FUSION
ANESTHESIA
What's the Rush?
Anesthesia Quality Reporting

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INTRODUCTION

Quality reporting has been a hot topic for several years. Many experts and publications have argued that virtually every anesthesiologist group will need to adopt quality reporting sooner rather than later for both clinical and financial reasons.

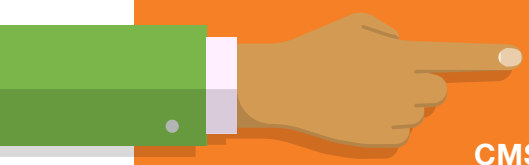
However, the metrics and methodology of quality reporting as adopted by CMS and other agencies have been extremely flawed. As a result, many anesthesiologists have been doubtful about the utility of these reporting measures for the purposes of clinical improvement. Nonetheless, many groups have been under the impression that they should adopt quality measures for financial reasons anyway.

In our experience, while there are sometimes sound business motives for adopting quality reporting measures, very few anesthesia groups need to adopt them for direct financial reasons and, in fact, most groups will find it a losing financial bet for the foreseeable future.

Furthermore, while we are not clinicians, many of our doctors tell us that they think their time in seeking clinical improvements is better spent with initiatives like a perioperative surgical home rather than in the morass of MIPS reporting.

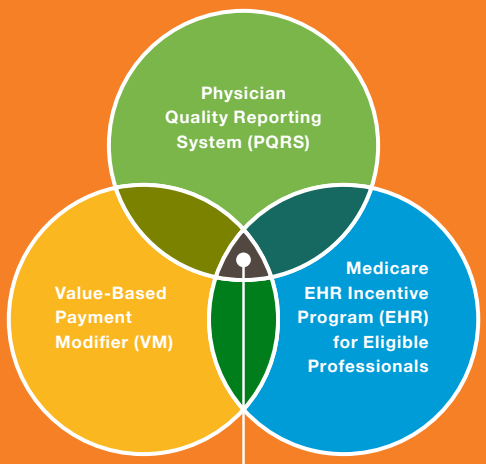
So ... should your practice be investing in quality reporting? Our answer may surprise you.

MIPS vs APM: A Refresher



MIPS stands for Merit-based Incentive Payment System.

CMS combined three legacy programs into this single system for reporting on quality, cost, improvement activities, and the promotion of interoperability:



These factors are combined into a single score that enables participants to gain a bonus on their Medicare Part B payments.

APM stands for Alternative Payment Model.

APMs are payment systems that provide added incentives to clinicians to provide high-quality and cost-efficient care. Note that anesthesiologists must participate in advanced APMs to avoid penalties if they substitute APMs over MIPS. Advanced APMs are simply a subset of APMs that require the use of EHRs, requires quality measures comparable to MIPS measurements, and requires that either the participants bear significant risk or the program be based upon a medical home model.

The details around choosing or implementing a quality measurement are beyond the scope of this eBook. However, there are a plethora of resources available online, or just give us a call at 262-787-4050.

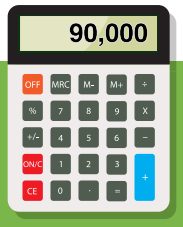
DO THE MATH ON MEDICARE

The primary payer that is requiring quality reporting is Medicare. So if you're looking at MIPS reporting for financial reasons, be realistic about how much Medicare you actually bill.

The magic number is $90,000 a year in Medicare billing per doctor. For most doctors billing Medicare $90,000 a year, it makes financial sense to participate in MIPS or an APM, if for no other reason than to avoid a 7% penalty for not participating in 2019.

If you're billing between $50,000 and $90,000 in Medicare annually, participating in MIPS is likely to be a wash in terms of direct costs/bonuses. Anesthesiologists billing less than $90,000 are not subject to penalties, and the bonuses they might make are likely to be offset by the direct costs of participating.

If you're billing less than $50,000 a year in Medicare, you almost certainly will not break even on your direct investment in setting up and reporting on MIPS. You may still want to implement quality reporting, but it shouldn't be in expectation of direct financial payback.



Here's what the math looks like:

+ If you bill less than $90K in Medicare for reporting as an individual (or participate in an advanced APM) you ***are exempt from penalties for not reporting***.

+ The maximum theoretical bonus for 2019 is +7% of your Medicare billing. That's $6,300 for a physician at the $90K "magic number" but only $3,500 for a more common $50K in Medicare billing.

+ Realistically, no one will get 7%, and most anesthesiologists will see more like 0.5% on average. That's $450 if you're billing $90K and a whopping $250 if you're at $50K.[1]

+ Even if you have a billing provider like Fusion Anesthesia that will help you set up your reporting frameworks for no additional charge, direct costs like software, submitting via qualified registry or a QCDR, paperwork, etc. will likely cost you at least $1,000 a year per provider.

+ Keep in mind that all of the above scenarios consider direct costs only. They effectively value your time at zero.

