SUMMER 2013

THE NORTH CAROLINA SOCIETY OF ANESTHESIOLOGISTS

the beacon for patient safety in North Carolina

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[FROM THE PRESIDENT]

R. PAUL RIEKER, JR., MD

"The achievements of an organization are the results of the combined effort of each individual." Vince Lombardi

There have been 50 years since Vince Lombardi dominated professional football as one of the greatest coaches in any sport. He was known for his professionalism, discipline, and demanding coaching style. The goals for his team were clear. He expected to win and understood that winning was the result of execution. His teams won the first two Super Bowls and one of the most coveted prizes will forever bear his name as the Vince Lombardi Trophy.

It may be difficult to compare the North Carolina Society of Anesthesiologists to the Green Bay Packers of the 1960s, but similarities exist. Both are goal-oriented organizations that rely upon teamwork for success. Instead of touchdowns and field goals, patient safety and professional advocacy are the winning objectives for the NCSA. Our team is composed of dedicated medical, legal, and executive professionals working together to promote those standards.

This year has been an important season for our specialty with the approaching implementation of the Affordable Care Act and the passage of House Bill 181 in the North Carolina General Assembly. Our Society and Profession have been well served by its active members who have been engaged in these issues by effective lobbying in Raleigh and around the state. There has been a steady presence of Anesthesiologists, in conjunction with our capable legislative affairs team, at the General Assembly during this 2013 legislative session. These combined efforts have been successful in promoting the importance of physician supervision of anesthesia for patient safety. Thanks to all who have met with the members of the General Assembly, attended and testified at committee hearings, and strongly advocated for physician supervision of anesthesia.

I recognized another similarity between the 1960 era Green Bay Packers and the North Carolina Society of Anesthesiologists while recently attending the

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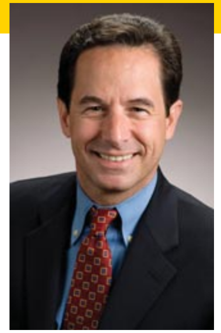

[FROM THE ASA DIRECTOR]

GERALD A. MACCIOLI, MD, FCCM

Healthcare as a service sector and healthcare reform have so much going on right now on such a diverse variety of fronts it's a cacophony. Some key areas of ASA's recent activity have revolved around the *(never ending?)* discussion and debate about Sustainable Growth Rate reform. The US House Committee on Energy and Commerce has proposed to repeal and replace the SGR Formula. ASA has been an active participant in this dialogue, and continues to stress our well-known '33%' problem. I have no doubt something will happen with the SGR . . . I am just not sure what! As those of you who have been involved well know, ASA has been advocating for resolution of our payment discrepancy for a long time without success.

CMS continues to move ahead with plans for utilization of the Value-Based-Payment-Modifier (VBPM) in 2015. As I have written before the VBPM is something that keeps me up at night. While these new criterion will influence our payments we do not, as of yet, know what they are. Oddly, CMS reports the 2015 VBPM will be based on performance in 2013 and 2014. All very Byzantine! The ASA Committee on Performance and Outcomes Measures (CPOM) and liaison group to the AMA Physicians Consortium for Performance Improvement (PCPI) continue to bring clarity to this matter for our specialty so we can understand the metrics and prepare to report them in a validated fashion. More to follow on this issue as the clock ticks down on the deadline for practicing physicians!

ASA continues to highlight the importance of maintaining the hardship exemption for anesthesiologists as regards the adoption and implementation of healthcare information technology. Specifically ASA is advocating for modifications to the 'meaningful use' criteria so that members of our profession do not have unreasonable barriers to achievement.

No doubt you have all been following the state-by-state battles on implementation of various components of PPACA (aka *'Obama Care'*). ASA along with many other medical specialty societies voiced a tremendous amount of concern over the IPAB (Independent Payment Advisory Board). To date the White House has not appointed any of the fifteen members of this committee nor has Congress elected to act to fill these appoints apart from the administration. Personally, I see this as a positive development but also as yet another example of a poorly designed component of a completely flawed piece of legislation. The administration's failure to follow their own law (PPACA) speaks volumes about the enormous number of implementation problems with the various rules and regulations enacted by Congress.

