THE NORTH CAROLINA SOCIETY OF ANESTHESIOLOGISTS

the beacon for patient safety in North Carolina

IN THIS ISSUE

[FROM THE PRESIDENT]

BRYANT MURPHY, MD

Even though it's a new year and Spring is here, I think about Christmas that just passed. Christmas has always been one of my favorite holidays. Aside from the religious celebrations that are associated with the season, I enjoy the vacation, the time with family, and the gifts. It was always been exciting to make a list and leave it lying around in hopes that Santa would somehow see it and make my wishes come true on Christmas morning. As we approach the spring and summer, I begin to look forward to "Christmas in July," a midyear celebration that gives me an excuse to make a list of things that I would like. As I make my Christmas in July list, there are a few things that I would really like to see this year.

I wish that Health care reform was more about patient care. It is now 2014 and many of the things that were promised by the Patient Protection and Affordable Care Act (ObamaCare) are starting to become clear. During the passage of the law, it became apparent that this was less about the patients, and more about political agendas. If you remember it took the interplay of Senator Kennedy and Scott Brown to finally pass the law. We became more acquainted with arcane terms about congressional procedures such as "reconciliation" than we did with new medical procedures. The passage of health care reform was not based on new medical treatments or payment models. The subject of individual mandates and Supreme Court decisions overshadowed individual stories of treatment and care. Hopefully this will be reversed. My wish is that we can now begin to use health care reform to actually begin caring for the patients. I hope that we can use some of these models such as Medicaid reform and Accountable Care Organizations to bring care to the uninsured, and that we can begin to change the discussion from "bending the cost curve" to "saving individual lives" and preventing disease.

I wish that the anesthesia care team was more of a team. We use the term anesthesia care team without actually focusing on the meaning of the word.

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[FROM THE ASA DIRECTOR]

GERALD A. MACCIOLI, MD, FCCM

The ASA Board of Directors (BOD) held it's annual interim meeting 1st and 2nd of March 2014. I was in attendance for the entire meeting representing North Carolina.

The SGR: One of the big topics for BOD discussion was what position should ASA take on *HR 4015* and *S 2000* (SGR Repeal and Medicare Provider Payment Modernization Act of 2014)? Highly spirited debate occurred among the BOD members spanning the full spectrum of potential positions. Ultimately, the BOD decided the ASA would take **NO POSITION** on this legislation. It should be noted that the AMA is *'all in'* on this bill as are many other medical specialty organizations.

My personal take is that this bill is not perfect, however, as we all know, the current SGR is clearly highly flawed. Furthermore, this bill is the only real, bipartisan, bicameral replacement to come along in a decade. The specifics of the bill are minimal on some key provisions as they apply to anesthesiology. This legislation will amalgamate PQRS, VBM, and MU EHR into a single system: "Merit-Based Incentive Payments" (MIPS). From a healthcare policy perspective, the lack of specifics in this legislation and the need for a framework to be 'built out' after passage is, I think, a big potential opportunity for our specialty.

During the years of 2018 through 2023, the MIPS program would annually calculate for the provider a composite score determined by performance in four domains:

- Quality (includes measures in the current PQRS, VBM, and MU programs)
- Resource Use (includes measures in the current VBM program)
- Meaningful Use (meaningful use of a certified EHR would continue to apply)
- Clinical Practice Improvement Activities (a new reporting requirement)

The annual MIPS score is then compared to a national benchmark resulting in a positive, negative, or neutral payment adjustment for the provider with the highest performing providers receiving proportionally larger incentive payments. Though MIPS does not appear to reduce the individual reporting requirements now in place for ambulatory care, and actually introduces a few new ones, the alignment and organization of multiple reporting efforts into a single program would be a welcome one.

Physicians Consortium for Performance Improvement (PCPI): We are moving ahead with vote on four (4) new perioperative care measures for anesthesiology. This is a highly positive development as this is as far as our specialty has moved on new measures. The meeting scheduled for March 2014.

New PQRS Measure: As of January 2014, anesthesiologists will be able to report on Physician Quality Reporting System (PQRS) Measure #44: Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery. According to the Individual Measure Specification Manual released last December, anesthesiologists may now report CPT® Codes 00566 and 00567 for CABG as well as CPT Code 00562.

OIG: The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has released its 2014 work plan. Several issues important to anesthesiology are in this work plan and ASA is tasking resources to respond.

