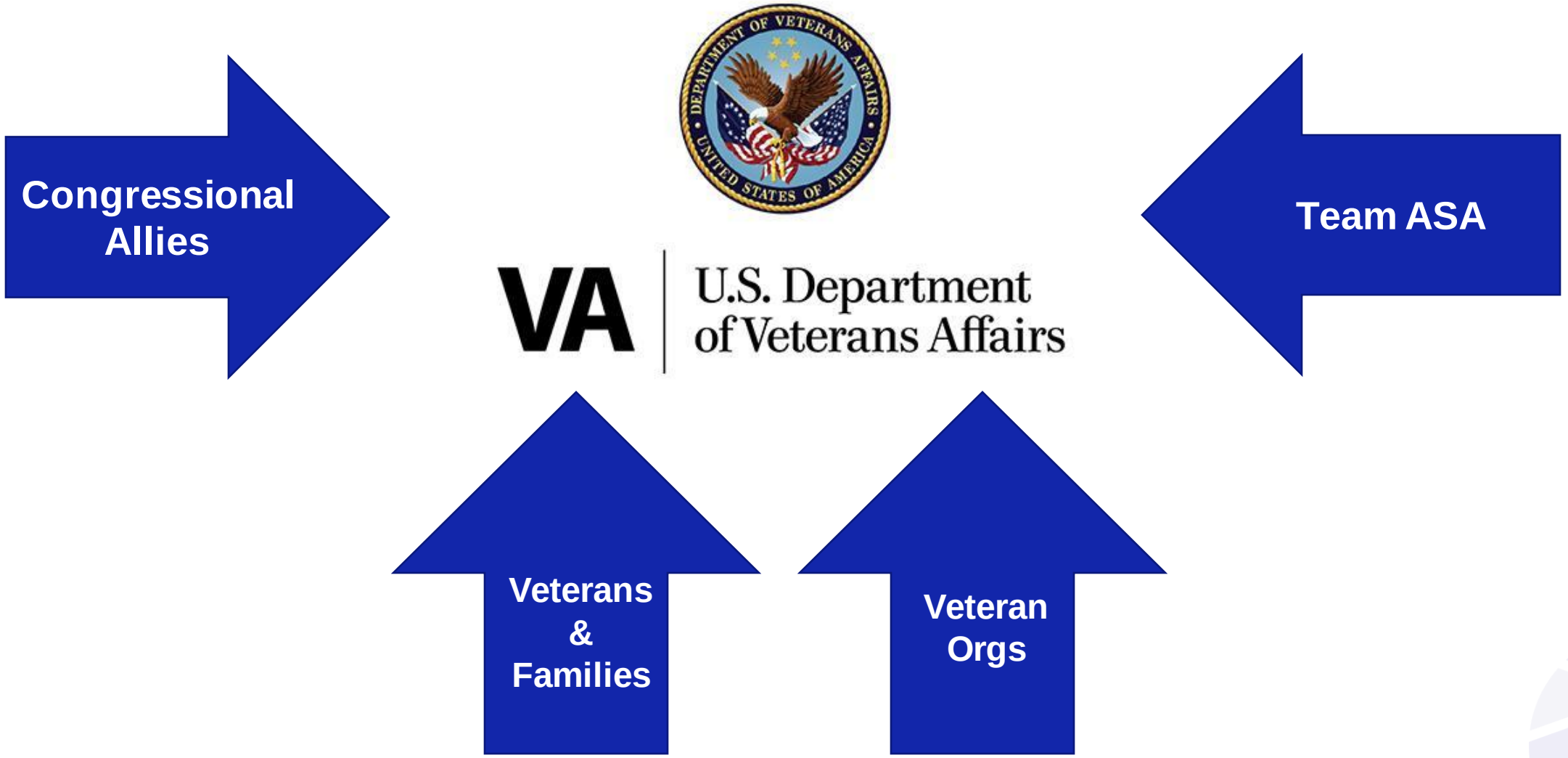
- Authority to practice in any state, regardless of state license.
- VA authority to determine professional's practice

"Formalize National Standards of Practice into Formal VHA Directives"



U.S. Department of Veteran Affairs, VA Supremacy Initiative, Briefing Slide Deck, July 2021