+ Don't forget, providers who choose to participate but score poorly on MIPS (below 30 points) will be subject to a 7% ***penalty***. So there is some financial risk to participating!

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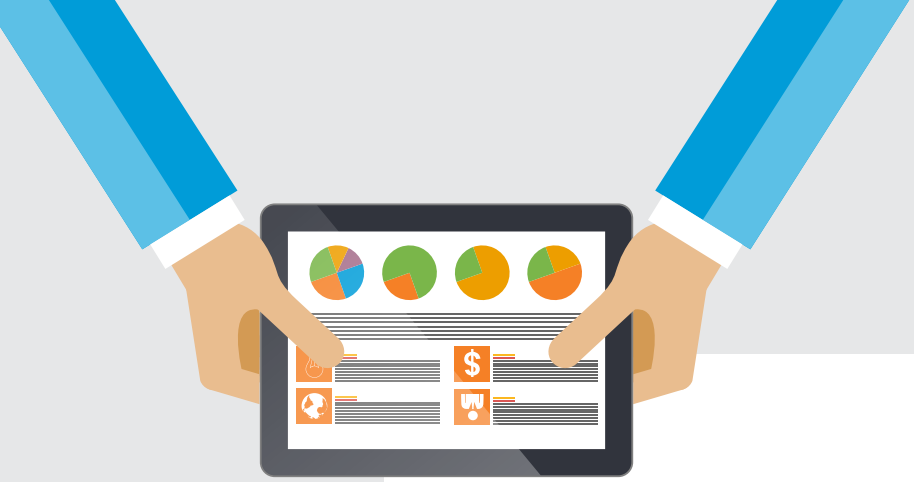
CHECK YOUR CONTRACTS

There are *some* private payers that are basing payments on MIPS-style quality scores, but these contracts are pretty uncommon. If you have a major payer in your market that is actively implementing a quality-based compensation scheme, then this will obviously change the economics of implementing MIPS and other quality measures. However, we think the market is rethinking how to measure, improve, and compensate quality measurements in anesthesia ... and MIPS won't be it.

What We See in the Market

Even payers who were publicly and enthusiastically embracing the idea of quality-based compensation a few years ago appear to be quietly shelving these plans for anesthesia. Few of these schemes got beyond pilot programs, and we see a general retreat from any MIPS-like measurements for commercial payers.



THE BIG PICTURE: MARKETING

While the direct financial benefits to MIPS reporting may be marginal or even negative for many anesthesiologists, some savvy practices may still find it financially advantageous to implement. The reason is more subtle than a check from Medicare: hospital relations.

Many hospitals want their service providers to participate in quality schemes (for reasons both rational and not). If your facilities can be counted in this group, then it may well make sense to participate even if it costs you a few bucks to set it up. Call it marketing, call it PR, call it being a good team player ... call it whatever you want, but the reality is that provider groups who proactively check all the boxes that are important to a hospital's administration have an easier time when it comes time to renegotiate their contract. And a good (or bad) contract makes all the other figures in this eBook irrelevant from a profitability standpoint.

PERIOPERATIVE SURGICAL HOME: AN ALTERNATIVE

The American Society of Anesthesiologists' Perioperative Surgical Home (PSH) model of care is a patient-centered approach to surgery. It includes a strong emphasis on shared decision making, rigorous process standardization, and evidence-based clinical care pathways, as well as robust coordination and integration of care. The PSH model guides patients through the entire surgical experience, from the decision to undergo surgery to 30 days post-discharge and beyond. It has gained great enthusiasm amongst many anesthesiologists for the opportunities it provides in streamlining care and improving patient outcomes.

If you're looking to implement a true quality initiative, rather than just checking boxes, PSH may well be a great model for your practice.