Regulatory / CMS PFS 2014: In response to the CY 2014 Medicare fee schedule final rule, which includes provisions that dramatically cut payments for certain pain codes, a "Pain Societies Letter to CMS" was developed in which ASA participated. The letter urged the Agency to stop the implementation of steep cuts to physician payments for Interlaminar Epidural procedures (CPT® Codes 62310,

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[FROM THE NCSA EDITOR]

FRANK M. SUTTON, JR, MD, MBA

The Newsletter is the most important communication tool between the NCSA and its members, and as such we take it very seriously. Its printed form largely unchanged, the Newsletter has served us well—keeping us informed on ASA activities affecting North Carolina anesthesiologists, educating us on federal and state policy issues, and sometimes calling us to action. Over the years, it has been the place where we share information and successes about protecting patients through physician supervision, improving access to care through Anesthesiologist Assistant licensure legislation, and lowering health care costs through historic tort reform. It is a proud heritage of one of the most effective state component anesthesia societies in America.

Communication methods continue to evolve, and the NCSA is considering ways to augment the Newsletter to better inform our members. Our desire is to communicate with you when, on what topics, and in what format you wish. To assist us in understanding your needs, a brief member survey will be sent to you over the summer. Your responses are very important, and they will help us shape future communications methods and topics.

To facilitate these efforts, the role of Associate Editor has been expanded and divided. We are pleased to have Matt Hatch, MD, MBA (Wake Forest University, Winston-Salem,) as the Associate Editor for the Newsletter, and Rob Royster, MD (American Anesthesiology, Raleigh,) as the Associate Editor for Digital Communications. Their insight and enthusiasm will greatly contribute to improving our service to you.

Thank you for your continued support of the Society. Please feel free to contact me directly should you have any ideas about how we can better meet your needs.

Frank M Sutton, Jr, MD, MBA
NCSA Secretary/Treasurer-Elect and Newsletter Editor
frank.sutton@allcareclinical.com
AllCare Clinical Associates, PA
Asheville

Members

To improve our efforts at effective communication, we have created a page on LinkedIn.com for NCSA members only. This can be found by visiting **http://www.linkedin.com/groups?gid=6626437**. Please visit and request to join! It is our desire to use this site to post pertinent dates, including flash updates and action items, and to encourage open discussion amongst our members. As an NCSA member, you will be able to join into or open a discussion here and receive feedback from NCSA leadership as well as other members. Used correctly, this powerful tool will help us to harness our collective knowledge and resources and become an even more effective society.



[LEGISLATIVE AND REGULATORY UPDATE]

DANA E. SIMPSON, ESQ.
JAMES A. HARRELL III, ESQ.
KARA WEISHAAR

The North Carolina General Assembly is busy preparing for its 2014 Short Session, which begins in May. A number of legislative committees are meeting to develop policy proposals on issues related to Certificate of Need, Medicaid Reform, and Scope-of-Practice Issues. Below is a preview of what NCSA members can expect from this year's legislative session.

CERTIFICATE OF NEED

For many years, the NCSA, along with other hospital-based specialties, has supported the North Carolina Hospital Association ("NCHA") in seeking to maintain the State's existing certificate of need ("CON") laws. CON rules help determine the need for additional operating rooms in various regions of North Carolina. CON laws have allowed nonprofit community hospitals to maintain their financial viability and avoid being "cherry-picked" of commercial patients by for-profit ambulatory surgery centers ("ASCs") that do not treat the same volume of Medicaid and uninsured patients.

During 2013, orthopaedic surgeons, ophthalmologists, and a few other surgical specialties mounted a legislative campaign seeking to eliminate CON determinations for single-specialty ASCs. The NCSA joined the NCHA, radiologists, emergency physicians, and other hospital-based specialists in opposing this policy change for fear of eroding the already difficult patient mix of North Carolina community hospitals. North Carolina community hospitals are already facing unprecedented challenges with the implementation of the Affordable Care Act, and the NCHA is concerned that major changes to the CON law will exacerbate these financial challenges.

A joint committee of House and Senate members is currently reviewing the single-specialty ASC reform proposal that was advocated last year by Rep. Marilyn Avila (R-Wake). It is unclear whether the General Assembly will push for reforms during the 2014 Short Session. Jim Harrell is taking the lead on this issue for the NCSA and may be in contact with NCSA members in particular areas, asking them to educate lawmakers about the difficulties that would be created by an explosion of new single-specialty ASCs that undermine the financial viability of community hospitals.

