Trends & Technology 11

Committee News: ASA Champions USP <797> Policy Victory 28

Resident's Review: Off the Beaten Path: The Footprint of Anesthesiologist Innovators 32

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How the No Surprises Act Privileges Insurance Companies Over Anesthesiologists – And What ASA Is Doing About It

Manuel Bonilla, MS Michael W. Champeau, MD, FAAP, FASA

The federal No Surprises Act (NSA), implemented in 2022, represents an important step forward in protecting patients from surprise medical bills and improving transparency within the health care system. Unfortunately, the NSA's flawed implementation has revealed significant problems for physicians seeking to navigate the law to secure appropriate payments. The challenges posed for anesthesiologists across the country confirm the society's longstanding concerns that the implementing regulations could benefit insurance companies to the detriment of anesthesiology practices of all sizes.

The law's implementation has been imbalanced, benefiting payers while creating financial challenges for anesthesiology practices, especially small and medium-sized community-based practices. Some practices operating with the most fragile economics may not be able to remain in business much longer. That's why ASA is working on multiple fronts to advocate for changes to protect anesthesiologists and their practices.

The problems

Although the challenges come in various shapes and sizes, it boils down to the fact that the implementing regulations have emboldened insurers to rig the system. In particular, they have made the all-important Independent Dispute Resolution (IDR) process unworkable – a problem the society and our members can't afford to ignore. To further understand what is going wrong, and how, ASA continues to invite feedback from members

Continued on page 4

Generations Research of Limited Value in Studying Workforce Economics

Thomas R. Miller, PhD, MBA

Presentations on the anesthesiology workforce often include a graph like Figure 1, which shows the estimated number of practicing anesthesiologists by age. It is especially interesting because of the drop in the supply of anesthesiologists ages 46-54 years (as of December 2021), which resulted from the substantial decrease in anesthesiology residents in the 1990s. In Figure 1, I identified the baby boomers, partly because

Continued on page 5

No One Is Immune

Ronald L. Harter, MD, FASA

The growing incidence of burnout among health care providers is well known. The unique and significant stresses of the pandemic, layered on top of the already high level of burnout that preceded the onset of COVID, has produced a degree of burnout throughout the health care sector beyond what we have ever experienced, exceeding an overall incidence of 60% by late 2021 (*JAMA Health Forum* 2022;3:e224163). Although system-level factors are a major contributor to burnout in the health care sector, that does not replace the need for mental health care for those who need it (Taking Action Against Clinician Burnout A Systems Approach to Professional Well-Being. 2019; *N Engl J Med* 2022;387). A recent survey of anesthesiologists reported that more than one anesthesiologist in five acknowledged they were depressed, either as a sole diagnosis or in combination with burnout (asamonitor.pub/3VGzTif).

As pervasive as burnout and related mental health issues have become, it is likely there are large numbers of our

Continued on page 7

SPECIAL SECTION
Pathways to Diversity 13-23
Guest Editor: Lalitha Sundararaman, MBBS, MD

PERIODICALS

No Surprises Act

Continued from page 1

and maintain open communication with all stakeholders. ASA has also organized multiple workgroups of anesthesiology stakeholders, in addition to hosting a hospital-based specialty coalition consisting of the American College of Radiology (ACR) and The American College of Emergency Physicians (ACEP). These groups work to better understand the new NSA landscape and to identify problems requiring the society's attention.

One of the most egregious practices we've seen is payers leveraging the NSA against community practices to push in-network anesthesiology practices out of network. Practices have reported threats of contract cancellation unless they accept reductions of 40%-60% of previously contracted rates – rates far less than the existing local median in-network contracted rates. Without mechanisms in law and regulation to counteract the payers, practices will continue to face challenges remaining in-network.

Excessively low insurer-calculated qualifying payment amounts (QPAs) are yet another challenge we're grappling with.

"ASA is proud of the progress we've made. And we're determined to address issues as they arise. We'll continue to collect information from members and other stakeholders, study solutions, and advocate tirelessly with agencies, legislators, and partner organizations."

ASA has received numerous reports of insurers utilizing QPAs as initial payments that bear no resemblance to a reasonable median in-network contracted payment amount. In many cases, the QPAs more closely resemble Medicare payment amounts. To highlight this gaming of the QPA, ASA initiated, and jointly funded with ACEP and ACR, a research paper by Avalere Health, a respected health policy research firm, to explore low QPA calculations. The final Avalere paper confirmed suspicions that payers were utilizing "ghost" rates – non-negotiated anesthesia payment rates buried in primary care contracts – in their QPA calculations. These primary care provider-contracted rates lead to QPAs that are much lower than commonly paid rates. While we are gratified that the regulating agencies recently updated their guidance to direct payers to stop using "ghost" and $0 payment rates in calculating QPAs, the lack of transparency around payer calculations of QPAs and the clear inaccuracy of QPAs remain top concerns for ASA.