VA Lobbying Campaign



Congressional Allies

H.R.7048, Protect Lifesaving Anesthesia Care for Veterans Act of 2022

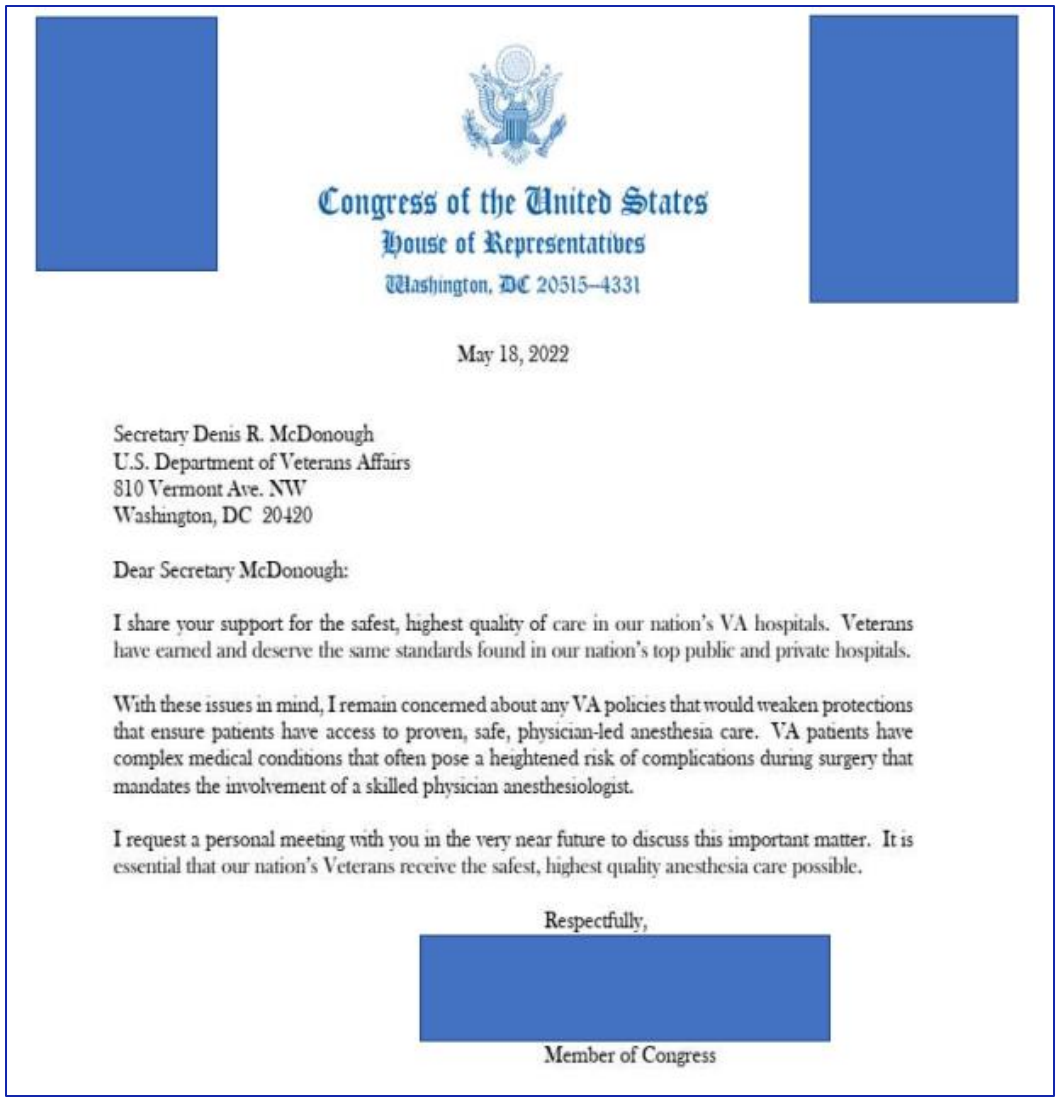
- Prohibits the VA "from modifying its policy relating to anesthesia care in a manner that would provide any medical professional other than a physician anesthesiologist with full practice authority for the furnishment of anesthesia care to veterans…"
- 22 cosponsors

Rep. David Scott (D-GA-13th)

… And, the AMA

Congressional Letters and Calls to VA

"…I remain concerned about any VA policies that would weaken protections that ensure patients have access to proven, safe, physician-led anesthesia care."



Congress of the United States
House of Representatives
Washington, DC 20515–4331

May 18, 2022

Secretary Denis R. McDonough
U.S. Department of Veterans Affairs
810 Vermont Ave. NW
Washington, DC 20420

Dear Secretary McDonough:

I share your support for the safest, highest quality of care in our nation's VA hospitals. Veterans have earned and deserve the same standards found in our nation's top public and private hospitals.

With these issues in mind, I remain concerned about any VA policies that would weaken protections that ensure patients have access to proven, safe, physician-led anesthesia care. VA patients have complex medical conditions that often pose a heightened risk of complications during surgery that mandates the involvement of a skilled physician anesthesiologist.

I request a personal meeting with you in the very near future to discuss this important matter. It is essential that our nation's Veterans receive the safest, highest quality anesthesia care possible.

Respectfully,

Member of Congress

VA Anesthesiologists

"We are writing for a fourth time to invoke "Stop the Line" and urge your immediate consideration of our concerns about a VA anesthesia policy that places our Veteran patients at risk.

- *Over 250 VA Anesthesiologists invoke VA "Stop the Line for Patient Safety" employee whistleblower program. 1/19/2022*

January 19, 2022

The Honorable Denis R McDonough
Secretary
Department of Veterans Affairs
801 Vermont Avenue
Washington, D.C., 20402

Dear Secretary McDonough:

We are writing for a fourth time to invoke "Stop the Line" and urge your immediate consideration of our concerns about a VA anesthesia policy that places our Veteran patients at risk. We renew our request to meet with you to discuss this critical policy.

Our request to meet with you is urgent, as we have just learned that the new VA National Standards of Practice for CRNAs may allow for Licensed Independent Practice of all CRNAs practicing in the VA, regardless of State licensing and regulations, when it is published. This model of nurse-only anesthesia care has already been debated and rejected by the VA in 2016-17 during the Obama-Biden Administration. It has also been rejected by the top-rated civilian hospitals in the United States. If VA considers moving to this anesthesia care model under the VA Federal Supremacy Project, the VA National Standard of Practice would be lower than those required in 46 states representing over 96% of our nation's population. **A National Standard of Practice which lowers the standard of care, will put Veterans' health and lives at risk.**

We believe that lowering the anesthesia standard of care for Veterans is a risky solution in search of a problem that doesn't exist. The data show there is no shortage of VA Anesthesiologists, nor are there access problems for VA anesthesia care. It is unfair for our nation's Veterans to needlessly receive a lower standard of care than that provided to nearly all U.S. civilians.

