How Anesthesia Helps ASCs Maximize Value-Based Purchasing Performance

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YOUR PRESENTER

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• VP, Quality Assurance, Somnia Inc.
• Executive Director, Somnia Patient Safety Organization
• >20 years hospital/anesthesia practice management; military, academic, tertiary, community hospitals/ASCs
• 100% in Anesthesia / Surgical / Perioperative/OR
• 8+ yrs. Perioperative/OR management (operational)
• 10+ years anesthesia practice management (financial)
• 6+ years anesthesia quality management (quality)
• Member, Anesthesia Quality Institute Advisory Council
Disclaimer

The opinions expressed in this presentation are that of the presenter and do not necessarily reflect the opinions of Becker’s or Somnia Anesthesia, Inc.

The presenter is employed by Somnia Anesthesia Inc.

There is no financial interest related to the content or delivery of this presentation.
What is “Value Based Purchasing”?

\[ \text{VBP} = \frac{\text{Quality (Outcomes)}}{\text{Payments}} \times \text{Volume} \times \text{Performance} \times \text{Costs} \]
Why is Value Based Purchasing important?

• Evolving method (future) of healthcare reimbursement

• “Value-based programs **reward health care providers** with **incentive payments for the quality of care** they give to people with **Medicare**. These programs are part of our larger quality strategy to **reform how health care is delivered and paid for**.”

• Paying providers based on the **quality, rather than the quantity** of care they give patients.

Source: [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html)
Evolution of CMS Value-Based Programs

2012: Start of new VBP program for ASCs (ASCQR)

ACA requires new VBP program for ASCs

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
How to Achieve Value in ASCs?

- Regulatory Compliance (CMS CfC, State DoH, etc.)
- Accreditation Standards (AAAHC, AAAASF, TJC)
- Evidence Based Practice (AORN/ASA/AANA)
- Clinical Outcomes (ASCQR, AQI, etc.)
- Patient & Surgeon Satisfaction

Validates Service
Validates Quality
Validates Practice Compliance & Standards

How to Achieve Value in ASCs?
CMS CfC defines Value-Based baseline

• The CMS Conditions for Coverage (CfC) provide the compliance standards and *Quality Assessment/Performance Improvement (QA/PI)* requirements to contractually participate with Medicare.

• **CMS Conditions for Coverage; QA/PI section, 416. 43**
  • “The ASC **must develop, implement, and maintain an ongoing, data-driven quality assessment and performance improvement (QA/PI) program**”
  • “The ASC **must measure, analyze, and track quality indicators, adverse patient events**, infection control, and other aspects of performance that includes care and services (**including anesthesia**) furnished in the ASC.”
  • “The ASC **must set priorities** for its performance improvement activities that
    • Focus on high-risk, high-volume, problem-prone areas
    • Consider incidence, prevalence and severity of problems in those areas
    • Affect health outcomes, patient safety, and quality of care
CMS Conditions for Coverage/QAPI (cont’)

• CMS Conditions for Coverage; 416. 43
  • “The ASC has many choices of indicators to use when assessing and improving quality and performance to include:
    • **Outcome Indicators**: Complication rates, Mortality rates, HAI rates, LoS, Re-admission rates, etc.
    • **Process Indicators**: Prophylactic Antibiotics timing, pre-surgical timeouts, syringe labeling, medication safety and security, infection control compliance, etc.
    • **Patient Perception Indicators**: Measure a patient’s experience/satisfaction with the care and services he/she received

• “The ASC must track and report all patient adverse events”

• CMS recommends at a minimum, that ASC’s track and report National Quality Forum (NQF) quality/patient safety indicators to include **Prophylactic Antibiotic Timing, Hospital Transfers**, and **Wrong Patient/Site/Side/Procedure** events. Facilities may choose to track and report other indicators as needed. (ASCQR)
ASCQR = Baseline “Value Based Purchasing”

- CY2015: 98.9% of the ASCs subject to ASCQR program requirements met the requirements and received the full annual M’Care payment update.
- ASCs that met the criteria for CY 2015 ASCQR program reporting receive a full payment update of 1.4%
- The few ASCs that did not meet the criteria for CY 2015 ASCQR program received a 2% reduction in their M’Care payments.