"Holds" on disputes filed by anesthesiologists are another area of concern and particularly frustrating to practices. Through some as-yet-undefined authority, the regulatory agencies have been able to simply pause or "hold" pending disputes that have entered the IDR process. Statutory and regulatory timelines for resolution of the disputes are suspended. Practices have reported IDR entity holds, some for 90 days or longer, on hundreds of claims with no explanation, causing significant economic damage to anesthesiologists' practices. Batching is another problem area. Agency guidance continues to limit the batching of anesthesia claims to the same service facility, CPT code, and payer. This approach hampers the ability of anesthesiologists to efficiently batch claims, which in turn exacerbates current problems related to the high volume of claims experienced by IDR entities.

And while the above-cited problems are some of the most serious challenges we're facing, they're not the only challenges. Payers are leveraging the IDR process to the detriment of anesthesiologists in a range of creative and problematic ways. For example, payers are using the 30-day negotiation period to delay timely payment dispute resolution by refusing to engage during the mandated period. Anesthesiologists have received electronic notifications from one payer rejecting any further negotiation within one minute of the anesthesiologists' electronic submission initiating the negotiation process. The anesthesiologists are then forced to wait the full 30-day period before they can access the IDR process. Disputes are also being rejected due to missing information or deadlines. Some anesthesiologists report that payers are omitting required information, slowing the process. Other reports indicate that communications from payers have been inefficient, minimal, or non-existent, blurring timelines and deadlines for IDR submissions and ultimately resulting in penalization and/or invalidation of claims for the initiating party.

The ambiguity of determining whether to appeal via a state versus federal mechanism also continues to cause confusion. ASA members in states with their own dispute resolution processes struggle to ascertain which venue to submit disputes to, resulting in wrong venue filings, lost eligibility, or the need for additional submissions to request for flexibility under extenuating circumstances.

And finally, ASA has received numerous reports of payers failing to pay anesthesiologists even after they have prevailed in the IDR process, in spite of clear guidance that the amount, once it is determined, must be paid within 30 calendar days. Whether intentional or inadvertent, payers are failing to meet the necessary timeline.

Simply put, the payment resolution process is not working as intended. Enabling payers to get away with gaming the process empowers misbehavior. If anesthesia practices were successfully getting disputes resolved through the process, insurers would be more likely to negotiate in good faith. It is essential that we continue to work to understand the challenges posed by implementation of the NSA and advocate on behalf of our members and the specialty to convince stakeholders to address these very real issues.

The solutions

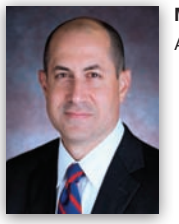
The problems are real and numerous. So ASA is actively advancing solutions to meet these challenges and ensure the NSA works as intended for anesthesiologists. We worked hard to get the law right. We cannot afford to let agency missteps in implementation unwind our efforts. To that end, ASA has identified a series of recommendations we believe will improve the process for our practices – solutions formally shared with the Centers for Medicare & Medicaid Services in a November letter and subsequently with key policymakers on Capitol Hill. We believe our suggestions will ensure the NSA functions as intended. After all, if insurers' QPAs are accurate, or close to accurate, practices would be less reliant on the IDR. If larger batches were allowed, IDR entities could more quickly resolve massive numbers of claims in a single action, rather than resolving hundreds of micro-batches.

To address concerns, we have asked the agency to:

- Support the addition of meaningful network adequacy requirements to the NSA. A network adequacy requirement is likely the only way to counterbalance the problem of insurers pushing practices out of network.
- Implement thorough and comprehensive audits of payer QPAs, issue regulations formally addressing "ghost" and $0 rates, and direct IDR entities to give equal consideration to all factors listed in the law.
- Eliminate "holds" and reform IDR efficiency to improve timelines of dispute resolution.
- Create a mechanism to allow the initiator of a payment dispute to proceed expeditiously to the IDR process if no meaningful negotiations are taking place.
- Align guidance to conventional anesthesia provider-payer contracting practices that are based upon an anesthesia conversion factor. New guidance should permit batching of all anesthesia claims by the same payer, with the same anesthesia conversion factor, in the same geographic area.
- Develop guidance for the IDR entities to investigate the status of missing items from the initiating dispute party before rejecting the claim, establishing if missing information is due to inadvertent or intentional omission by any party, and allow claims to be resubmitted.
- Mandate the use of already existing Remittance Advice Remark Codes (RARCs) codes (not proprietary payer codes) to designate the correct dispute resolution venue at the time of remittance or notice of denial.
- Ensure payer compliance with necessary payment deadline rules and guidance.