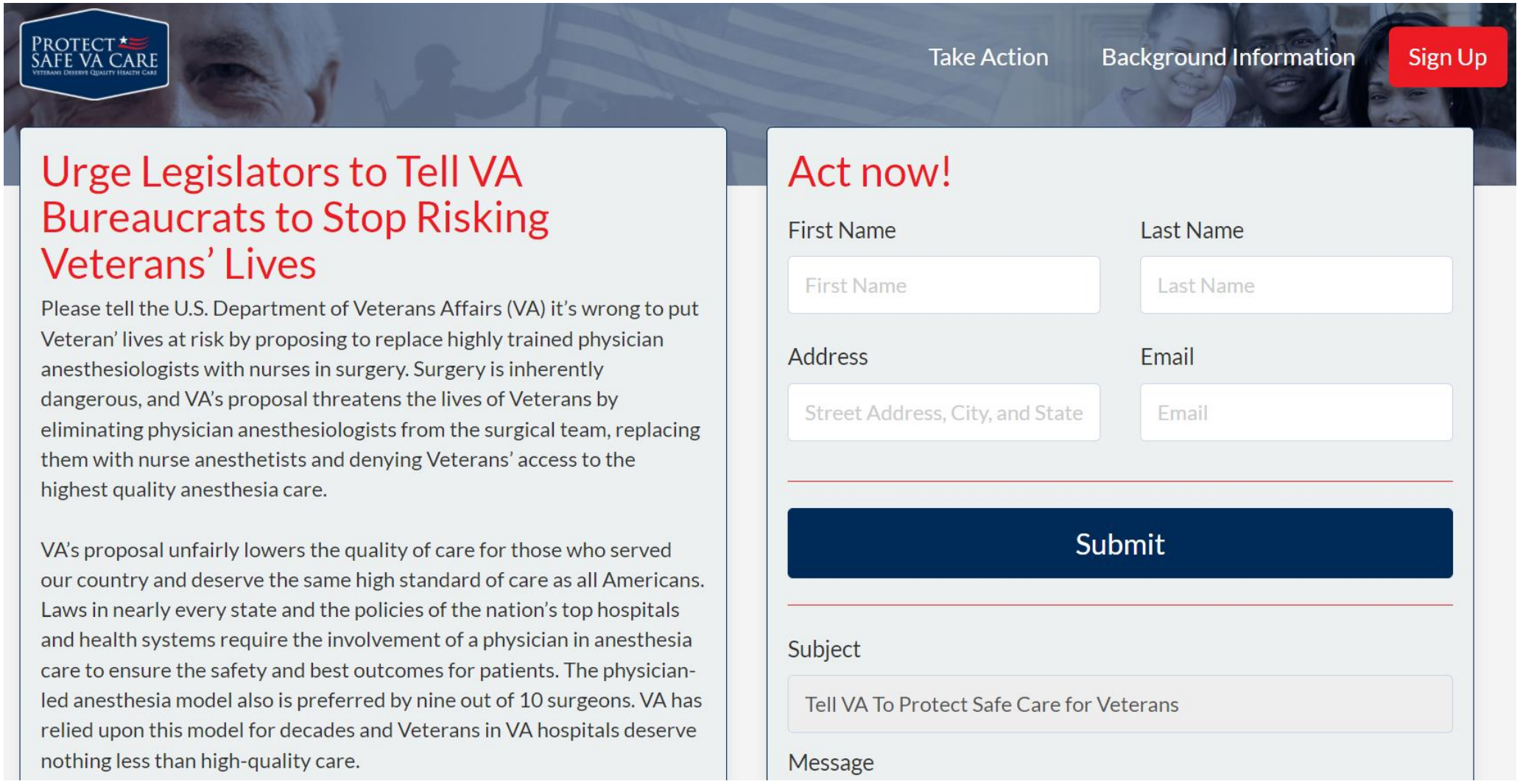
In 2013, VA put in place a critically important whistleblower program: "Stop the Line for Patient Safety". VA touted this program by saying, "Stop the Line for Patient Safety" supports the VA's Blueprint for Excellence by encouraging proactive, personalized, patient-driven care in an environment that makes Veteran and employee safety and well-being a priority." In 2018, VA told employees, "Stop the Line" is a VA-wide initiative that empowers VHA employees to speak up immediately if they see risk to patient safety…It's everyone's responsibility to ensure patient safety."

Over one-third (>350) of all VA Anesthesiologists, including Chiefs of Anesthesiology, leading researchers, educators, and academics in the field of anesthesia, have invoked "Stop the Line for Patient Safety" on three previous occasions in the last two years, and each time their concerns have been ignored and gone unanswered. **On behalf of our Veterans, we once again invoke "Stop the Line for Patient Safety" and request an urgent meeting with you, Secretary McDonough, to discuss our serious concerns regarding this proposed VA policy change, which could needlessly put Veterans' health and lives at risk.**

If VA's "Stop the Line" process is not respected when over one-third of all its anesthesiologists had the courage to come forward and invoke this whistleblower policy, then it would be hard to imagine how other VA employees, regardless of their patient safety concerns, would be willing to risk their careers to speak up on behalf of Veterans' patient safety. Also, if VA policies are based on what is best for

Veterans and Their Families

Take Action: Go to SafeVACare.org



No Surprises Act

- Jan 2022
- Balance Billing prohibited
- IDR Process
- GFE, beginning in Jan. 2023