Parallel to all of this Washington action, a variety of 'interested parties' and various institutes continue with their own agendas and activities as they relate to healthcare reform. One that I wanted to highlight is the Healthcare Incentives Improvement Institute (HCI3) recent report on Bundled Payments One Year Later. This report was released on 30 May 2013 and is an excellent overview of the implementation and operational findings vis-à-vis bundled payments. The full report can be found at: **http://www.hci3.org/sites/default/files/files/IB.BundledPayment-June2013-L3_0.pdf**

As always thank you for the privilege of serving as your ASA Director. Please do not hesitate to contact me if I can be of service to you.

[LEGISLATIVE AND REGULATORY UPDATE]

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

The North Carolina General Assembly adjourned its 2013 Session on July 26th. This Session was dominated by debates over tax reform and the competing policy agendas of newly-inaugurated Governor McCrory and GOP leaders in the House and Senate. From the perspective of the North Carolina Society of Anesthesiologists ("NCSA") scope-of-practice issues were at the forefront of the legislative agenda this year. In addition, the NCSA was involved heavily in policy debates regarding Medicaid reform and reimbursement.

PHYSICIAN SUPERVISION OF NURSE ANESTHESIA SERVICES (HB 181)

In late February, a bipartisan group of House and Senate members introduced bills to clarify and put into statute the existing legal requirement that CRNAs providing anesthesia services in North Carolina must be supervised by a physician. Representatives Nelson Dollar (R-Wake), Tim Moore (R-Clayton), Mark Hollo (R-Alexander) and Michael Wray (D-Northampton), filed HB 181 to codify the existing physician supervision requirement. Simultaneously, Senator Bob Rucho (R-Mecklenburg) filed similar legislation in the North Carolina Senate with support from a bipartisan group of co-sponsors. The goal of both bills was to codify existing North Carolina law and to end, once and for all, the confusion caused by a handful of CRNAs who have repeatedly attempted to challenge the requirement of physician supervision.

At the same time, the North Carolina Association of Nurse Anesthetists ("NCANA") introduced legislation to eliminate the existing legal requirement of physician supervision. Specifically, Senator Jim Davis (R-Jackson) filed SB 179, which defines CRNAs as performing nurse anesthesia activities "in *collaboration* with a physician, dentist, or podiatrist." Representative Jeff Collins (R-Nash) filed a similar collaboration bill in the North Carolina House. Thankfully, neither of these bills was taken up by any committee in the North Carolina House or Senate, and are, therefore, not eligible for consideration in 2014.

HB 181 was debated in the North Carolina House by two legislative committees. A number of NCANA leaders testified that physician supervision should not be required in North Carolina. NCSA President Paul Rieker, MD, and NCSA member and former CRNA Bob Wilson, MD, testified in support of HB 181. In addition, HB 181 was strongly supported by the North Carolina Medical Society, the North Carolina Dental Society, and the North Carolina Hospital Association. After receiving overwhelming support in both House committees, HB 181 was passed by a strong, bipartisan majority of the North Carolina House of Representatives with a vote of 93-22.

Despite having strong bipartisan support, HB 181's progress stalled in the North Carolina Senate after it was referred to the Rules Committee. Fortunately, a bipartisan majority of the Senate supports the bill, and it remains eligible for consideration by the Senate in 2014.

While we are disappointed that the Senate did not enact HB 181 this year, we are pleased that large, bipartisan majorities of both the House and Senate agree with the NCSA that physician supervision of CRNAs should remain North Carolina law. We are hopeful that this important legislation will be considered by the Senate in 2014.

OTHER SCOPE-OF-PRACTICE ISSUES

This year, the NCSA joined with the North Carolina Medical Society and other specialty societies to undertake a multimedia campaign to educate legislators about the patient safety benefits of physician supervision. The North Carolina Coalition to Protect Patients posted weekly reports about the value of physician supervision on their website – **www.protectncpatients.com**. This educational effort was

particularly beneficial, given the number of scope-of-practice expansion bills introduced in the General Assembly.

