The second article in this three-part Health Capital Topics series focusing on quality trends in Accountable Care Organizations (ACOs) discusses the changes included in the 2015 Medicare Physician Fee Schedule (MPFS), which was finalized this month.1 With many ACOs aiming to achieve “quality care rather than quantity of care,”2 it is important to closely examine the changes in the MPFS, which include an increase in the number of quality benchmarks from 33 to 37 in order to earn shared savings.3 This article will describe those changes and their potential effects on the efforts of ACOs to achieve quality care.

With the recent release of “Performance Year 1 quality performance results for ACOs with 2012 and 2013 agreement start dates,” by the Centers for Medicare & Medicaid Services (CMS), the public is able to discern the progress of federal ACOs in improving the quality of healthcare. Prior to the release of this new data, only five of the current 33 benchmarks had been reported on by the federal ACOs, despite Medicare’s efforts to increase transparency for both cost and quality in the healthcare sector.4 Avalere Health Center for Payment and Delivery InnovationTM (Avalere), analyzed the data released by CMS, and found a disconnect between achieving quality care and earning shared savings.5 The CEO and Founder of Avalere Health, Dan Mendelson, commented on these results by stating:

“Acos incur startup costs of about $2 million, so the financial results alone highlighted a need for program changes. But these quality results [from the CMS “Performance Year 1 quality performance results for ACOs with 2012 and 2013 agreement start dates”] lend additional credibility to calls to reform the program.”6

Some of the reforms that CMS is planning to implement in regard to quality benchmarks, and which reforms are listed in the final rule for the 2015 MPFS, include:

1. Eliminating Medication Reconciliation, the fifth most achieved benchmark;7
2. Adding the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM);8
3. Retiring components of the Diabetes and Coronary Artery Disease (CAD) composites;9
4. Decreasing the number of measures for Diabetes from five to four;10
5. Increasing the number of measures for CAD from two to four;11 and,
6. In total, implementing 12 new measures, retiring eight, and renaming the EHR measure from “Percent of Primary Care Physicians (PCPs) who Successfully Qualify for an Electronic Health Record (HER) Incentive Program Payment” to “Percent of PCPs who Successfully Meet Meaningful Use Requirements.”12

These potential changes to ACO quality benchmarks have been both praised and criticized for the speed by which the Medicare program is steering away from the fee-for-service model and advancing toward improved reimbursement models.13 Some specific concerns involve whether changing two-thirds of the quality benchmarks is too aggressive of an approach, particularly for such a large program that is still relatively new.14 According to the Health System Transformation Task Force, such broad changes place an undue burden on ACOs, as these organizations must reform their practice design in order to achieve these new benchmarks.15 CMS contends that the burden would not be increased since certain redundancies have been eliminated, and the number of measures directly reported through the CMS website (and not through surveys or other claims data) would actually decrease by one.16

An additional change to the 2015 MPFS involves the implementation of a quality improvement measure, which will award bonus points to an ACO in each of the four quality domains for achieving statistically significant levels of improvement across a domain.17 CMS will award up to two points per domain, but will not exceed the total points allowed in each quality domain.18 For example, if an ACO scores 12 out of 14 points initially, but demonstrates a statistically significant improvement, then it could receive the bonus points, applied on a sliding scale, for a new score of up to 14 out of 14 points.19 But if an ACO had originally scored 13 points, the bonus points would only bring them to a new score of 14, not 15.20 Commentators from the Health System Transformation Task Force support the proposed improvement scores, but some would like to see the bonus increased to four points in order to strengthen organizations’ incentives to achieve yearly improvements.21 CMS argues that awarding four

(Continued on next page)
points could apply undue weight to the improvement measure, particularly since the program as a whole already rewards improved performance with more shared savings.22 Similarly, suggestions have been voiced to award ACOs in the top 10 percent of total quality scores with a financial bonus.23

This quality improvement measure could be very beneficial to ACOs in the future, as demonstrated by recent ACO performance data. In the first two years of operation, Pioneer ACOs increased their mean quality score from 71.8% in 2012 to 85.2% in 2013, achieving an overall increase of 19%.24 Additionally, Pioneer ACOs improved on all but five of the 33 quality measures, and achieved an average change in improvement of 14.8%.25 Medicare Shared Savings Program (MSSP) ACOs also saw improvement on 30 of the 33 quality measures in their first performance year.26 If these same levels of improvement were to be demonstrated with the improvement measure in effect, both Pioneer and MSSP ACOs could receive even higher quality scores from 71.8% in 2012 up to two points added to each quality domain. Therefore, with the release of the finalized 2015 MPFS, ACOs should be mindful of how they can adapt their practices to meet this new set of quality benchmarks, and consistently strive to achieve “quality care rather than quantity of care.”