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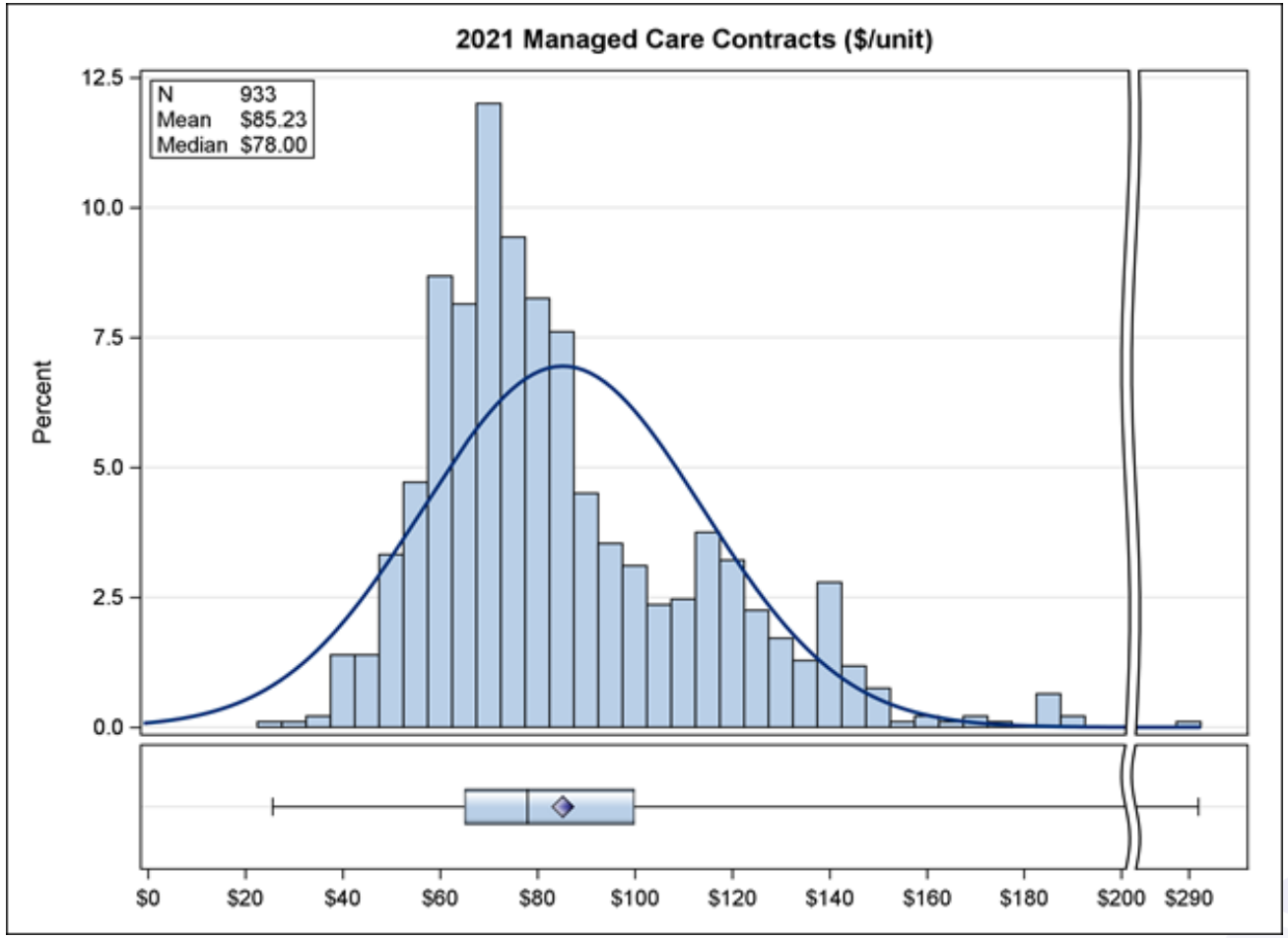
The Widening Gap

- Current commercial conversion factors:
  - Mean $85.23
  - Median $78.00
- Medicare:
  - $21.56
  - $11.09 adjusted for inflation
  - Now a 25% problem



No Surprises Act Implementation

- Flawed implementation
- ASA engagement
  - Litigation- TMA, AMA/AHA. ASA/ACEP/ACR
  - Documenting issues
  - Further engaging HHS/CMS/CCIIO
  - Engaging new House leadership for 2023

ASA Urges DoJ to Take Action

"…writes to express its concerns with the conduct of UnitedHealth Group ("UHG") that is terminating participating provider agreements with anesthesia practices across the country at a high rate…

"We respectfully request that the Antitrust Division of the Department of Justice ("the Division" or "DOJ") conduct a thorough investigation of this conduct…"

American Society of Anesthesiologists

1061 American Lane | Schaumburg, IL 60173-4973 | (847) 825-5586
905 16th Street N.W., Suite 400 | Washington, D.C. 20006 | (202) 289-2222

October 7, 2021

Richard Powers, Esq.
Acting Assistant Attorney General
Antitrust Division U.S. Department of Justice
Robert F. Kennedy Department of Justice Building
950 Pennsylvania Avenue, N.W.
Washington, DC 20530-0001

Dear Acting Assistant Attorney General Powers:

On behalf of our over 54,600 members, the American Society of Anesthesiologists ("ASA") writes to express its concerns with the conduct of UnitedHealth Group ("UHG") that is terminating participating provider agreements with anesthesia practices across the country at a high rate with exclusionary intent and consequences.

We respectfully request that the Antitrust Division of the Department of Justice ("the Division" or "DOJ") conduct a thorough investigation of this conduct because UHG's actions have harmed competition for anesthesia services by forcing otherwise willing anesthesia practices to be out of network for patients. UHG is vertically integrated and has the ability and incentive to leverage its UnitedHealthcare ("UHC") subsidiary's status as a health insurer, including to favor UHG's healthcare provider subsidiary Optum and its employed anesthesiologists unfairly. UHG's conduct results in higher out-of-pocket costs for patients due to UHC's higher cost sharing requirements for patients who are treated by out-of-network anesthesiologists and reduced numbers of in-network anesthesiologists for patients to access. UHC also operates as a third-party administrator ("TPA") for employer sponsored health plans. Through the guise of a "Shared Savings" program, UHG has a perverse incentive to reduce the number of in-network anesthesiologists to increase UHG's profits, while *increasing* the fees and overall costs passed on to employers. Additionally, anesthesiologists have been harmed by being foreclosed from access to UHG's members, particularly in areas around the country where UHG's members represent a substantial share of commercially insured patients, which anesthesiologists need to access to remain economically viable. In many instances, the agreements anesthesiologists have had with UHC have been in place for several years and have been mutually beneficial such that their sudden termination makes no economic sense, especially with anesthesia payment rate inflators often lagging UHG's premium cost increase trends. UHG's conduct can only be explained by a desire to inflict anticompetitive harm.