In addition to the two CRNA "collaboration" bills mentioned previously, legislation was filed to eliminate the requirement of physician supervision for nurse midwives, to eliminate medical oversight of nurse practitioners, to license professional (non-medical) midwives, and to license naturopaths. The medical community opposed each of these legislative efforts and ultimately none were passed by the General Assembly. The final state budget does, however, include a provision requiring a study of the elimination of the requirement of physician supervision of nurse midwives.

MEDICAID REFORM

One of the first pieces of legislation passed this year by the General Assembly was SB 4, which prohibits the Governor from expanding North Carolina Medicaid under the federal Affordable Care Act without further legislative authorization. This bill set the tone for a year that featured significant debate about the future of North Carolina's Medicaid program.

In April, new Secretary of Health and Human Services Aldona Wos and Governor Pat McCrory proposed a substantial makeover of North Carolina's Medicaid program by turning it over to for-profit Medicaid HMOs to administer the program. This proposal was strongly opposed by the medical community, the North Carolina Hospital Association, and most other health care provider groups. This opposition stems from the experience of other states with Medicaid HMOs that have seen cost savings generated primarily through limiting patient access to services and substantial cuts in physician reimbursement. Instead of turning Medicaid over to out-of-state HMOs, most physician organizations believe North Carolina should enhance and expand its nationally-recognized medical home model called Community Care of North Carolina.

Despite the push by the Governor, legislative leaders were reluctant to embrace the administration's idea of privatizing Medicaid. In fact, the final state budget prohibits the administration from implementing any Medicaid reform without further legislative authorization. It establishes a joint Legislative-Executive Branch Study Committee that will propose new Medicaid reforms. The Study Committee is expected to make its recommendations to the General Assembly prior to the 2014 Short Session.

MEDICAID RATES

The final state budget includes a 3% rate cut for physician Medicaid services beginning January 1, 2014. This cut affects physicians and inpatient hospitals, as well as other Medicaid providers. The state budget includes language directing the Department of Health and Human Services ("DHHS") to work with the provider community to develop a shared savings plan to "provide incentives to provide effective and efficient care that results in positive outcomes" returning some portion of the funds accumulated from the rate cut-back to providers beginning in 2015. DHHS must provide the Legislature with a report of this shared savings plan by March 1, 2014.

The budget also includes significant cuts for North Carolina hospitals. While hospitals avoided the elimination of their sales tax refunds in the final tax package approved by legislators, they were not so fortunate in the final budget. The budget increases the state's retention of hospital provider assessment "taxes" by $52-million, or 25.9% of the total assessment paid by hospitals. Additionally, outpatient payments to hospitals are reduced from 80% to 70% of costs, which will result in $48-million in total hospital cuts once fully implemented. Finally, hospitals face the same 3% rate cut/shared savings incentive as physicians.

CONCLUSION

We will provide a more in-depth overview of these and other health policy issues confronting North Carolina lawmakers at the NCSA's Annual Meeting at the Grove Park Inn in September. We hope you will make plans to join us for this discussion. In the interim, please do not hesitate to contact Kara Weishaar, Jim Harrell, or Dana Simpson if you have any questions regarding NCSA legislative or other matters.

[GUEST COLUMN]

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

THE NEW EXCLUSIVE CONTRACTING DYNAMICS AND HOW TO PREPARE

According to a recent survey of hospital executives, 97% predict that by 2015, their hospital will be involved in bundled payments and 75% will be active in accountable care organizations ("ACOs"). Both of these new methodologies are predicated on the premise that providers will be paid for value (highest quality at the lowest cost), not volume, like the fee-for-service system. Hospital consultants – like The Advisory Board and the American Hospital Association – are uniform in their advice that survival under these models commands that hospitals find, partner with, and incentivize physicians who can improve quality, streamline processes, reduce unjustified variation, work in teams to better coordinate care across the continuum, and engage the patient. It must be "win/win" as success in providing high-quality care below the bundled payment cap, or creating substantial shared savings under an ACO, depends on every team member excelling. This is a very stressful time for hospital executives and these radical changes create even more stress by pulling them way out of their comfort zones. Human nature dictates that there will be tremendous instinctive pressure to do just the opposite – forget partnering and revert to "command and control" mode and think "win/lose" (i.e., a dollar you get is a dollar they don't).

