American Society of Anesthesiologists®

Kentucky Society of Anesthesiologists

Fall 2016

Kentucky Society of Anesthesiologists
www.ksaweb.org
(800) 659-0007
dmaskey@ksaweb.org

KSA Reception at ASA Annual Meeting

Attending the ASA Annual meeting later this month? Then please join us for the annual KSA reception, jointly sponsored by the KSA, University of Kentucky and University of Louisville. This is a great opportunity to network with colleagues and friends. Many of your KSA officers and delegates to the ASA House of Delegates will be in attendance and can update you on the important issues for our specialty at both the state and national levels. Most importantly, there will be lots of good food and drink with fantastic city views from the top floor of the W Hotel Lakeshore. Details are below.

When: Monday, Oct. 24
Time: 7:00 – 10:00 PM
Where: W Hotel Lakeshore, Skyline Room (top floor)
644 North Lakeshore

KSA 2017 Annual Meeting

Mark your calendars for the 2017 KSA Annual Meeting. It will be held March 18 in Lexington at the Boone Center on the University of Kentucky campus. The theme for the meeting is Enhanced Recovery after Anesthesia. Further information about speakers along with online registration will soon be available on our newly revamped website.

KSA Legislative Update

The legislative committee continues to work with our lobbyists on scope of practice issues affecting our specialty. Some of the issues we are monitoring and seeking to impact involve a redrafted House Bill 296 from the 2016 session. This bill involved the use of fluoroscopy by APRN's and raised some concerns among our members due to its potential impact on nurse supervision of fluoroscopy procedures. We are working with the radiologists as well as KMA to define scope of practice and limit efforts to expand scope of practice of APRNS's. We are also witnessing efforts by Physician Assistants to expand prescribing practices and will work with our lobbyists to monitor these efforts during the 2017 session.

We will continue to update you on the revamping of Medicaid and the recently submitted Medicaid waiver to CMS as part of Governor Bevin's promise to do away with KYNECT and address the rising cost of Medicaid.

One of our main issues continues to be the proposed rule to mandate independent practice by all APRN's including CRNA's in the VA health system. We want to THANK everyone for submitting their comments to the Federal Register. We are now waiting as the VA is reviewing all submitted comments. We will keep you posted as events unfold.

Again please consider contributing to the ASAPAC and KSAPAC to help protect and advance our specialty. And it is now much easier to contribute to the KSAPAC. On our new, redesigned KSA website there is a link that allows you to make online donations.

Anjum Bux, M.D., Chair, KSA Legislative Committee

ASA UPDATES

ASA Member Elected to AMA Board of Trustees

On June 14, ASA member William A. McDade, M.D., Ph.D., was elected to the Board of Trustees for the American Medical Association (AMA). Dr. McDade is a longtime member of ASA's delegation to the AMA. He is also a past president of the Illinois State Medical Society and presently serves as chair of its Board of Trustees. He joins another ASA member Jesse M. Ehrenfeld, M.D., M.P.H., on the AMA's Board of Trustees. Dr. Ehrenfeld was elected in 2014.

Dr. McDade is the deputy provost for research and minority issues and an associate professor, Department of Anesthesia and Critical Care at the University of Chicago. He also is a director with the Accreditation Council for Graduate Medical Education and is immediate past chair of the AMA's Council on Medical Education. In 2012, he was named the Chicago Medical Society's "Physician of the Year." This July, Dr. McDade will begin his newest role as Ochsner Health System's executive vice president and chief academic officer.

Dr. McDade's election is the result of years of service as a physician leader. With the ever growing list of matters on which the AMA is called to weigh in, it is critical that physician anestheisologists be a part of the discussion. Whether it be scope of practice, insurance, allied team member, or related issues, having physician anesthesiologists at the table is required for the promotion and protection of the specialty.

Congratulations Dr. McDade!

New Scope-of-Practice Publications

Two studies co-authored by ASA Health Policy Research about the anesthesia opt-out rule were recently published in peer-reviewed journals. Each used a different data set (Medicare claims and the National Inpatient Sample) to examine the effect of opting out on access to anesthesia services. Of the 17 governor opt-out letters, 10 specified access to anesthesia care as being relevant to the opt-out decision. However, both of these recent studies found that opting out has not improved access to anesthesia services. Download the full studies on the ASA Health Policy Research webpages (http://www.asahq.org/resources/health-policy-research).