Background on Anesthesiologists

Anesthesiologists are physicians who specialize in anesthesia care, pain management, and critical care medicine. Anesthesiologists evaluate, monitor, and supervise patient care before, during, and after

Key Problems

- Insurers gaming their median in-network rates (QPA)
  - Offering unreasonably low rates to force physicians through the IDR process
- Broken IDR process
  - IDR entities seem overwhelmed and not able to process disputed claims in a timely fashion

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 30555
SALT LAKE CITY UT 84130-0555
PHONE: 1-800-752-6982

[redacted]

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

Insurer Median (50th percentile) QPA Unrealistically Low: Forces Small Community Practice into IDR Process

- United **median** QPA amount - $418.50
- FAIR Health **median** amount - $1605.52

[redacted]

PAYMENT DATE: 02/02/22
TIN: [redacted]
NPI: [redacted]
PAYEE NAME: [redacted]
PAYMENT NUMBER: [redacted]
PAYMENT AMOUNT [redacted]
GROUP NUMBER: [redacted]
GROUP NAME: [redacted]

PATIENT: [redacted]

SUBSCRIBER ID: [redacted]
REND PROV ID: [redacted]
SUBSCRIBER NAME: [redacted]
REND PROV: [redacted]
CLAIM DATE: 01/[redacted]/22-01/[redacted]/22
DATE RECEIVED: 01/20/22
CLAIM NUMBER: [redacted]
PRODUCT: CHOYC+

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
[redacted]					[redacted]				$334.80	$83.70

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	SUB UNITS	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	QPA AMOUNT	REMARK/ NOTES
[redacted]	01/[redacted]/22 - 01/[redacted]/22		00630	AA		87	87	[redacted]			PR PI	2 242	$334.80	$418.50	CL N830
CLAIM# [redacted]							SUBTOTAL						$334.80		

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.
This claim has been identified as a surprise bill. Additional information is at the end of this statement.

TOTAL PAYABLE TO PROVIDER [redacted]

NOTES
PI242 PAYER INITIATED REDUCTIONS - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS .

[redacted]

Communication from Overwhelmed IDRE

- IDRE acknowledges errors in tracking which claims are pending for which initiating party

From:
Sent:
To:
Cc:
Subject:

Hello,

Yes **is on hold** due to insufficient information from the non-negotiating party which would be

For the CMS portal had the following information provided for us

Initiating Party:

Non-Initiating Party

During our phone call, it was my understanding you were pointing out the discrepancy of two different disputes were being addressed simultaneously in the letter which only belonged to you. You also wanted to update the primary contact information.

The is being redacted from belonging to you. Please disregard The will be the only one in question. Which had the original contact information listed.

After speaking with you, the following information for can be confirmed:

- Initiating Party:
  -
- Non-Initiating Party:
  -
- Patient Inf
  -
- Primary Contact:
  -
  -
  -
- Secondary Contact:
  -
  -
  -

I will reach out to CMS to find out if a case is on hold, which is, would payment be requested since CMS needs to investigate the discrepancy of information provided by

Hi team,
The following is an update to our initial claim submission to the Federal IDR.

- 117 claims were submitted on April 27. These were claims for procedures performed on the first 30 days of January. Each claim had to be manually entered, they were checked multiple times for accuracy.
- On May 2 we received notification that [redacted] would be our arbitrator
- On May 3 we received an email from [redacted] that our dispute is ineligible because we submitted April service dates (this is not possible as we have not even submitted claims for much of April and certainly not disputed any)
- When we contacted [redacted] we were directed to the NSA Help Desk. The Help Desk was very polite but not did not have any information.
- We asked [redacted] if we could review our submission again and demonstrate no April dates of service. [redacted] did not offer any guidance on how/if this could be accomplished. We were told that "no one really knows what they are doing and it is a learning curve for all."
- Due to the May 6 deadline approaching we reentered all 117 line items and resubmitted the claims.

To say this is frustrating is an understatement.
Please reach out if anyone needs any additional information.
Best,
[redacted]

Physician Practice Reports Overwhelmed IDRE Losing Track of 117 Claims:

- NSA on-line portal lacks mechanism to review submitted claims
- "No one really knows what they are doing…"

Center for Consumer Information and Insurance Oversight (CCIIO)/CMS/HHS

ASA-CCIIO Call 5/3

- Concerns about low QPA
- State vs. Federal IDR
- Propriety portals
- Batching of anesthesia claims

ASA Pushes for Congressional Engagement

2022 LEGISLATIVE CONFERENCE

- "Congress is urged to carefully monitor the implementation of the No Surprises Act, including pressing the agencies to:
- Begin audits of insurers' QPAs;
- Follow the directive language of the No Surprises Act in creating an unbiased IDR process that does not favor a flawed insurer-calculated payment amount."

American Society of Anesthesiologists

No Surprises Act's Qualifying Payment Amount (QPA) Requires Congressional Oversight

ISSUE

The enactment of the No Surprises Act (NSA) creates new patient protections from surprise medical bills. The law also creates a new health care provider payment system. While rulemaking to implement the law is underway, the governing agencies have ignored Congressional intent and flaws remain with how physician payment is being calculated.

Specifically, the NSA's insurer-defined "qualifying payment amount" (QPA) is being miscalculated and misused and is harming physician practices by underpaying for patient care. Congressional oversight and engagement on this key feature of the new law is necessary to preserve the balanced intent of the law.

BACKGROUND

Pursuant to the law, the QPA is calculated by each individual insurance company and is intended to accurately reflect a health insurer's median-in-network payment rate for physician services in that geographic area.

The QPA is an important calculation used to guide health insurers' payments to physicians. Some insurers use the QPA as their initial payment to physicians. The calculation is also used as one of several factors considered in the law's independent dispute resolution (IDR) process—the mechanism used to adjudicate payment disputes between physicians and health insurance companies.

There is evidence that health insurers are calculating unusually low QPAs, including potentially using "phantom" payment rates that were never actually paid or even negotiated. As a result, the rates from these insurers are far below anticipated and even actual median rates in the geographic area.