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<thead>
<tr>
<th>Number</th>
<th>Measures for CY 2018 Payment Year</th>
<th>Data Submission Dates</th>
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<td>ASC-1</td>
<td>Patient Burn</td>
<td>Claims submitted for services furnished between January 1, 2016 and December 31, 2016</td>
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<td>ASC-2</td>
<td>Patient Fall</td>
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<td>ASC-3</td>
<td>Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant</td>
<td>Claims submitted for services furnished between January 1, 2016 and December 31, 2016</td>
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<tr>
<td>ASC-4</td>
<td>All-Cause Hospital Transfer/Admission</td>
<td>Claims submitted for services furnished between January 1, 2016 and December 31, 2016</td>
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<td>ASC-5</td>
<td>Prophylactic Intravenous (IV) Antibiotic Timing</td>
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<td>ASC-12</td>
<td>Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy</td>
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<th>Number</th>
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<th>Submission Period</th>
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Anesthesia impacts 50% of ASCQR Measures

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Web-Based Measures (Data Submitted Via an Online Tool)

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Who should lead, and ensure daily success with your value-based initiatives?
Anesthesia!

• Daily Physician/CRNA medical leaders
• Involved in every operational aspect of care
• Responsible for safe throughput and outcomes
• Influences all QA/PI compliance standards
• Already responsible for 50% of ASCR measures
6 common ASC challenges with anesthesia

1. Leadership/Management
2. Dedicated/Consistent Staff
3. Practice compliance
4. Quality/safety
5. Patient/Surgeon satisfaction
6. Unknown financial impact?!?
The risk/impact of those anesthesia challenges

1. Surgeon Satisfaction
2. Patient Satisfaction
3. ASC Staff Satisfaction
4. Competitive Advantage
5. Growth/Bottom Line
ASC VBP requires effective Anesthesia leadership

The ASC is a “team sport” and requires daily team leadership!

Are your anesthesia leaders interdisciplinary “connectors” or “dividers”?

Are they effective and dedicated to your ASC, or to the local hospital?

Who are they accountable to??!!
ASC VBP requires consistent Anesthesia staff

Revolving door of Anesthesia providers??

Anesthesia often torn between Hospital vs. ASC

Inconsistent anesthesia staff = inconsistent standards, inconsistent safety inconsistent quality (VBP)
ASC VBP requires “Quantified” Anesthesia Quality

Is your Anesthesia group quantifiably demonstrating and validating:

• **Compliance:** CMS CfC (QA/PI), Accreditation, ASA, etc.
• **Clinical Outcomes:** occurrence reporting (AQI), review, feedback
• **Patient Satisfaction:** Anesthesia-specific surveys/questions
• **Clinical Effectiveness:** PONV, Pain Management, PACU LoS, etc.
• **Emergency Preparedness:** Mock Drills for MH, Codes, etc.
• **Surgeon & ASC Staff Satisfaction:** Surveys to solicit feedback
• **Anesthesia Clinician Evaluations/Review:** Critical staff feedback
Somnia Case Study: Kentucky ASC, Lexington, KY

Demographics:
Multi-Specialty ASC
Annual Cases: + 8,000
ORs: 6-7 daily
Anesthesia Care-Team Model

Quantified Quality:
• ACCQR & SCIP: 100% compliance annually
• Adverse Event Rate: .2% (occasional PONV, Pain, Regional Blocks, Difficult Airways)
• Clinical Effectiveness: post-op pain study to standardize effective pain protocols
• Patient Satisfaction: > 98% annually
• Surgeon Satisfaction: > 95% annually
• Emergency Preparedness: Mock Drills, Cognitive Aids, etc.
• Accreditation Surveys: 100% success
• Anesthesia Peer Review/Evaluations: 100% annually
Anesthesia Challenge: Translate “Know How” into “Can Do”

Ability to Execute??? Accountability?

Menu
Effective Leadership
Consistent Staff
Operational Efficiency
Compliance
Quantified Quality
Financial Stewards
2016 = Big changes for Anesthesia VBP (PQRS-VBPM)

- **2007 – 2015**: Anesthesia could meet PQRS reporting requirements by reporting >80% of eligible cases via Medicare paper/electronic claims reporting using the Measure Application Validity (MAV) process; essentially reporting up to 3 measures (Prophylactic Antibiotics, Normothermia and Central Line sterility); plus 1 cross-cutting measure (advance directive) in 2015.

- **2016**: CMS requires anesthesia to report >50% of eligible cases via registry reporting (qualified registry (QR) or a qualified clinical data registry (QCDR)).