---

2 “Input on the Center for Medicare & Medicaid Services’ (CMS) proposed rule that addresses changes to the physician fee schedule and other Medicare Part B payment policies for calendar year (CY) 2015 as published in the Federal Register on July 1, 2014” By Health System Transformation Task Force, To Administrator Marilyn Tavenner, Centers for Medicare & Medicaid Services, September 2, 2014.
6 Ibid.
7 Ibid.
8 “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015” Vol. 79, No. 133, pgs. 40475-40485.
10 “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015” Vol. 79, No. 133, pgs. 40475-40485.
11 Ibid.
12 Ibid.
13 “Input on the Center for Medicare & Medicaid Services’ (CMS) proposed rule that addresses changes to the physician fee schedule and other Medicare Part B payment policies for calendar year (CY) 2015 as published in the Federal Register on July 1, 2014” By Health System Transformation Task Force, To Administrator Marilyn Tavenner, Centers for Medicare & Medicaid Services, September 2, 2014.
14 Ibid.
15 Ibid.
16 “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015” Vol. 79, No. 133, pgs. 40475-40485.
17 Ibid. at 40490-40492.
18 Ibid.
19 Ibid.
20 Ibid.
21 “Input on the Center for Medicare & Medicaid Services’ (CMS) proposed rule that addresses changes to the physician fee schedule and other Medicare Part B payment policies for calendar year (CY) 2015 as published in the Federal Register on July 1, 2014” By Health System Transformation Task Force, To Administrator Marilyn Tavenner, Centers for Medicare & Medicaid Services, September 2, 2014.
22 “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015” Vol. 79, No. 133, pgs. 40490-40492.
23 “Input on the Center for Medicare & Medicaid Services’ (CMS) proposed rule that addresses changes to the physician fee schedule and other Medicare Part B payment policies for calendar year (CY) 2015 as published in the Federal Register on July 1, 2014” By Health System Transformation Task Force, To Administrator Marilyn Tavenner, Centers for Medicare & Medicaid Services, September 2, 2014.
25 Ibid.
26 Ibid.
Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&amp;AA, serves as Chief Executive Officer of Health Capital Consultants (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Certified Appraiser); and, Certified Merger & Acquisition Advisor (CM&amp;AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "Accountable Care Organizations: Value Metrics and Capital Formation" [2013 - Taylor & Francis, a division of CRC Press], “The Adviser’s Guide to Healthcare” – Vols. I, II & III [2010 – AICPA], and “The U.S. Healthcare Certificate of Need Sourcebook” [2005 - Beard Books]. His most recent book, entitled "Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" was published by John Wiley & Sons in March 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “Shannon Pratt Award in Business Valuation” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institute of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of Health Capital Consultants (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA). He has co-authored “Research and Financial Benchmarking in the Healthcare Industry” (STP Financial Management) and “Healthcare Industry Research and its Application in Financial Consulting” (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser’s Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Matthew J. Wagner, MBA, CFA, is Senior Vice President of Health Capital Consultants (HCC), where he focuses on the areas of valuation and financial analysis. Mr. Wagner has extensive experience in healthcare related enterprises, assets and services, including but not limited to, physician practices, diagnostic imaging service lines, ambulatory surgery centers, physician-owned insurance plans, and medical financial analysis. Mr. Wagner manages the research services database for clients, including advanced statistical analysis, economic modeling, and economic and financial analysis.

John R. Chwarzinski, MSF, MAE, is Vice President of Health Capital Consultants (HCC). Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as, a Master’s Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.

Jessica L. Bailey, Esq., is the Director of Research of Health Capital Consultants (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.