Update on Governmental and Other Regulations Affecting Anesthesiology

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Disclosures
- No financial conflicts of interest to disclose
- The opinions expressed are my own and not necessarily those of the University of Colorado or the American Society of Anesthesiologists

Objectives
- Provide updates on governmental and other regulatory action affecting health care delivery and payment for anesthesia services
- Understand how the American Society of Anesthesiologists is responding to the challenges created by health care reform
- Learn what you can do at the group, department, and individual level to prepare for MACRA and MIPS

pol·i·tics  (pŏl'tĭ-ks) –noun, plural
- 1. a: the art or science of government b: the art or science concerned with guiding or influencing policy
- 2. a: the total complex of relations between people living in society b: relations or conduct in a particular area of experience especially as seen or dealt with from a political point of view

The Imperative: Improving Value in Health Care Delivery

The Triple Aim
- High Quality
- Low Cost
- Affordability
- Patient Experience
- Access
- Healthier Living
The current administration and Congress will continue to accelerate these efforts.

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**Progress Towards Achieving Better Care, Smarter Spending, Healthier People**

Jan 26, 2015

By: Sylvia Mathews Burwell, HHS Secretary

Since my very first days as Secretary, you’ve heard me talk about improving our nation’s health delivery system to better meet the needs and expectations of the people of America.

Whether you happen to be a patient, a provider, a business, a health plan or a taxpayer, it’s in our common interest to build a health care delivery system that’s better, smarter and healthier - a system that delivers better care; a system that spends health care dollars more wisely; and a system that makes our communities healthier.

Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.

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**2018 Medicare Conversion Factor: Anesthesia**

**TABLE 49: Calculation of the Final CY 2018 Anesthesia Conversion Factor**

<table>
<thead>
<tr>
<th>CY 2017 National Average Anesthesia Conversion Factor</th>
<th>22.4044</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion Factor</td>
<td></td>
</tr>
<tr>
<td>Stadium Update Factor</td>
<td>0.80 percent (1.0000)</td>
</tr>
<tr>
<td>CY 2018 RUGI: Budget Neutrality Adjustment</td>
<td>-0.10 percent (0.9990)</td>
</tr>
<tr>
<td>CY 2018 Target Resource Amount</td>
<td>-0.00 percent (1.0000)</td>
</tr>
<tr>
<td>CY 2018 Anesthesia Fee Schedule Practice Exposure and Malpractice Adjustment</td>
<td>0.34 percent (1.0034)</td>
</tr>
<tr>
<td>CY 2018 Conversion Factor</td>
<td>22.1887</td>
</tr>
</tbody>
</table>

The anesthesia conversion factor as finalized represents a significant change from the proposed rule. The proposed rule projected a decreased anesthesia conversion factor (22.2005) that would have been a result of a CMS proposal to change how the malpractice component of the overall fee schedule is calculated. The current proposal incorporates with other proposals considered CMS to not implement that proposal which would have negatively impacted every anesthesia service provided to Medicare Part B beneficiaries.

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**Intravascular Catheterization Procedures**

- CPT code 36556 (Insertion of non-tunneled centrally inserted central venous catheter, percutaneous, age 6 months to 5 years, not otherwise specified) identified as potentially misvalued (high expenditure screen) resulting in required review of these four codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2017 Medicare Allowed Amount (facility setting)</th>
<th>2018 Medicare Allowed Amount (facility setting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>36556</td>
<td>Insertion of non-tunneled centrally inserted central venous catheter, age 6 months to 5 years, not otherwise specified</td>
<td>$130.18</td>
<td>$81.64</td>
</tr>
<tr>
<td>36556</td>
<td>Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older</td>
<td>$234.99</td>
<td>$108.52</td>
</tr>
<tr>
<td>36620</td>
<td>Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous</td>
<td>$52.76</td>
<td>$145.72</td>
</tr>
<tr>
<td>39505</td>
<td>Insertion and placement of flow-directed catheter (eg, Swan-Ganz) for monitoring purposes</td>
<td>$132.43</td>
<td>$207.64</td>
</tr>
</tbody>
</table>