MEDICAID BILLING SYSTEM (NCTRACKS)

North Carolina health care providers have experienced significant Medicaid billing difficulties since the State introduced a new Medicaid claims processing system—called NCTracks—in July. For several months, health care providers did not receive full reimbursement for Medicaid claims submitted to the new system. Legislators conducted multiple oversight panels in the Fall, seeking answers from the NCTracks vendor (CSC) and the Department of Health & Human Services ("DHHS"). A panel of Medicaid billing experts testified before the General Assembly in October regarding the numerous deficiencies in the new NCTracks system. The North Carolina Anesthesia Practice Managers Association ("NCAPMA") was well represented on this panel by Sherry Williams of Piedmont Triad Anesthesia in Winston-Salem.

Medicaid claims processing and reimbursement has gradually improved over the last few months, but challenges remain. In January, a group of physician practices sued CSC and DHHS as part of a proposed class action lawsuit related to losses by Medicaid providers as a result of NCTrack's implementation. NCSA continues to work closely with the North Carolina Medical Society ("NCMS") in seeking to assist NCSA member practices that have concerns regarding NCTracks.

MEDICAID REFORM

Since the General Assembly adjourned in July 2013, Governor McCrory's Administration has listened to the health care community about concerns with the Administration's initial Medicaid reform plan that proposed contracting with HMOs to run the State's Medicaid system. Following a three-month listening tour, DHHS officials worked hard through the Winter to develop an alternative plan. In late February, DHHS presented a revised reform plan to the Governor's Medicaid Advisory Task Force. The new reform proposal is much improved and is based on solutions advocated by the NCMS and other Medicaid providers. Specifically, in lieu of HMO management of the Medicaid system, DHHS is now proposing to reform Medicaid by using physician-driven accountable care organizations ("ACOs'). NCSA members have been working several years on ACOs and other value-based payment reforms through the leadership of NCSA General Counsel Bo Bobbitt. ACOs are designed to align the incentives of primary care physicians, specialists, hospitals, and other providers to slow the growth of Medicaid expenditures. If an ACO is able to lower Medicaid expenditures for a particular Medicaid population below budget targets (while also meeting quality metrics), then the ACO's health care provider participants will share in the savings with the State. Likewise, if forecast targets are exceeded by the ACO, then the ACO will share in the downside risk with the State.

Members of the Medicaid Advisory Committee applauded the Governor's new proposal. Rep. Nelson Dollar (R-Wake) was very supportive of the new plan because he has been a champion of provider-driven ACOs and the State's existing medical home network—Community Care of North Carolina. NCSA Past-President, Richard Gilbert, MD of Charlotte, is the only physician member of the Governor's Medicaid Advisory Committee. Dr. Gilbert was a strong, effective proponent during Committee discussions in support of allowing physicians and other health care providers to manage Medicaid costs, rather than turning the system over to HMOs.

DHHS officials continue to work on a detailed plan for implementing ACOs, along with other proposed Medicaid changes in behavioral health and long-term care. A final plan is expected to be unveiled by DHHS in mid-March and voted on by the Medicaid Advisory Committee. It is unclear whether the General Assembly will enact the proposed reforms during the 2014 Short Session or carry over reform discussions into 2015. The NCMS and NCSA are cautiously optimistic that the final plan adopted by DHHS will be one that the medical community can support at the Legislature.

PHYSICIAN SUPERVISION/SCOPE OF PRACTICE

On the scope-of-practice front, HB 181 passed the North Carolina House in 2013 with an overwhelming bipartisan majority. This legislation codifies the existing North Carolina legal requirement that CRNAs providing anesthesia services must be supervised by a physician. Unfortunately, HB 181's progress was stalled in the North Carolina Senate after it was referred to the Rules Committee. Because HB 181 passed the NC House last year, it is eligible for consideration in the 2014 Short Session. Although a bipartisan majority of the Senate supports the Bill, it remains unclear whether the Rules Committee will take it up for a vote during the 2014 Short Session. Fortunately, the Senate did not take up in 2013 competing legislation that would have eliminated the requirement of physician supervision of CRNAs; therefore, that legislation is not eligible for consideration this year.

On a related front, a Joint Legislative Study Committee is considering a proposal to eliminate the requirement of physician supervision for nurse midwives. The elimination of the longstanding requirement of physician supervision of nurse midwives is opposed by the NCMS, the North Carolina OB/GYN Society, and other physician groups, including the NCSA.