Hospital executives in North Carolina are at a real crossroads – will they grasp and have the courage to follow the unknown path of partnership or will they cling to the old and familiar patterns of the fee-for-service world? This is currently playing out in hospital/anesthesiologist exclusive contract dynamics. Worst case – you and your administrator are contracting to cover the 2015 period when the world has changed, but are negotiating using yesterday's mutually destructive perspectives.

I. **Progressive Scenario** – If you read the hospital consulting and association recommendations as the new reality, your hospital will know that their anesthesiologists need to provide high quality, engage in perioperative process and workflow management, optimize patient pre-op to minimize delays and cancellations, reduce variation, and provide patient-centered care.

- Bundled Payment Example – The hospital, anesthesiologists, and surgeons will collect historical data, lock in the episode of care covered by the bundle, (i.e., a total hip replacement), severity adjust the data, and set a complications factor based on that historical information. The hospital executive knows that being successful under bundled payments is NOT about fee reductions, but rather in the following:
  - Reduced complications.
  - Improved and standardized procedures and processes across all operating rooms in the hospital system (includes pre-op protocols with referring physicians).
  - Fewer readmissions.
  - Fewer infections.
  - Standardized, most cost-effective use of devices, equipment, and medications.
  - Lower cost with equal quality site of procedure selection.

As you know, anesthesiologists are in an excellent position to facilitate accomplishment of these goals. In short, under value-based reimbursement, there will be new recognition of your value-add role as manager of the "surgical home." On the cost/benefit ratio, your historic "cost" is relatively small (i.e., 4%-7% of bundle), but now in the value-based reimbursement world, your "benefit" potential is significant.

Progressive Scenario Strategy

- They don't know what you do. Months before negotiations, make sure that your practice is actually in position to be a high-value partner. Once talks start, assume that you will have to tell your quality and savings value-add story. Make sure they are viewing the relationship through the new value-based reimbursement "lens." This is a huge opportunity, but will be new to both of you. Use as sources their trusted advisor recommendations to back your win/win proposition. You are the "go-to" value-add group that "gets it."
- Confidentiality. They will need historical fee and compensation data to establish the core bundled payment fee. Your innovative processes will have intellectual property ("IP") value. You will need a confidentiality clause that protects use of your financial, proprietary, and patient information. You should negotiate to have a third party review the historical data without disclosure to the hospital or others.
- Build an On-Ramp for Success. Anticipate the collaborative activities and processes and the quality and efficiency metrics that will come into play. Don't be passive.
- Partnership Terms. Under the progressive scenario, you should get less pressure to accept the usual "deal-killers" in a one-sided exclusive contract – "clean sweep," take-all managed care contracts, unilateral reductions in scope of your exclusive, or unilateral changes to rules related to supe• Avoid Hospital-Only ACO Lock-In. A progressive administrator will understand that it is way too early to predict how ACOs will develop generally, much less in your area. If you are a "go-to" value-add group, you should be a desirable partner for all ACOs, which means it makes the hospital a more likely candidate for fee-for-service referrals. However, you may need to raise awareness of the win/win wisdom of you not being locked into just the hospital's ACO. This raises interesting antitrust and public policy enforceability issues.

II. **Reactive Scenario** – Under all the pressures facing hospitals now, under this "reactive" scenario, your administrator has unfortunately clung to the familiar "command and control," win/lose thinking and to viewing anesthesiologist services as fungible commodities. Under this old-school misperception, you are a "cost" and there is no "benefit."