- CMS requires anesthesia to successfully report a minimum of 9 measures, across 3 national quality forum (NQF) domains, including 1 outcome measure.
Anesthesia now has significant financial risk

**PQRS**

- Individual provider (NPI#) based
- Binary (Y/N/NA) compliance
- > 9 measures; 3 NQF domains
- > 50% of eligible cases
- Compliant = neutral
- **Non-compliant = 2% penalty**

**Illustrative Example:**

<table>
<thead>
<tr>
<th>PQRS Measure</th>
<th># Eligible</th>
<th># Reported</th>
<th>% Reported</th>
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<tbody>
<tr>
<td>Smoking Abstinence</td>
<td>1,000</td>
<td>850</td>
<td>85%</td>
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<tr>
<td>Periop. Mortality</td>
<td>1,000</td>
<td>875</td>
<td>88%</td>
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<tr>
<td>Adverse Event Rate</td>
<td>1,000</td>
<td>800</td>
<td>80%</td>
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<tr>
<td>Corneal Injury</td>
<td>1,000</td>
<td>900</td>
<td>90%</td>
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<tr>
<td>PONV Combo Therapy</td>
<td>1,000</td>
<td>950</td>
<td>95%</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>5,000</strong></td>
<td><strong>4375</strong></td>
<td><strong>88%</strong></td>
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**VBPM**

- PQRS data is aggregated
- Group TIN# based
- Group level “reporting” compliance
- Not rate/outcome based; ie: mortality rate, adverse events, etc.
- Quality “tiering” against national mean

**Value Based Physician Modifier**

- Low Quality: +2.0%*
- Average Quality: +4.0%*
- High Quality: +6.0%
- Low Cost: 0.0%
- Average Cost: -2.0%
- High Cost: -4.0%

Illustrative example:

- Group reporting compliance: 88%
- National quality mean: 80%
- Group above mean = VBPM incentive
- Below mean = penalty
- At mean = neutral
Possible Anesthesia ASC CMS PQRS Measures

- **Smoking Abstinence** DoS: Anesthesia discusses w/ patient before surgery
- **Safe Surgical Checklist** before surgery used and documented
- **Periop. Temperature Management** (> 60min. Case); future ASCQR measure?
- **PACU patient transfer/handoff** protocol used for all patients
- **Patient transfer to hospital/ICU**
- **PONV combination therapy** used; if GA is used

Additional possible QR/QCDR (ASA, etc.) measures:
- **Anesthesia adverse events**; from dental trauma through mortality
- **Post-op pain assessment**
Greater $$$ risk lies ahead for Anesthesia (ASCs)

Implementing MACRA's Physician Payment Reforms

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<td>Fee updates</td>
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<td>Doctors treating Medicare beneficiaries will be in one of two newly designed payment paths</td>
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<td>MIPS+ (Merit-Based Incentive Payment System)</td>
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<td>Doctors will be graded on four factors...</td>
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<td>Clinical practice improvement activities</td>
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<td>Meaningful use of EHRs</td>
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<td>Resource use</td>
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<td>MIPS MAXIMUM BONUS OR PENALTY (+/-)</td>
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<td>(-/- 9% continues after 2022)</td>
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<td>APMs ACROSS-THE-BOARD BONUS</td>
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<td>Additional funding</td>
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<td>$20 million available every year for technical assistance to small practices</td>
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<td>Up to $500 million authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019–24)</td>
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Somnia ANESTHESIA
Current/Future VBP Risk for Anesthesia (and You!)

Shared Risk:
1. CMS VBP evolution (ASCQR, PQRS/VBPM, MACRA, etc.)
2. Commercial payers adopting VBP models
3. Bundled Payments (shared quality/risk!)

Shared Impact:
1. Risk to Anesthesia bottom line, solvency, recruit and retain staff, and fund infrastructure and resources needed for quality.
2. ASC at risk to financially support Anesthesia
3. ASC at risk in not maximizing payer rates
6 key questions about your Anesthesia

1. Is your **Anesthesia leadership engaged, effective and accountable** to you and the ASC leadership; operationally, qualitatively, and financially?

2. Does Anesthesia have the **invested infrastructure and resources** to keep up with healthcare reform challenges; VBP, etc.?

3. Do you have **dedicated and consistent anesthesia staff** or a revolving door?

4. Is anesthesia **flexible** in adjusting to your surgical schedule?

5. Does anesthesia help you **market/recruit surgeons** and develop new service lines?

6. Do you have the **right anesthesia partner** for now and the future?
Questions?

Thank You!

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