POLITICAL UPDATE

The filing period for North Carolina's 2014 elections ended on February 28th. While a large number of incumbents do not face challengers this Fall, many others do confront either a primary or general election battle…or both. North Carolina anesthesia practice-based PACs will be active during this election cycle to support candidates of both parties who support good health policies that promote patient safety and access to care.

As always, please do not hesitate to contact Kara Weishaar, Jim Harrell, or Dana Simpson if you have any questions regarding NCSA regulatory or legislative matters.

[SPECIAL REGULATORY UPDATE]

JULIAN D. ("BO") BOBBITT, JR., ESQ.

DON'T BE STRONG-ARMED IN EXCLUSIVE CONTRACT NEGOTIATION: OIG ADVISORY OPINION NO. 13-15 CAN HELP

In an interesting twist, a group of anesthesiologists sought and obtained a favorable Advisory Opinion from the Office of Inspector General ("OIG") that the strong-arm tactics the hospital used in carving out the anesthesiologists' exclusive contract services in favor of referral sources violated the federal anti-kickback statue. NCSA members may recall that NCSA legal counsel raised this point regarding a widespread practice of managed care companies and hospitals whereby a hospital would be under pressure to have all of its hospital-based providers contracting with that managed care company, regardless of the inadequacy of the reimbursement, lest the hospital be "punished" through a discount by the managed care company. This created pressure on anesthesiologists to sign on for otherwise totally unacceptable managed care rates. The logic is that anesthesiologists have long argued that such arrangements trigger the anti-kickback statute, which prohibits remuneration paid purposefully to induce or reward referrals of items or services paid by a federal health care program. Although logical, absent a specific Advisory Opinion against this type of indirect scheme, the utility of this argument was limited for anesthesiologists.

In the fact situation presented in OIG Advisory Opinion No. 13-15, a hospital sought to carve out of its anesthesiologist exclusive contract the anesthesia services provided a new psychiatry group with attractive referrals relocated to the hospital. A subsequent amendment included a provision that if the psychiatry group needed the support of an anesthesiologist, the anesthesiology group could either reach an agreement to provide those services at fair market value as determined by the hospital, or the psychiatry group could get those services from an outside anesthesiologist. Later on, the psychiatry group said that it needed a part-time physician to provide anesthesia services and would pay on a per diem rate. As the OIG wrote, "The Psychiatry Group would retain the difference between the amount collected and the per diem rate."

The OIG made clear that, "The opportunity to generate a fee could constitute illegal remuneration under the anti-kickback statute, even if no payment is made for a referral. … The Proposed Arrangement appears to be designed to permit the Psychiatry Group to do indirectly what it cannot do directly; that is to receive compensation in the form of anesthesia services revenues in return for the Psychiatry Group's referrals of ECT patients to [hospital] for anesthesia services."

The OIG went further in stating that it could not exclude the possibility that the hospital agreed to negotiate with the psychiatry group in exchange for a reward for its referrals to the hospital, that the hospital leveraged its control over its anesthesia referrals to force the anesthesiologists to agree to the carve-out, and that the anesthesiologists agreed to the carve-out in exchange for the stream of anesthesia referrals from the hospital.

Implications – The American Society of Anesthesiologists ("ASA") expressed approval of the ruling, which, in their opinion, addressed one of the main problems with the company model-like arrangement in a hospital setting. In fact, the ASA has called for OIG investigations into company model arrangements. An ambulatory surgical center newsletter took the opposite tack and stated that its reaction to the Opinion was that, "The anesthesia community has become unusually adept at utilizing the Advisory Opinion process to influence market activity."

Any time you are being held hostage to take blatantly unreasonable exclusive contract terms, this Advisory Opinion is arguably applicable. The hospital is trying to extract something of value beyond what is fair and reasonable in exchange for its flow of anesthesia referrals. This may include, as noted, the "take-all-managed-care-contracts" clause often seen, and certainly would implicate carve-outs that are not consistent with sound medical care best practices and/or hospital medical staff policies and procedures or Joint Commission accreditation standards.