Next steps

ASA is proud of the progress we've made. And we're determined to address issues as they arise. We'll continue to collect information from members and other stakeholders, study solutions, and advocate



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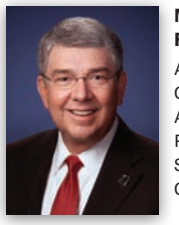
ASA Chief Advocacy Officer.



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tirelessly with agencies, legislators, and partner organizations. Here are some of the efforts we're engaged in now:

- We are in frequent contact with the Center for Consumer Information and Insurance Oversight with our recommendations, including conducting a long call with them recently to discuss challenges and potential solutions around "batching."
- In addition to filing a lawsuit in Chicago, we have submitted an amicus brief for the Texas Medical Association's second lawsuit targeting the weighting of the QPA by the IDR. We're considering additional legal remedies if proposed resolutions are not adopted in a timely manner.
- We are conducting a national survey of QPAs, collecting the data we know we'll need to move the needle on the challenges we face.
- We're working with a variety of coalitions and workgroups, including the coalition with ACR and ACEP that meets regularly to share learnings and align on our efforts, a leadership workgroup, and another workgroup that includes business managers.
- And in addition to viewing these challenges and solutions from a national lens, we are focusing on state-level challenges, working with members and state societies to finely tune our asks to best meet local and regional needs.

We're listening, meeting with stakeholders to advocate for members, and collecting and collating information so we're prepared to tell your stories. You can track our battles, support our efforts, and make your voice heard by following our dedicated webpage at **asahq.org/advocating-for-you/payment-progress/surprise-billing-resources**. Please speak out via the ASA Community (community.asahq.org/home) as well as our Twitter (@ASALifeline), Facebook (facebook.com/AmericanSocietyofAnesthesiologists), and LinkedIn (linkedin.com/company/american-society-of-anesthesiologists) pages. ■

Curious Economist: Generations Research

Continued from page 1

they are approaching retirement, and partly because that is the "generation" to which I belong. But is such a designation meaningful?

Generations research

Of course, there are generations besides the baby boomers. I'm reminded of this frequently by emails from news services I subscribe to that have generational references in the titles of stories. I became curious about generations research and its use in workforce and health services-related research. A quick search on PubMed shows that generational research has been a topic in the life sciences for more than three decades (Figure 2) (asamonitor.pub/3UD88G8).

There are currently six generations described in the research literature. Researchers define the generations by age cohort and describe each by its unique characteristics, major influencing events, and primary concerns (Table). The article associated with the Table notes that members of Generation X are self-reliant (*Ochsner J* 2016;16:101-7). However, according to research at Stanford's Center for Advanced Study in the Behavioral Sciences, Generation Z are also self-reliant, pragmatic, and highly collaborative (asamonitor.pub/3F93xWf). Members of Generation Z value diversity and finding their own unique identities. What about people near generation border years? How different is someone born in December 1964 (baby boomer) compared to someone born in January 1965 (Generation X)? My curiosity quickly edged toward skepticism.

"Do all Generation X anesthesiologists 'work to live'? Are they all self-reliant with the primary concern of a work-life balance? Are there baby boomer anesthesiologists or Generation Y anesthesiologists who also share these characteristics and concerns?"

Do all Generation X anesthesiologists "work to live"? Are they all self-reliant with the primary concern of a work-life balance? Are there baby boomer anesthesiologists or Generation Y anesthesiologists who also share these characteristics and concerns?

However, researchers acknowledge the challenges of generalizing and the nuances of those individuals born on the cusp between generations. Researchers also recognize multiple factors influencing each generation. The three major effects cited in the literature are life cycle, period, and cohort effects (asamonitor.pub/3P6gq8d).