- Worsened by Hospital-As-Payor Shift. These mutually destructive tendencies are exacerbated by the fact that hospitals may be holding

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[FROM THE NCSA EDITOR]

TIMOTHY GUNDLACH, MD

When I lived in Wisconsin, I had the privilege of serving on the Board of Directors of Racine Lutheran High School for seven years and as its president for the last five. Even though my father had been a high school teacher and I had been active at the elementary school my children attended, I spent the first several years on the Board trying to figure out what our job was and how we were supposed to accomplish it. I thought I was the outlier with regards to this until we had an outside group come in to survey the school and offer recommendations for improvement. They asked a simple question of each board member: "What is the Board's job?" Nobody had a clear, concise answer. We all knew we were responsible for the budget and generally for the future direction of the school, but had no clear idea of how we were supposed to impact things like teacher performance and student accomplishments.

After the survey, it was suggested that we look at policy governance and consider implementing it at the school. As president, I had the responsibility to learn what policy governance was and led the board in determining whether it was right for our school. I read two books by John Carver who developed policy governance. Put in its simplest terms, policy governance asks the board to do only a few things. First, determine the "ends," namely, **what** is being delivered, to **whom**, and at what **cost**. Once that is determined the board sets limits on how to accomplish these ends. Specifically, what **cannot** be done to accomplish them. For example the institution cannot operate at a fiscal deficit. After this groundwork has been laid, the board is responsible for providing the resources to accomplish its ends and monitoring the leadership of the institution to make sure there is progress to achieving the ends and that the set rules for accomplishing them are being followed.

Two important aspects that I have taken with me from that experience are, I think, important in many areas of life and in healthcare. First, the board can't micromanage the daily workings of the school without taking the responsibility to **personally** monitor compliance with its directives. Secondly, by only limiting what **cannot** be done to accomplish the ends, the board allows creativity and innovation. The fixation we have in this country on top down solutions to problems and uniformity of processes stymies creativity and ignores the differences that exist between institutions and communities. I'll cite one example. I have always found ridiculous the Joint Commission's micromanaging of policy to prevent wrong-side surgeries. Why tell physicians what word may be written where and tell the world that is the single best way for every single health care facility in the **entire country** to assure patient safety. Why not set and end of no wrong sided surgeries and allow hospitals to figure out what is the best way to do that for their specific patients? For example, I applaud the goals of the AMA's Committee on Innovators (and know that Jerry Maccioli is doing great work to help anesthesia's cause on the Committee). However, I worry that in the end, the AMA could inadvertently discourage innovation in its efforts to build a consensus that bureaucrats in Washington will approve, and then institute across the entire country, penalizing anyone who doesn't follow them to the letter.

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[FROM THE PRESIDENT] CONTINUED FROM THE COVER

American Society of Anesthesiologists' Legislative Conference. Just as the National Football League has named the Super Bowl trophy after one of its legendary coaches, the ASA has named the Excellence in Government Affairs Award after Dr. Bertram W. Coffer. He served our society for many years as a Past President and Director. His reputation and many relationships with other professionals and government leaders were extraordinary. Smart and powerful people listened to Bert Coffer. This award recognizes extraordinary individuals "for exemplary contributions to the Medical Specialty of Anesthesiology and its Practioners and their Patients." Dr. Coffer himself was the 2004 ASA Excellence in Government Affairs Award recipient, before it was named in his memory, in recognition of his longtime efforts advocating for patient safety. The legacy of advocacy that Dr. Coffer fostered continues to flourish for the NCSA.

I often receive inquiries from Anesthesiologists across the state about how to get involved with the North Carolina Society of Anesthesiologists. My response is to attend the meetings, special events, and participate with your local PAC. It is not hard to get involved. Beyond the current legislative efforts, the next opportunity to be engaged will be the Annual Meeting to be held at the Grove Park Inn September 6th-8th, 2013. Dr. Bryant Murphy is the course director who has organized an informative program. That weekend will include the next Business Meeting, which is open to NCSA Members. Please plan to attend and look for the registration material.

In closing, the NCSA continues the work of advancing patient safety and professional advocacy in our state. Our team has been successful because of the dedicated past and present participation of many. The alignment of the NCSA with effective executive and legislation affairs professionals has further enhanced the abilities of the North Carolina Society of Anesthesiologists. I encourage your continued support and involvement.