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[FROM THE PRESIDENT] CONTINUED FROM THE COVER

A team comprises a group of people ….linked in a common purpose. Teams are especially appropriate for conducting tasks that are high in complexity and have many interdependent subtasks. A group in itself does not necessarily constitute a team. Teams normally have members with complementary skills and generate synergy through a coordinated effort which allows each member to maximize his/her strengths and minimize his/her weaknesses. Team members need to learn how to help one another, help other team members realize their true potential, and create an environment that allows everyone to go beyond their limitations. (www.wikipedia.org)

Although we work side-by-side, day-by-day with our CRNA and AA colleagues, are we really functioning as a team? Do we really all have the same goals, or are we just working together while secretly trying to advance our own agenda? If that is the case, then we will never succeed. We often say that a chain is only as strong as its weakest link. What is the weakest link of our anesthesia care team? Some would say it is the CRNAs continued push for independent practice, while others would say it is anesthesiologists who should do more to foster team work. I don't know the answer but the solution lies in determining everyone's true motivations, and finding a way to turn our focus toward the patient. Until we can all work together, we will never succeed. Michael Jordan was one of the greatest basketball players of all time. Until he received additional players to help him in Chicago, they did not win any championships. One part of the team cannot succeed without the rest.

I wish that more anesthesiologists were members of the ASA. We as physicians have a problem with being politically engaged. We sometimes perceive it as being unnecessary, or sometimes unethical. The ASA clearly has done a lot for our specialty, from education to lobbying and legislative activity. If we were to try to do this all alone, we could not do it. The educational activities that are available at the ASA annual meeting make the cost of membership worthwhile. In addition, when it comes to lobbying and political activities, the fact of the matter is that we have to be engaged. It is no longer acceptable to simply go to work every day and take care of patients. We have to focus on the bigger picture and the ASA is the vehicle to get this done, both nationally and locally. Although we don't want to think about political fundraising, our elected officials need money to run their campaigns and get into office. It is important that we have elected officials who share our concerns about patient safety and other opinions on health care matters. We need to be engaged, not just when there is an issue, but always. We should be trusted health care advisors to our elected officials so that they come to us when there is an issue instead of vice versa.

This is a big wish list, but I have three more months until Christmas in July, who knows what may happen.

[SPECIAL REGULATORY UPDATE] CONTINUED FROM PAGE 6

The OIG specifically noted as a possible legal concern that the anesthesiologists actually agreed to the deal so that they could get the referrals under the exclusive contract. If you have absolutely no leverage so that taking these unreasonable terms would be what we lawyers call a "contract of adhesion," it is prudent to at least note in internal e-mails or other documentation that your group is not willingly accepting these terms and that so doing is not purposefully done to induce the hospital to send referrals to your practice.

If you have any questions or comments, please feel free to contact NCSA general counsel or Bo Bobbitt (bbobbitt@smithlaw.com).

NC society of
ANESTHESIOLOGISTS
THE BEACON OF PATIENT SAFETY

P.O. Box 1676
Raleigh, NC 27602

DATES TO REMEMBER

May 5 – 7, 2014
ASA Legislative Meeting
Washington, DC

September 19 – 21, 2014
2014 NCSA Annual Meeting
The Pinehurst Resort
Pinehurst, NC
Email Kara Weishaar
(kweishaar@smithlaw.com) if you have
interested exhibitors or questions.

[FROM THE NCSA EDITOR] CONTINUED

62311, 62318, 62319). We have taken the highly unusual approach a requesting a 'Refinement Panel'. No response as of yet to the letter.

Regulatory / RUC: The American College of Surgeons requested ASA sign on to their letter to Dr. Barbara Levy, Chair, American Medical Association (AMA) Relative Update Committee (RUC), regarding AMA RUC Revisions to Pre Time Packages and Introduction of New Packages for Facility Immediate Post Service Time. ASA joined in this effort and again, we are awaiting a response.

Veteran's Health Administration: As some of you may know, the current Anesthesia Service Handbook sets policies and procedures related to anesthesia within the VHA. Last year reflected a new draft "VHA Nursing Handbook" that sought to: 1) replace care "provided in a team fashion" with a requirement that all Advanced Practice Registered Nurses (APRN), including nurse anesthetists, "attain independent status;" 2) strip local Chiefs of Anesthesiology from decision-making, shifting privileging decisions to VA's Washington, DC office; and 3) eliminate scope of practice as defined by any state. Many see this as an attempt by the nurse anesthetists as an attempt at a *defacto* national 'opt out'.

ASA has taken a Three Pronged Strategy in response to this action.

U.S. Congress Engagement: Representatives Grimm and Kirkpatrick have joined together to author a Congressional sign-on letter to VA Secretary Eric Shinseki expressing concern about the proposed VHA Nursing Handbook and its application to the surgical/anesthesia setting.