US ANESTHESIA PARTNERS

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Statement to the State All Payer Claims Databases Advisory Commission
July 22, 2021

On behalf of US Anesthesia Partners (USAP), we appreciate the opportunity to provide testimony to inform the recommendations of the State All Payer Claims Databases Advisory Committee. USAP is owned and clinically governed by practicing physicians, including some of the world's foremost experts in anesthesia. Our anesthesiologists, CRNAs, CAAs, and all members of our care teams share operational and clinical best practices organization-wide, helping to facilitate the delivery of consistent, high-quality services for patients, surgeons, facilities, and payers.

We are optimistic that the recommendations of the Committee will improve and expand access to state all-payer claims data. We believe this information is important for employers and consumers and serves as a useful reference point for negotiations between plans and providers. For the databases to be a valuable asset to stakeholders, it is important that it gains the respect of all stakeholders as a neutral, high-integrity source of reliable information. Chief to achieving that trust is the consistent, accurate reporting of data by plans coupled with sound methodology for cleaning and presenting the data.

Anesthesia is a unique medical specialty with billing rules not mirrored elsewhere in healthcare – a method that uses time-based units multiplied by a conversion factor and adjusted for patient and provider or delivery characteristics. On the one hand, it is an extremely simplistic system; however, the simplicity has been complicated unique payment arrangements between plans and providers to address special circumstances.

We have learned from the experience of multiple states constructing anesthesia benchmarks that the technical requirements for data submission and cleaning are critical. Some states such as Washington, are still without a benchmark to be referenced in their independent dispute resolution process. Alternatively, the Colorado state database administrator cleaned up data issues late last year, resulting in a more than 20 percent adjustment to their benchmarks – changes significantly impacting how plans and providers approach initial claim payments as well as decisions about arbitration.

From these experiences, we have surmised that the following technical requirements (not all of which are limited in importance to anesthesia) are critical to producing a true measure of the competitive prices paid by carriers in a geography:

Technical Specifications

- Requirements
    - Exclude zero and negative allowable rates
    - Include commercial plans only
    - Include In-network claims only
    - Include only facility claims (based on revenue code)
- Use the smallest geography possible to calculate rates where a statistically significant sample is possible.
- Include ERISA (self-insured) plans as much as possible as these represent the majority of claims as well as a faster growing set than fully-insured market.
- Ensure that time units represent 15-minute increments for all observations. In some APCD sets, certain combinations of payers and providers are submitted using minutes rather than units,

resulting in incorrect conversion rates. To standardize the calculations, claims from each payer-provider combination should be plotted on an allowed amount vs. units graph. Calculated regression slopes significantly below commercial norms should be flagged for further evaluation and adjusted based on conversations with payer and provider to confirm the contracted rate.

- Calculate rates for OB epidural procedures separately from other procedures as they are often capped by agreement between provider and payer at a certain number of units.

We also believe it is important to ensure that the methodology for calculating the qualifying payment amount (QPA) under the No Surprises Act is not embraced by this body as an appropriate mechanism to calculate competitive rates. That benchmark, designed to establish a ceiling on patient out-of-pocket expense, is calculated using rules that tilt the median toward smaller provider groups that may not be representative of the actual in-network rates experienced by plans and providers or groups that do not primarily provide anesthesia services (e.g., pain management physicians). Below we highlight a few aspects of that median calculation of the QPA that should be avoided or specifically addressed in this committee's recommendations.

- The calculation of the median rate takes the median of a set of provider-contracted rates by plan where the contract, rather than the volume of claims, constitute an observation. There are two potential issues here:
    - The use of contracted rates versus actual claims amounts would potentially include superfluous rates which are "contracted" but not used (e.g., no associated volume)
    - Secondly, in arranging contracted rates from least to greatest rather than arranging actual claims from least to greatest, more weight likely will be placed on rates with smaller providers or providers who do not principally provide anesthesia services and less to larger groups of providers.
- The 25% sufficiency point does not necessarily "fix" either of the previous two points because it puts no limit on the number of small-claim contracted rates that are included. In addition, this means that 75% of a payers' claims might be excluded from the calculation.
- The definition of geographic areas is also not specified. The larger the geographic area, the more diverse the rates that exist within it. As a result, smaller geographic areas tend to better reflect the appropriate cost of living and true cost of care provided.
- Similar to the point on "contracted, but not used", QPA would potentially incorporate contracted rates for employed anesthesiologists at facilities that accept low contracted anesthesiology rates as ancillary services to high profile quaternary surgical care, for example. This is not representative of the contracted rate of an anesthesiologist that is independent of the surgeon—the very focus of surprise billing legislation.
- Many APCD datasets, and potentially the QPA calculation may exclude ERISA (self-insured) commercial plans. These ERISA rates should be included in the calculation of rates for three reasons: (1) self-insured plans represent the majority of all claims and are growing at a higher rate than fully-insured, (2) ERISA payer mix is often different and skews toward higher reimbursing payers, and (3) payers tend to reimburse at higher rates within their ASO products.

Thank you again for the opportunity to share our views with the committee. We hope these observations help accelerate the committee's work given the statute's aggressive timeline for recommendations. If you have any questions or need additional information, please do not hesitate to contact Marian Lowe, Chief Strategy Officer at marian.lowe@usap.com.