Study citations:

Sun EC, Miller TR, Halzack NM. In the United States, "opt-out" states show no increase in access to anesthesia services for Medicare beneficiaries compared with non-"opt-out" states. A&A Case Reports. 2016; 6(9):283-5.

Sun EC, Dexter F, Miller TR. The effect of "opt-out" regulation on access to surgical care for urgent cases in the United States: Evidence from the National Inpatient Sample. Anesth Analg. 2016; 122(6):1983-91.

Additionally, a cost effectiveness analysis comparing anesthesia delivery models was recently accepted for publication in the Journal of Clinical Anesthesia. Check the Health Policy Research web pages for future updates about its publications!

ASA® 2016 ANESTHESIA ALMANAC

The ASA 2016 ANESTHESIA ALMANAC is a compilation of perioperative data for the United States recently published by ASA Health Policy Research (HPR). It includes information about surgical volume, anesthesia utilization trends, anesthesia workforce characteristics and practice acquisitions collected from a variety of data sources.

The ANESTHESIA ALMANAC includes simple figures and detailed tables that may be useful for meetings with policymakers or conducting additional analyses. It is free to access and can be downloaded from the HPR webpages (http://www.asahq.org/resources/health-policy-research).

We also expect that the ANESTHESIA ALMANAC will change from year to year and encourage you to submit any comments or suggestions to the ASA Health Policy Research Department at ask.HPR@asahq.org or call Thomas R. Miller, Director of ASA Health Policy Research at (847) 268-9215.

ASA Leaders Participate in Federal Out-of-Network Payment Roundtable

On April 27, as part of ASA's ongoing work related to out-of-network payment issues, ASA First Vice President James D. Grant, M.D., and Sherif Zaafran, M.D., chair of ASA's Ad Hoc Committee on Out-of-Network Payment, represented ASA at a meeting with leadership of the U.S. Department of Health and Human Services (HHS) in Washington, D.C. concerning the rising problems with out-of-network payment. The meeting, arranged by HHS, served as a forum for HHS leadership to elicit feedback from provider stakeholders about initiatives needed to address the topic.

The President's HHS 2017 Budget provides that "[i]n an effort to promote transparency on price, cost, and billing for consumers, the Budget supports the standardization of billing documents and eliminating surprise out-of-network charges for privately insured patients receiving care at an in-network facility."

Out-of-network payment, commonly termed "surprise bills" or "balance billing," occurs when a patient receives a bill for the amount remaining between the out-of-network provider's fee and the amount contributed by the patient's insurer after copay and deductibles. In most cases, balance billing is the result of a large gap between what the insurer chooses to pay in an out-of-network setting and the physician's billed charge. Per the FY 2017 Budget in Brief, "Hospitals would have to take reasonable steps to match individual patients with providers that are considered in-network for their plan. Furthermore, all physicians who regularly provide services in hospitals would be required to accept an appropriate in-network rate as payment-in-full. Thus, if the hospital failed to match a patient to an in-network provider, the patient would still be protected from surprise out-of-network charges."

Recognizing the evolving impact out-of-network payment has on advocacy and public relations efforts of state component societies, in 2015 ASA's Executive Committee approved an Ad Hoc Committee on Out-of-Network Payment (AHCONP) which is developing advocacy materials and providing support to states engaged in out-of-network payment initiatives. Drs. Zaafran and Grant, through AHCONP, have been working with a number of the physician stakeholder groups represented at the meeting, leading to dialogue where the medical societies were building off one another to help HHS understand the nuances and complexities of this insurance industry created problem patients are enduring.

Dr. Grant helped the group understand that even in elective surgeries, complications and emergencies occur that sometimes require other health care professionals who may not be in-network. Dr. Zaafran highlighted the need for a Patient's Bill of Rights, that an out-of-network deductible apply to an in-network deductible, and that insurers must have an adequate number of physicians in the plans they sell. The Bill of Rights would outline patient rights, provide a solution for what really is an

insurance gap, and advise how to know what the insurance product is as well as what is and what is not covered.