- Life cycle effects are directly age-related. For example, young people are less likely than older adults to vote and engage in politics. Related to health care, people tend to develop medical conditions as they age and use more health care services.
- Period effects occur when events and circumstances (such as wars, social movements, economic booms or busts, and scientific or technological breakthroughs) and broader social forces simultaneously impact everyone, regardless of age. For example, the COVID-19 pandemic is a period effect, and period effects typically have lasting impacts on an entire population, that is, across generations.

Thomas R. Miller, PhD, MBA
ASA Director of Analytics and Research Services, and Director of the ASA Center for Anesthesia Workforce Studies (CAWS).

- Cohort effects include attitudes, beliefs, and behaviors common to people of a particular generation. Differences between generations can be the byproduct of the unique historical circumstances that members of an age cohort experience, especially during the years when they are in the process of forming opinions. Some cohort effects may result from a period effect an older generation experienced that subsequent generations did not.

Generations vary by race composition, marriage statistics, and political affiliation. There are differences among generations in policy views of topics such as same-sex marriage and the legalization of marijuana. However, there does not seem to be a variance across generations in gun control preferences (asamonitor.pub/3P6gq8d). In addition, there is substantial variation within a generation across many dimensions. Overall, factors associated with generational differences are complex and overlapping. Additional factors that likely contribute to differences across and within generations include place of birth, socioeconomics, race, education, religion, travel experiences, and influence of family and friends. There are relatively more females in younger cohorts of anesthesiologists (e.g., Generation Y), which may confound attempts to apply generation research to anesthesiology workforce economics.

I agree that certain education, communication, and marketing approaches may be more effective for a particular generation, but I question the usefulness of generation research in workforce economics. Although trends in the ages of anesthesiologists are essential to understand the workforce and related economics, observations from generation research seem less relevant. Moreover, I am surprised that

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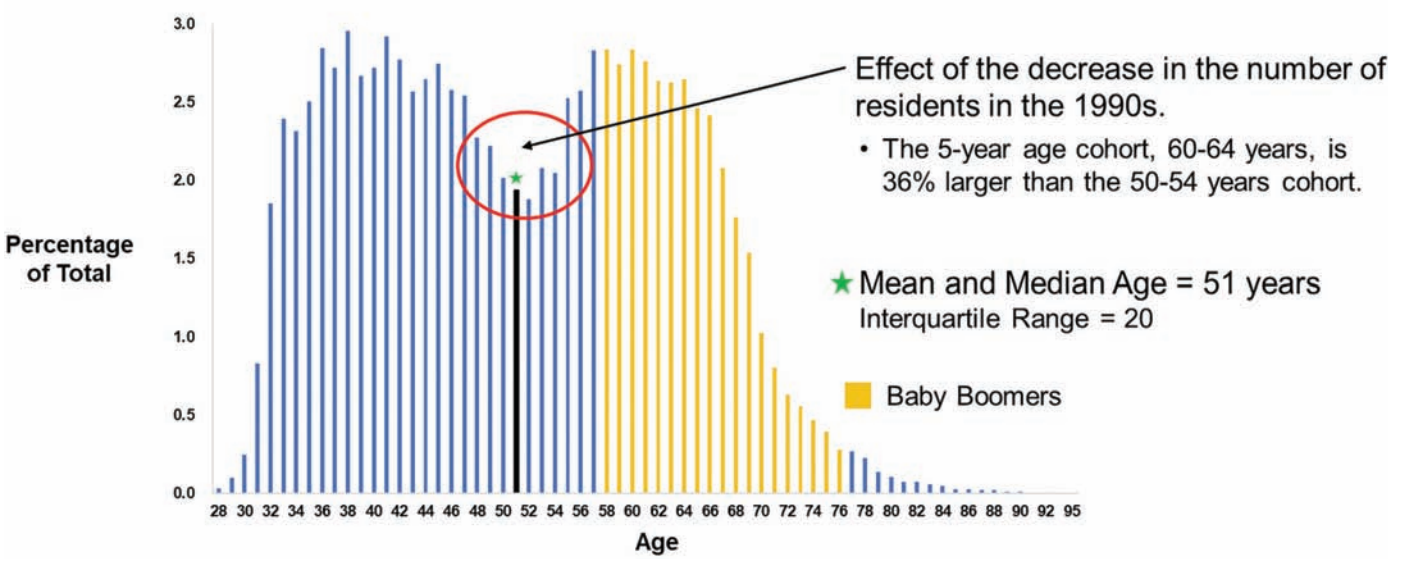

Figure 1: Age distribution of anesthesiologists as of December 31, 2021. Estimates by the ASA Center for Anesthesia Workforce Studies based on AMA data and the ASA member database.