FEBRUARY 2017

Periop™

ANESTHESIA MONTHLY

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Aetna Won't Return To Exchanges It Left

National insurer Aetna has no plans to re-enter the ACA exchanges in any of the 11 states it left last year, despite the public scolding it received recently from a federal judge. The judge concluded that Aetna pulled out of the exchanges to improve chances of closing its merger with Humana, and that it wasn't a business decision related to financial losses. The Hartford, CT based insurer will continue to evaluate its 2018 participation in the four states where it currently sells exchange plans. Other insurers are also grappling with how to plan for the future when it's unclear what the next iteration of healthcare reform will look like once the GOP-controlled Congress dismantles the ACA. "We have no intention of being in the market for 2018," Aetna CEO Mark Bertolini said on an investor call recently to announce the insurers fourth-quarter earnings. "Currently, where we stand, we'd have to have markets worked up, prices worked up, for '17 in order to apply, and there is no possible way we'd be prepared to do that given the unclear nature of where regulation is headed." Bertolini said losses stemmed from plans sold on the individual market were $100 million more than previously projected. Last October, Aetna projected a full-year operating loss in its individual commercial products of $350 million. Commercial insurance membership declined by 4% since 2015. Like other insurers, Aetna has been struggling to turn a profit on the plans it sells through the ACA insurance exchanges. Members in those plans tend to be older and sicker with higher medical costs.

Providers Lobby To Follow Path Away From Medicare Fee-For-Service

Providers and insurers are among healthcare leaders lobbying Congress and the Trump administration to continue to push Medicare into value-based payment models.

A number of healthcare organizations, including the Healthcare Leadership Council, sent letters recently to Republican lawmakers hailing the benefits of payment models that focus on quality and value. The reasoning behind the push is that adopting value-based payment models, such as accountable care organizations, can cost anywhere from millions to billions depending on the practice or system size, according to estimates by the American Medical Group Association. The models require technology to track quality metrics and encourage collaboration between providers that could also result in added costs. Those investments could be lost if those models end. The fear of penalties, felony conviction, or exclusion from Medicaid and Medicare has dampened interest in alternative pay models. Congress would have to intervene to add more flexibility to the anti-kickback laws.

> "Budget reconciliation bills can only include provisions with a budgetary impact and do not raise spending, so there would likely be a delay before implantation."

"We're looking for a signal from incoming policymakers that they continue to support (these models) and the investments being made in the private sector," said Jeff Micklos, executive director of the Health Care Transformation Task Force, a consortium of payers, providers and purchasers and others who have committed to putting 75% of their business in alternative pay models in 2020.

Meet Periop At An Upcoming Conference!

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NJSSA Annual Meeting

New Brunswick, NJ

Opt-Out Rules Do Not Improve Access To Anesthesia Care

Eliminating the requirement that nurse anesthetists be supervised by physicians does not appear to increase patients' access to anesthesia care, a recent study suggests.

In 2001, the Centers for Medicare & Medicaid Services issued a rule allowing states to opt-out of the requirement that nurse anesthetists be supervised by physicians.

To find out whether the rule improved access to care, Eric C. Sun, MD, PhD, assistant professor of anesthesiology, perioperative and pain medicine at Stanford University Medical Center, California, and colleagues compared the average distance traveled by patients in the 17 "opt-out" states with that of patients in the other states for seven common procedures. For six out of seven procedures, no significant difference in distance traveled was found.

"Patients in 'opt-out' states were no less likely to avoid traveling further distances to undergo these common procedures than those in non-opt-out states," Dr. Sun said in a press release about the study. "By looking at distance traveled as a measure of access, we're adding to the body of literature that increasingly shows 'opt-out' is unlikely to be a silver bullet when it comes to improving access to care."

Most previous studies have emphasized the effect of opt-out rules on the quality of anesthesia care rather than access to that care, even though access is "the normative intent of the administrative rule," Dr. Sun and colleagues write in an article published online in *Anesthesiology*. A few studies examined the number of procedures performed, but not the distance patients had to travel to undergo those procedures. "While useful, these studies shed light on only one measure of access to care and focused on the use of urgent surgical procedures."

For this analysis, Dr. Sun and colleagues used a random sample of 20% of Medicare beneficiaries to study claims for five elective procedures: total knee arthroplasty, total hip arthroplasty, colonoscopy/sigmoidoscopy, esophagogastroduodenoscopy, and cataract surgery. They also studied two urgent procedures: appendectomy and hip fracture repair. The patients' home ZIP codes and the ZIP code of the care provider were used to estimate the distance traveled for care. The authors constructed a sample of patients who underwent one of the study procedures in a single calendar year between 1999 and 2011 and had been continuously enrolled in a Medicare fee-for-service plan for the calendar year in which the procedure was performed. After adjustment for patient- and population-related factors, the researchers found no significant differences between the patients in either group in terms of average distance traveled or in the percentages of people traveling outside their home ZIP code to receive care. The authors conclude that, combined with earlier studies showing no association between opt-out rules and the number of surgeries performed, "our work suggests that 'opt out' has not been effective in increasing two important dimensions of access to anesthesia care: number of procedures performed or decreased distances for surgery." They recommend more research to understand why "'opt out' has not achieved its intended goal."

National Patient Safety Efforts Save 125,000 Lives, Nearly $28 Billion

A report released by the U.S. Department of Health and Human Services (HHS) shows that nationwide efforts to make healthcare safer are paying off.

The National Scorecard on Rates of Hospital-Acquired Conditions represents demonstrable progress over a five-year period to improve patient safety in hospitals. This data, compiled and analyzed by the Agency for Healthcare Research and Quality (AHRQ), builds on results previously achieved and reported in December 2015. That year's data showed that 87,000 fewer patients died due to hospital-acquired conditions and $20 billion in healthcare costs were saved from 2010-2014.

"Hospitals and health systems, along with their frontline clinicians, can take great pride in this progress," said Jay Bhatt, D.O., American Hospital Association Chief Medical Officer and president of AHA's Health Research & Educational Trust. "Not only have they saved lives, but they've also developed tremendous capacity to tackle safety challenges—a foundation that will help them get to zero incidents."

Hospital-acquired conditions include adverse drug events, catheter-associated urinary tract infections, central line associated bloodstream infections, pressure ulcers and surgical site infections, among others. These conditions were selected as focus areas because they occur frequently and appear to be largely preventable based on existing evidence.

"These achievements demonstrate the commitment across many public and private organizations and frontline clinicians to improve the quality of care received by patients across the county," said Patrick Conway, M.D., deputy administrator for innovation and quality and chief medical officer at CMS. "It is important to remember that numbers like 125,000 lives saved or over 3 million infections and adverse events avoided represent real value for people across the nation who received high quality care and were protected from suffering a terrible outcome. It is a testament to what can be accomplished when people commit to working towards a common goal. We will continue our efforts to improve patient safety across the nation on behalf of the patients, families, and caregivers we serve."