These unusually low QPAs are also compromising the fairness of the IDR process. As part of the NSA rulemaking, the U.S. Departments of Health and Human Services, Labor, and Treasury erred in ignoring Congress' directive to the agencies to create a neutral IDR process centered on the equal consideration of a variety of factors presented by the insurer and physician. Instead, the agencies issued an interim final rule (IFR) that biased the process to give preference to one factor—the insurers' QPAs. While a Texas federal court found the agency's action to be unlawful, the federal government announced on April 22 its intention to appeal the court's ruling.

Recent guidance released by the Centers for Medicare and Medicaid Services (CMS) states, "It is not the role of the certified IDR entity to determine whether the QPA has been calculated correctly by the plan..." thereby assuring that the IDR process will continue to utilize a potentially flawed QPA.

The accuracy of the QPA combined with the misuse of the payment amounts in the IDR process has tilted the entire payment process in the favor of insurance companies and against physician practices of all sizes, but especially small, independent community practices.

REQUEST:

Congress is urged to carefully monitor the implementation of the No Surprises Act, including pressing the agencies to 1) begin audits of insurers' QPAs; and 2) follow the directive language of the No Surprises Act in creating an unbiased IDR process that does not favor a flawed insurer-calculated payment amount.

Recent Development

Final Rule has left DoL and is now under review by Office of Management and Budget (OMB)

AGENCY: DOL-EBSA
TITLE: Requirements Related to Surprise Billing, Part 2
STAGE: Final Rule
** **RECEIVED DATE:** 06/15/2022

RIN: 1210-AC00

ECONOMICALLY SIGNIFICANT: No
LEGAL DEADLINE: Statutory

Status: Pending Review

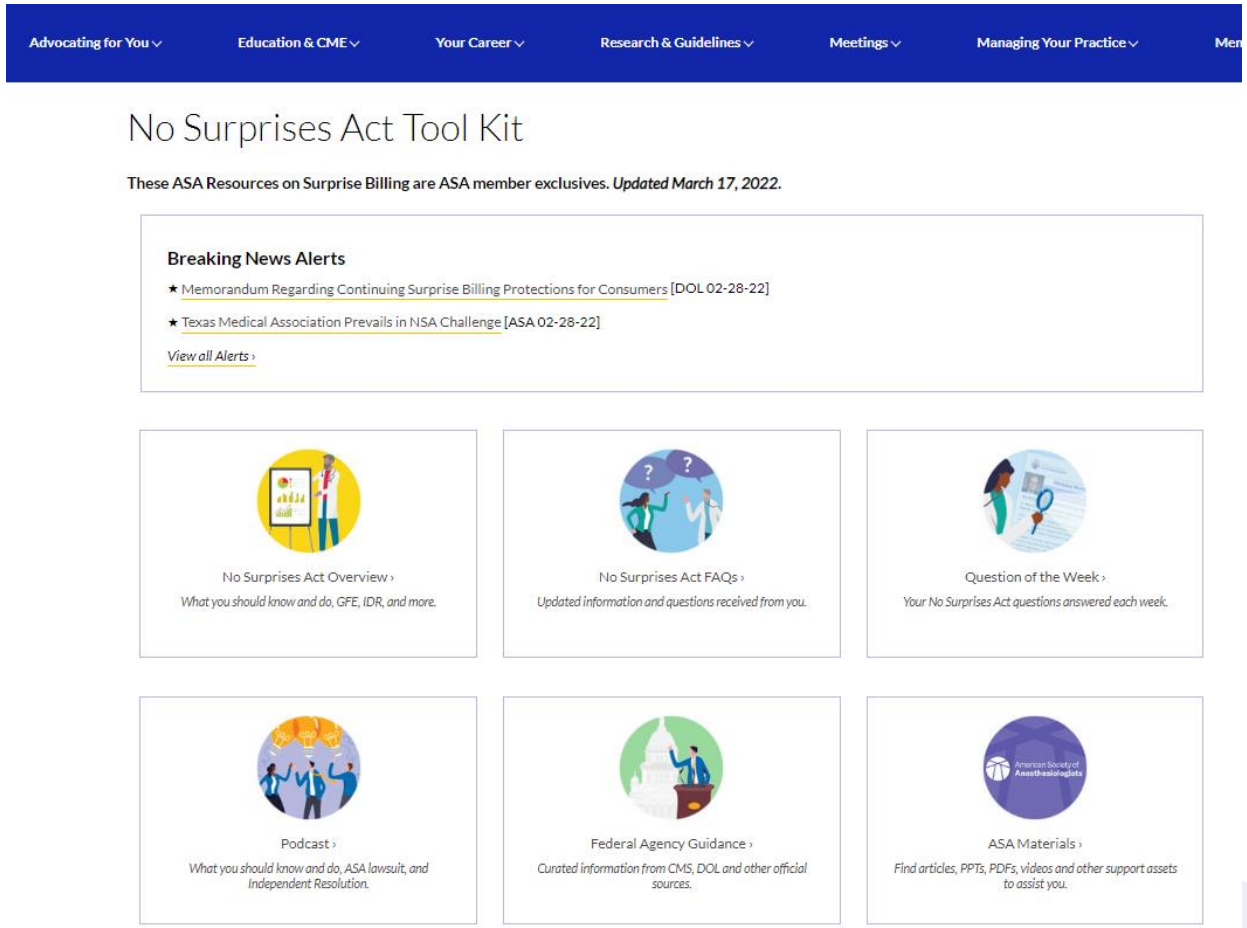
- Will it resolve pending litigation?
- Create new litigation?