Respectfully submitted,

R. Paul Rieker, Jr., M.D.

[GUEST COLUMN] CONTINUED FROM PAGE 5

all the bundled payment and ACO shared savings monies. It is just natural then to tend to dole out as little as possible of "their" money. They don't see yet that the way to succeed in the new health care is to coordinate with and incentivize you to "compress the episode of care" as to consultants, say, and to generate savings for a patient population. Sadly, under this reactive scenario, it is still all about costs, each player still in their silos.

Following this out logically, from this viewpoint, look for pressure like never before to see contract terms making you replaceable by another fungible lower cost commodity. They don't want you to hold them "hostage" and will demand that you take all managed care contracts, however unreasonable. In a very destructive move that would disrupt standardized best practices so crucial to success, they would seek to chop up the anesthesia scope of the exclusive among non-anesthesiologists and practice sites.

- Reactive Scenario Strategy – You absolutely need to understand your new value-add potential, then reduce that into a compelling story. Use hospital trusted third party authorities as well, to make your point that it is in the hospital's enlightened self-interest to give you a minimally stable contract to allow you to leverage your value-add skills for their bundled payment success.
  - Be Concrete. Show them a real bundled payment or ACO initiative and how important you are to meeting those milestones.
  - Anesthesiologist Shortage. Use their sources to show that you can't recruit or retain without a reasonable contract. If they want expanded OR coverage to entice surgeons, they need to pay you a stipend. There is still a positive "ROI" – or return-on-investment, after the stipend.
  - Consider the Alternative. Illustrate the disjointed chaos if an itinerant replacement group was brought in. Show how liability issues, loss of reputation, loss of surgeon referrals, increased complications and delays may happen. You are not a fungible commodity.
  - Suppose the Hospital Never "Gets It?" Unfortunately, these exclusive contracts are like the "canary in the coal mine," in that they are being negotiated now, when the world really has not changed too much and hospital executives are under maximum stress, but will cover a time period later when that world will be vastly changed. If the hospital never gets it, they probably won't be around. You may not want to sign that exclusive, especially if it is so Draconian.

III. Conclusion – In summary, under either scenario, it is crucial to show an understanding of bundled payments and ACOs under value-based reimbursement, and your significant abilities to contribute to hospital success. If you don't, there is almost a perfect storm of pressures on hospital administrators to view you as a marginalized commodity and for you to distinguish yourself from competition only through a race to the bottom of lowering fees until your physicians leave. There are very different exclusive contracting dynamics in play today and the consequences will be significant. The good news is that opportunities for partnering success have never been greater. Will your hospital realize that in time?

For more information, please contact either Kara Weishaar (kweishaar@smithlaw.com or 919-838-2027) or Bo Bobbitt (bbobbitt@smithlaw.com or 919-821-6612).

NC society of
ANESTHESIOLOGISTS
THE BEACON OF PATIENT SAFETY

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2013/2014 DATES TO REMEMBER

September 6-8, 2013
NCSA Annual Meeting
The Grove Park Inn, Asheville, NC
Visit www.ncsoa.com to register!

October 12 – 16, 2013
ASA Annual Meeting
San Francisco, CA

December 8, 2013
Executive Committee Meeting
The Grandover Hotel, Greensboro, NC

September 19-21, 2014
NCSA Annual Meeting
Pinehurst Resort, Pinehurst, NC

[FROM THE NCSA EDITOR] CONTINUED

In 2015 CMS will start to use the Value-Based-Payment-Modifier (VBPM). To my knowledge, they have not yet determined what criteria they will use to monitor anesthesia and adjust our payments. I do know that whatever criteria they decide on will not be subject to review and modification by anesthesiologists who know their patients and healthcare facilities and who could probably make some changes that would improve the overall safety and quality. The implementation of Obamacare is not going well. Costs are rising. Barriers to implementation that were obvious to physicians and other healthcare workers a long time ago are just now apparent to the healthcare bureaucracy. Perhaps the time has come to quit micromanaging healthcare delivery and take a hard look at reforming it by defining what we are looking to deliver, to whom, and at what cost.