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2015 MPFS and New Quality Benchmarks

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 Innovation™* (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

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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 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*."

1 "2015 Medicare Physician Fee Schedule (MPFS) Proposed Rule Released" American Society of Cataract and Refractive Surgery, 2014, http://www.ascrs.org/newsroom/news/2015-medicare-physician-fee-schedule-mpfs-proposed-rule-released (Accessed 9/30/14).

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.

3 "Physician fee schedule would modify Medicare ACO measures" By Melanie Evans, Modern Healthcare: Healthcare Business News, July 3 2014, http://www.modernhealthcare.com/article/20140703/NEWS/307039940 (Accessed 9/29/14).

4 "Limited Medicare ACO quality data show sharp variations in performance" By Melanie Evans, Modern Healthcare: Healthcare Business News, May 3 2014, http://www.modernhealthcare.com/article20140503/MAGAZINE/305039990?AllowView=VDl3UXk1TzhDdmVCbnhMTEJmaUxCVGEyakV3UkN1VlVFQk1B (Accessed 9/29/14); "Medicare gives first glimpse of ACO quality performance" By Melanie Evans, Modern Healthcare: Healthcare Business News, September 22 2014, http://www.modernhealthcare.com/article/20140922/NEWS/309229940/medicare-gives-first-glimpse-of-aco-quality-performance (Accessed 9/29/14).

5 "Avalere Analysis: Most Medicare ACOs Earning Shared Savings Payments Were Below Average on Quality" By Erik Johnson, Avalere, September 25 2014, http://avalere.com/expertise/life-sciences/insights/avalere-analysis-most-medicare-acos-earning-shared-savings-payments-were-be (Accessed 9/30/14).

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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.

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11 *Ibid.*

12 *Ibid.*

13 "Input on the Center for Medicare & Medicaid Sercices' (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.

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