At the event, attendees shared that the challenge with this topic is as much about patients being unaware of what their plans actually cover as it is about the unexpected bill they receive. As it stands, providers may know their charges but are not aware of a carrier's payment for the health services to be rendered, especially with the complex array of different insurance products offered to consumers. As such, while patients are responsible for educating themselves on their coverage, the insurers must be made to be more forthcoming with information. Moreover, insurers should do more to educate patients so when they schedule a procedure/surgery, others - such as a physician anesthesiologist, radiologist, or pathologist - may be involved and it is important to determine their network status as well.

With the complexity of plans, the narrowing of networks and increasing use of network tiers where a provider may be in one tier and not the other, the carriers were again noted as the single source for where patients could go for such information. The group also discussed that while the media has promoted out-of-network payment as an emerging issue, the data still points to this being an important matter that impacts a very small percentage of patients. Proposed solutions to the challenge included references to states that are using an independent database of billed charges to address benchmarking for out-of-network concerns.

In addition to HHS' consideration of out-of-network payment, legislative efforts are pending in a number of states on this subject including prohibitions on balance billing, requirements for "good faith estimates," out-of-network disclosure/consent requirements for non-emergency services, and mediation triggered by a minimum price threshold. HHS will likely seek more information on out-of-network payment and ASA will continue to report the efforts of ASA physician leadership to educate policymakers on this important subject.

For more information, contact Jason Hansen, Director of State Affairs, at j.hansen@asahq.org.

ASA Member Elected President of Massachusetts Medical Society

On May 5, ASA member James S. Gessner, M.D. was elected president of the Massachusetts Medical Society. Dr. Gessner is a past president of the Massachusetts Society of Anesthesiologists and currently serves as chair of its Judicial Committee. Dr. Gessner also is a past president of the New England Society of Anesthesiologists and currently serves as its secretary-treasurer.

Board certified in anesthesiology and pediatrics, Dr. Gessner currently works in private practice and is an assistant professor of Anesthesiology at Boston Medical Center. He received his medical degree from Harvard and completed his residency in anesthesiology at Peter Bent Brigham Hospital.

Physician anesthesiologists are currently serving as president or president-elect of state medical societies in other states including Georgia, Michigan, and Utah. Serving within the leadership of a state medical society is an incredibly important component of an effective advocacy program. As state medical societies consider advocacy related policies and positions, it is vital for physician anesthesiologists to be involved in those discussions. As these leaders bring their expertise to the state medical societies, anesthesiology is better informed and most importantly, represented.

We congratulate Dr. Gessner on his accomplishments!

ASA Physician Leader Becomes President of the Michigan State Medical Society

On April 29, longtime ASA member David Krhovsky, M.D., became president of the Michigan State Medical Society. Dr. Krhovsky is an ASA alternate director for the Michigan Society of Anesthesiologists and previously served as president. He serves as vice president of medical affairs at Spectrum Health Hospital Group – Grand Rapids. Dr. Krhovsky received his medical degree from Wayne State University in Detroit and completed his residency at Detroit Medical Center.

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Congratulations, Dr. Krhovsky!

The APRN Compact: APRN Independent Practice Imposed on All Adopting States

By Jeffrey Plagenhoef, M.D., ASA President Elect and Erin Berry Philp, M.A., J.D., Senior State Affairs Associate.

Those of us who are involved in state advocacy have witnessed numerous advocacy attempts by nurse anesthetists and advanced practice registered nurses (APRNs) in general to eliminate existing requirements for patient-centered, physician-led care. Many times, legislation or proposed regulatory language is obvious in its attempt to abandon the care team model, but sometimes … well, sometimes an incremental approach takes such a long time to implement, the last steps in the process can be downright shocking. This is the case with the so-called APRN Compact.

We have been aware of the APRN Consensus Model for several years and have tried to inform ASA members about this dangerous trend. In a nutshell, the APRN Consensus Model is 2008 draft state legislative language developed by the National Council of State Boards of Nursing (NCSBN) that gives the APRN title to four roles of advanced practice nurses: nurse anesthetists, nurse practitioners, nurse specialists, and nurse midwives. Although it is usually touted by APRNs as simple name change legislation, nothing could be further from the truth. If you Google "APRN Consensus Model," you can read the draft language yourself; the language increases scope of practice for APRNs – including nurse anesthetists – and makes them independent practitioners. The Consensus Model toolkit on the NCSBN website clearly states that APRNs are to be licensed as "independent practitioners with no regulatory requirements for collaboration, direction or supervision."