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**2018 Changes – Codes and Values for Anesthesia for GI Endoscopy**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CMS Rate</th>
<th>RBR Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>36780</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced transnasal to duodenum</td>
<td>5 5</td>
<td>5 5</td>
</tr>
<tr>
<td>36785</td>
<td>Anesthesia for lower gastrointestinal endoscopic procedures, endoscope introduced transanal to duodenum, rectum or transverse colon</td>
<td>5 5</td>
<td>5 5</td>
</tr>
<tr>
<td>36780</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced transnasal to duodenum, not otherwise specified</td>
<td>5 5</td>
<td>5 5</td>
</tr>
<tr>
<td>36780</td>
<td>Anesthesia for lower gastrointestinal endoscopic procedures, endoscope introduced transanal to duodenum, not otherwise specified</td>
<td>4 4</td>
<td>5 5</td>
</tr>
<tr>
<td>36780</td>
<td>Anesthesia for transoral endoscopic procedures, endoscope introduced transnasal to duodenum, not otherwise specified</td>
<td>2 2</td>
<td>5 5</td>
</tr>
</tbody>
</table>
**Case Study 1: PQRS and VM Payments**

In 2018, CMS retroactively lowered the threshold for satisfactorily participating in the Physician Quality Reporting System.

- **Remember, 2018 PFS payment based upon 2016 performance.**

<table>
<thead>
<tr>
<th>Before 2018 PFS</th>
<th>After 2018 PFS</th>
<th>Regulation v Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 9 measures</td>
<td>Report 6 measures</td>
<td>Regulatory (Change)</td>
</tr>
<tr>
<td>Report across 3 NQS domains</td>
<td>No NQS domains required</td>
<td>Regulatory (Change)</td>
</tr>
<tr>
<td>Report cross-cutting measure</td>
<td>No cross-cutting measure</td>
<td>Regulatory (Change)</td>
</tr>
<tr>
<td>2% penalty for unsatisfactory reporting</td>
<td>2% penalty for unsatisfactory reporting</td>
<td>Legislative (Same)</td>
</tr>
</tbody>
</table>

**Case Study 2: MACRA and MIPS Payments**

CMS has made regulatory changes to “reduce burden” among many physician anesthesiologists in MIPS Performance Year 2018.

<table>
<thead>
<tr>
<th>Performance Year 2017</th>
<th>Performance Year 2018</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility threshold of at least $30,000 and 100 Medicare patients per year.</td>
<td>Eligibility threshold of at least $90,000 and 200 Medicare patients per year.</td>
<td>CMS saw “hidden selection” fail, made opportunity for payment inversely to practices.</td>
</tr>
<tr>
<td>MIPS Total Score Threshold at 3pts</td>
<td>MIPS Total Score Threshold at 15 pts</td>
<td>Need to avoid additional data or attestations.</td>
</tr>
<tr>
<td>MIPS Cost Component at 0% of MIPS Total Score</td>
<td>MIPS Cost Component at 20% of MIPS Total Score</td>
<td>Some eligible clinicians may be scored in MIPS Cost Component.</td>
</tr>
<tr>
<td>Pick Involvement Option</td>
<td>Report MIPS quality for 12 months, report ACI and IC components for at least 90 days</td>
<td>CMS saw “burden reduction”, practices need to update systems earlier in the year.</td>
</tr>
</tbody>
</table>

**MIPS Payment Adjustment**

<table>
<thead>
<tr>
<th>2017 Performance/2019 Payment</th>
<th>2018 Performance/2020 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>+/- 4%</td>
<td>+/- 5%</td>
</tr>
</tbody>
</table>

**Reminder**

For 2019/2021 cycle: +/- 7%
For 2020/2021 cycle and on: +/- 9%

**Budget Neutrality**

A scaling factor of up to 3x may be applied to positive adjustments.

**MIPS Reporting Requirements**

- Report Quality, IA, and ACI for a minimum of 90 Days
- Report for full year

**Avoiding a Negative MIPS Adjustment**

- Report 40 points of improvement activities, or
- Earn the Advancing Care Information base score and submit 1 quality measure that meets data completeness criteria, or
- Earn the Advancing Care Information base score and attest to one medium-weighted Improvement Activity, or
- Submit 6 quality measures that meet data completeness criteria
Facility Based Measurement Option

2017 Performance/2019 Payment
- Not available

2018 Performance/2020 Payment
- Finalized in 2018 Final Rule but not implemented until 2019 performance period
- Specific MIPS eligible individuals or groups may choose to use facility-based measures as a proxy for their their quality and costs scores
- ≥75% of services in inpatient or emergency department

Improving Value: How is ASA Responding?

Navigating MACRA
American Society of Anesthesiologists

Moving physician payment from volume to value

FIRST STEP: Learn your eligibility and status for MACRA

MACRA Memo
Centers for Medicare & Medicaid Services (CMS)

MACRA Memo

ASA Solutions & Resources
American Society of Anesthesiologists

Shaking Up the Status Quo

I want a raise.
Money can't buy happiness.
Then who do people want to avoid unhappy?