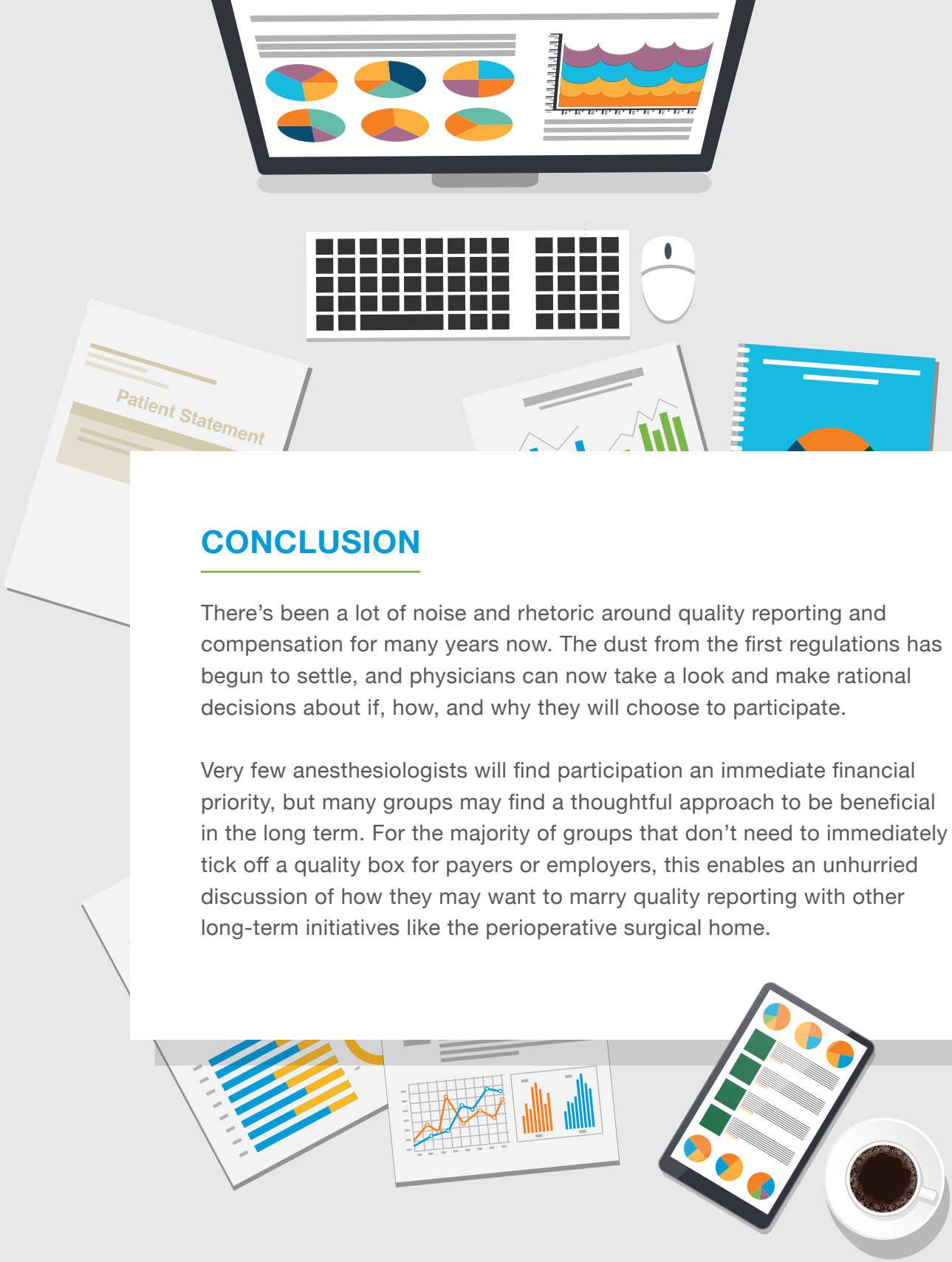
Your Own Secret Weapon

Many of the large national anesthesia groups have used quality reporting and software as a competitive weapon when attempting to wrest control of contracts from smaller regional players. Whether they use the data collected or not, many hospital administrators are suckers for pretty dashboards and promises of data interoperability.

Competing with these franchised behemoths in this area is not as difficult as it might seem. Check with your billing provider to see if they can help you determine the best metrics to report on, the easiest way to collect the information, and the most appropriate reporting systems for your group.

Fusion Anesthesia includes quality reporting consulting as part of our normal service at no additional charge. We're platform-agnostic and work with our client groups to set up customized quality reporting schemes that best accomplish practice goals—whether that's a system that is dictated to you by your hospital or one of your own choosing—complete with glittery dashboards and direct data integration.

Don't know what to choose but just want to get on the MIPS or APM bandwagon? That's fine. We can help you set up a road map of what you should track, determine the easiest way to do this with your current systems, and submit all the reporting you need.



CONCLUSION

There's been a lot of noise and rhetoric around quality reporting and compensation for many years now. The dust from the first regulations has begun to settle, and physicians can now take a look and make rational decisions about if, how, and why they will choose to participate.

Very few anesthesiologists will find participation an immediate financial priority, but many groups may find a thoughtful approach to be beneficial in the long term. For the majority of groups that don't need to immediately tick off a quality box for payers or employers, this enables an unhurried discussion of how they may want to marry quality reporting with other long-term initiatives like the perioperative surgical home.

ABOUT FUSION ANESTHESIA

Fusion Anesthesia is dedicated to comprehensively addressing the billing and back-office needs of anesthesiologists across the United States. We provide complete revenue cycle management services as well as accounting and practice management services as an integrated part of our billing and collections services.

In addition to billing, we bundle our services into a comprehensive package.

All included ***at no extra charge***.

- **Contract Negotiation**
- **Compliance & Quality Reporting**
- **Accounting, Tax & Payroll**
- **Bookkeeping & Bill Paying**
- **Scheduling & Efficiency Analysis**
- **Credentialing Support**
- **Practice Management**

This means you can focus on patient care, rather than worrying about paperwork.

Call us at 262-787-4050 or email at jbuss@fusionanesthesia.com for a free no-obligation analysis of your current billing systems. We'd be happy to show you where you're leaving money on the table and how you can increase your take-home by 5-15%.