Many states have enacted parts of the APRN Consensus Model, with most of them picking and choosing language and not changing their already-standing statutes or regulations regarding the team care model. A majority of states now lump all advanced practice nurses into the "APRN" categorization. You may be asking, "why does a name matter? What does it matter what we call advanced practice nurses?" It matters because even a small name change is a huge step in an incremental plan by APRNs to remove physicians as leaders of the care team.

Last year, the NCSBN approved draft legislation titled the "APRN Compact." The compact would allow APRNs who hold a multistate license to practice in other compact states. The NCSBN says that in order to be considered a compact state, a state must pass the draft legislation without "any material differences." Unlike the Federation of State Medical Boards' Interstate Medical Licensure Compact, the APRN Compact seeks to automatically eliminate physician involvement requirements for APRNs who practice under a multistate license. Additionally, if one reads the entirety of the legislation, you'll see that the term "APRN" is never defined. All the "simple

name change" bills states have passed mean that nurse anesthetists automatically fall under the term "APRN" for the purpose of this compact.

Article III, Section (h) of the legislation says:
This means if an APRN (including a nurse anesthetist) receives a multistate license under the compact, he or she would be able to function independently, regardless of what the party state's law says.

Forty-six states and the District of Columbia, by statute or regulation, require nurse anesthetists to work in a team-based relationship with a physician (not necessarily a physician anesthesiologist), whether through physician supervision, collaboration, direction, consultation, agreement or other arrangement for the delivery of anesthesia services. The APRN Compact would completely usurp these states' laws and regulations. Words matter. Legislators and regulators carefully chose language to indicate that nurse anesthetists must work in those kinds of relationships with physicians when providing anesthesia care within their state lines.

Other sections of the draft legislation say that the APRN Compact will govern licensing. This takes many decisions away from state boards of nursing and puts it in the hands of the NCSBN, who will govern the APRN Compact. An outside organization will have authority to say who should or should not receive an APRN license. The APRN Compact carelessly brushes aside laws and regulations crafted by states' democratically elected legislators or executive-appointed regulatory boards, all in the interest of gaining independent practice by any means necessary.

The APRN Compact fails to recognize the crucial difference between primary care and surgical anesthesia/ critical care. Removing physician involvement (any physician, not just physician anesthesiologists) from anesthesia compromises patient safety. Nurse anesthetists are a valued member of the anesthesia team, but removing physician involvement from anesthesia care makes no more sense than removing it from any other critical care location. We are not trying to keep advanced practice nurses from obtaining a multistate license, but we are opposed to it when the mechanism to do so usurps state laws pertaining to patient safety. This is an underhanded attempt to eliminate the physician-led care team patients rely on in states where advanced practice nurses have not been able to do so via obvious legislative means.

The APRN Compact language says that only 10 states have to enact the compact into law to have it go into limited effect. So far during the 2016 legislative session, Idaho, Iowa and Wyoming saw the APRN Compact introduced, and Idaho and Wyoming signed it into law. Some have said, "my state is one of the four states that has independent practice for nurse anesthetists. What does it matter if we pass the Compact?" Please do your part to keep the APRN Compact from going into effect! With Idaho and Wyoming now Compact states, only eight states stand between APRNs gaining automatic independent practice in every Compact state under a multistate license. Even some state boards of nursing are acknowledging that the APRN Compact is over-the-top. During an April 2015 Texas Board of Nursing meeting, the board discussed the

APRN Licensure Compact and noted their board should abstain from accepting Article III (h) "since such provision is not authorized under Texas law." Article III, Section (h) is not authorized under 46 state laws and regulations!

For the remainder of this legislative session, and in preparation for the 2017 legislative session, determine the definition of "APRN" in your state. It's also important to monitor regulatory boards to make sure they are not unilaterally changing definitions in state regulations, as well. We must vigorously oppose the APRN Compact in its current format in order to prevent the usurpation of state laws regarding patient safety. For more information about the APRN Compact and what you can do in your state, contact Jason Hansen, Erin Philp or Ashli Eastwood.