No Surprises Act (NSA) Resources

ASA No Surprises Act Tool Kit

- All known federal government guidance and documents
- ASA Developed FAQs
- NSA Question of the Week

asahq.org/advocating-for-you/payment-progress/surprise-billing-resources



Take Action: Notify ASA

- Problems with the NSA – contact ASA
- Document your problems – redact any payment and identifying information

Education and Science

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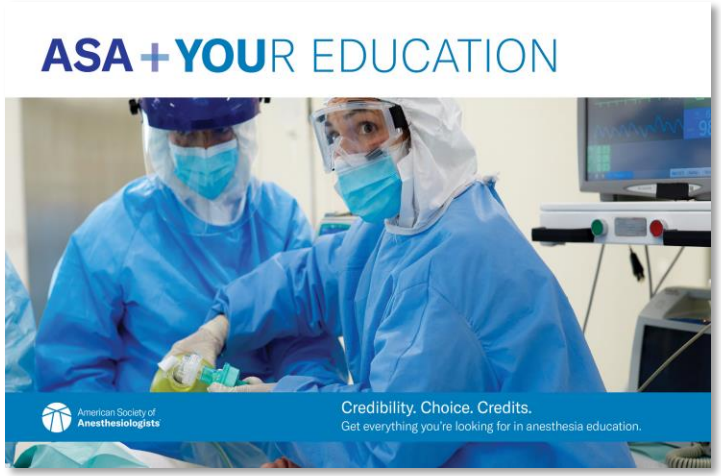

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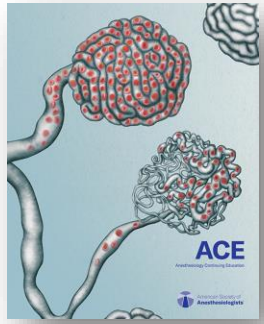
- **Anesthesia SimSTAT:** Powerful, realistic online simulation training
- **ACE:** Reinforce and refresh fundamental knowledge
- **Summaries of Emerging Evidence (SEE):** Key insights from 30+ journals worldwide
- **Fundamentals of Patient Safety:** Fresh review of core concepts
- **NEW:** Patient Safety Highlights, QI Activities, Patient Safety Updates
- **Simulation Education Network:** ASA-endorsed sim centers deliver experiential training around the country.
- **Online CME courses**



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- Exchange ideas with industry thought leaders and innovators

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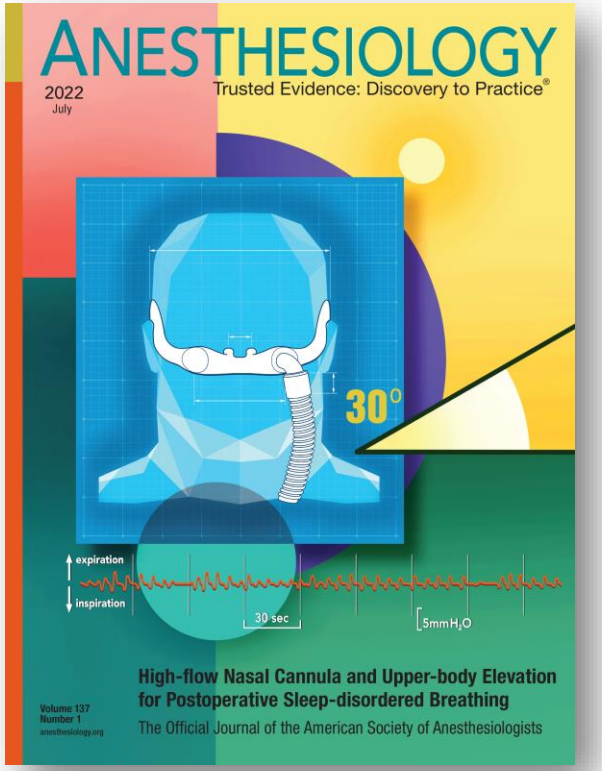

anesthesiology.org

Pacira Libel Case Against *Anesthesiology*

- Lawsuit filed against ASA, Anesthesiology editor-in-chief and 11 authors by Pacira Biosciences Inc. dismissed 2/4/22
- Suit filed in April, 2021 regarding articles about pain medication, EXPAREL, in February 2021 Anesthesiology issue, a related podcast and other materials
- Judge found that a "scientific conclusion based on nonfraudulent data in an academic publication is not a 'fact' that can be proven false through litigation," adding that holding otherwise "would chill robust and open debate about the efficacy of drugs within the medical community."
- Pacira Biosciences filed appeal 3/7/2022

Among Top-Used Clinical Resources

- *ASA Monitor*® asamonitor.org
- *ASA Monitor*+ supplement
  - Anesthesiology 2030: What Does the Future Hold
- Standards and Practice Parameters; Statements and Committee Resources
- Online CME courses
- Non-Clinical Research Services – Center for Anesthesia Workforce Studies

Leadership Perspectives: The Challenge of Payment Advocacy 9
How ASA Provides Rolls-Royce Education at Chevy Prices 17
Levels of Maternal Care: The Anesthesiologist's Role in Reducing Maternal Mortality 34

American Society of Anesthesiologists

Volume 86 ■ Number 7 ■ July 2022
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ASA Monitor®

THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

CRISPR/Cas9 Genomic Editing

Richard Simoneaux Steven L. Shafer, MD, FASA Editor-in-Chief

On October 7, 2020, the Royal Swedish Academy of Sciences awarded the Nobel Prize in Chemistry to Jennifer A. Doudna and her research associate Emmanuelle Charpentier from the University of California, Berkeley for their discovery of "one of gene technology's sharpest tools: the CRISPR/Cas9 genetic scissors" (asamonitor.pub/39IHOul42).

We are writing about CRISPR because it is the most profound discovery in biology since Franklin, Watson, and Crick determined the structure of DNA. If DNA is the program code for every human cell, CRISPR/Cas9 is the first editor for that program. With CRISPR you can write programs in the language of adenine, thymine, guanine, and cytosine that are executed within all cells. CRISPR has "sparked a revolution in genome editing" (asamonitor.pub/3Naxfw1l).

Continued on page 5

Fail Often. Hold Fast!

Sean Runnels, MD, D.ABA

I am not especially skilled with a fiberoptic bronchoscope. No matter. The only fiberoptic scope on the surgical ship Africa Mercy was broken (asamonitor.pub/3wBz8f9). The only fiberoptic scopes on hand were a box of Anubu aS-copes. The monitor was not included in the donation, so these could only serve as steerable bougies.