What's my best-case scenario here?
I'll motivate you toward a neutral, positive, low-excitement.
Improving Value
- Perioperative Surgical Home
- Health Policy Analysis and Research
- Practice Management
- Anesthesia Quality Institute & NACOR: QCDR
- Measure Development
- Exploring and Promoting Alternative Payment Models
- Population Health

Anesthesia Quality Institute – National Anesthesia Clinical Outcomes Registry
- Received designation as a Qualified Clinical Data Registry in 2014
- Allows AQI to specify the outcomes to be measured without complicated NQF process
- Easily incorporated into other AQI reporting

Aqui 2.0
- $14 million since start in 2008
- $1.6 million in 2015 redesign (in order to move from startup to mature organization)
- Currently receiving $1.4 million per year in fees
- Contract signed in October 2015 with ArborMetrix
- Data delivery is now standardized
- Data integrity is much improved
- Now with ability to scale to much larger programs

More Information
- ASA White Paper on Perioperative Surgical Home
- 2014 - 2018 Practice Management Conferences
- 3rd ASA PSH Meeting
- 2nd ASA Quality Meeting
- ASA Website: https://www.asahq.org/psh
- Special thanks to Zeev Kain, MD (UC Irvine), Stan Stead, MD (ASA VP Professional Affairs), and Mike Schweitzer, MD (now managing Population Health for Premiere, Inc.)
Alternative Payment Models

Qualifying Participant in an Advanced APM

- 2017 and 2018 Performance/2019 and 2020 Payment
- Payment Method:
  - 25% of your Part B payments are from the APM;
- OR
- Patient Count:
  - 20% of your Medicare patients are from the APM

Advanced APM participants can check the Qualifying APM Participant (QAP) Status at:
https://data.cms.gov/api/breakup

2016 BPCI Participation

CMS's Innovation Center Announces BPCI Advanced

BPCI-A Inpatient Episode Bundles

- Fractures of the femur and hip or pelvis
- Cardiopulmonary resuscitation
- Hip & femur procedures except major joint
- Lower extremity/forefoot procedures except
- Major bowel procedures
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Percutaneous coronary intervention
- Renal failure
- Severe
- Stroke
- Urinary tract infection
American College of Surgeons Standards for Pediatric (Anesthesia) Care

Table 1: Summary of Proposed Pediatric Anesthesia Care Designations

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Designations</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborns</td>
<td>Score Advanced</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Infants</td>
<td>Score Advanced</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Toddlers</td>
<td>Score Advanced</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Children</td>
<td>Score Advanced</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

Timeline: BPCI Advanced

Timeline: BPCI Advanced

Questions / Comments

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American College of Surgeons
Perioperative Release:
March 2, 2014

Pediatric Surgeons and Anesthesiologists Develop Standards for Optimal Resources for Children’s Surgical Care in the United States

American College of Surgeons reports new comprehensive guidelines that define the resources the nation’s surgical facilities need to perform operations effectively and safely on infants and children. The standards—Recommended Resources for Children’s Surgical Care—are intended to help hospitals create and implement effective improvements in the delivery of care for children, based on the experiences of leading pediatric surgeons and anesthesiologists. The recommendations, which were developed by the Task Force on Children's Surgical Care, were endorsed by the American College of Surgeons in December 2013.

In addition to defining optimal resources for children's care, the guidelines also provide a means for hospitals to measure their own performance and to improve care for children. The standards are intended to help hospitals create and implement effective improvements in the delivery of care for children, based on the experiences of leading pediatric surgeons and anesthesiologists.

Table 1: Proposed Resources for Children’s Care Designations

<table>
<thead>
<tr>
<th>Resource</th>
<th>Basic</th>
<th>Advanced</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating room</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anesthesia equipment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Surgical equipment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Support staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Operating room supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anesthesia supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Surgical supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

For More Information
https://innovation.cms.gov/initiatives/bpci-advanced
ASA 3/14 Letter to the Editor
- “Clarifies” the track record for driving improvements in specialty care
- Asserts that the ACS proposal may have negative consequences for access to care
- May overburden specialty facilities
- Improperly concludes age <1 cannot be properly cared for in ambulatory facilities
- Does not recognize that pediatric care is a core competency of anesthesiology training

Current Status
- 5 sites listed on ACS website (Level 1)
- Site visiting team being assembled
- 60-70 hospitals have indicated an interest in participating
- ASA ad hoc committee to study impact and plan next steps
- Contact me (randall.clark@childrenscolorado.org) if this is an area of concern for you or your practice

randall.clark@childrenscolorado.org