My patient, 8-year-old Abubakar, had an Abbe flap in need of debridement (shown). This flap is a surgical marvel. The lower lip flap is raised, rotated, and sewn in place to fill cleft lip defects. The flap's pedicle acts as an umbilical cord of blood flow while the tissue develops a new blood supply from the upper lip. Three to four weeks later (and several debridements requiring GETA), the pedicle is severed and the flap's migration from lower lip to upper lip is complete.

This procedure is life-changing for the patient. The result is also satisfying for the surgeon, as it enables a seemingly impossible repair. However, for the anesthesiologist, multiple intubations of an 8-year-old with his mouth partially sewn shut is terrifying. Without a working fiberoptic scope, and concurrently

Continued on page 7

SPECIAL SECTION
Airway Management Updates and Future Directions 21-31
Guest Editor: Muhammad B. Rafique, MBBS, FASA

PERIODICALS

'Quality,' Mediocrity, and Unintended Consequences

Karen S. Sibert, MD, FASA

Today's noteworthy definitions, not new but often ignored:

1. Unintended consequences: The principle stating that an intervention in a complex system tends to create unanticipated and often undesirable outcomes.
2. Good intentions: The paving stones of the road to hell.

In anesthesiology, these precepts should be kept firmly in mind in our attempts to improve "quality." Anyone who speaks out against measures that are taken under the banner of improving "quality of care" or "patient safety" risks coming across as reckless, heartless, or both. Yet the pursuit of "quality" in health care has a track record of implementing changes and policies that haven't been subjected to any rigorous scientific study, in effect "prioritizing action over evidence" (*N Engl J Med* 2021;357:608-13).

Quantitative neuromuscular monitoring

In anesthesiology, we love our gadgets. We especially like gadgets that generate numerical values we can track. It's no wonder that quantitative nerve stimulators measuring thumb movement via acceleromyography are gaining in popularity. They give us a ratio of neuromuscular recovery that we can document and trumpet as evidence of high-quality care, blessed by the Anesthesia Patient Safety Foundation (APSF) in its most recent recommendations for patient monitoring (APSF Newsletter 2022;37:7).

A recent review article in *Anesthesiology* concluded that "the use of quantitative monitoring may reduce the risk of hypoxemic events and episodes of airway obstruction in the PACU, decrease the need for postoperative reintubation, and

Continued on page 10

Leadership and Professional Development Resources

NEW ASA Leadership Academy Modules 1 & 2!

- Module 1 - Leadership Roles – Attendees will learn the Society's mission and organization, ASA's leadership path, and how to maximize the member experience for personal and professional growth
- Module 2 - Creating a Personal Leadership Path - Attendees will assess leadership gaps, strengths and create a personal leadership pathway

Leadership and Professional Development Resources

- Executive Physician Leadership Program (EPLP) at Northwestern University's Kellogg School of Management
  - 4-day Intensive Program September 15-18, 2022
- ASA Customized Leadership Training
  - Virtual or live training opportunities to component, subspecialties, residency programs, practice groups and industry partners

Resident and Medical Student Educational Offerings

- Residents in a Room podcast series
- Online Grand Rounds modules
- Resident career development curriculum
- Medical student career development resources and video interviews
- Resident and medical student educational tracks at ANESTHESIOLOGY Annual Meeting; Resident Track at ASA ADVANCE
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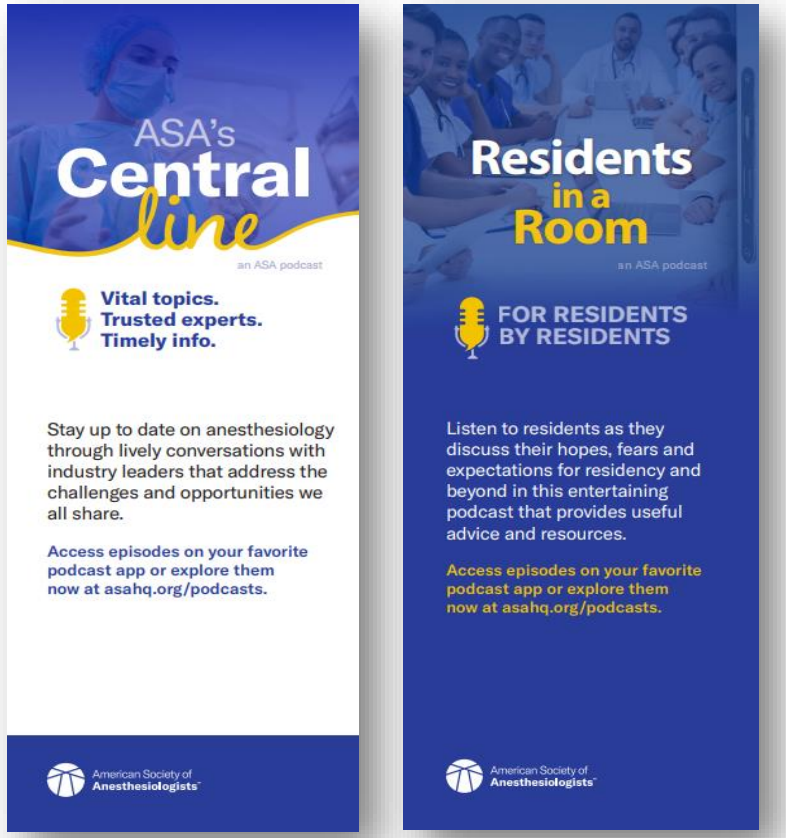
Residents in a Room

- Candid "fly-on-the-wall" resident conversations, what's keeping them interested and up at night
- 30+ episodes – including testing, personal experiences, DEI, clinical preparation, and subspecialty pathways



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THANK YOU!

Questions?

Patrick Giam, MD, FASA

Speaker, House of Delegates

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