



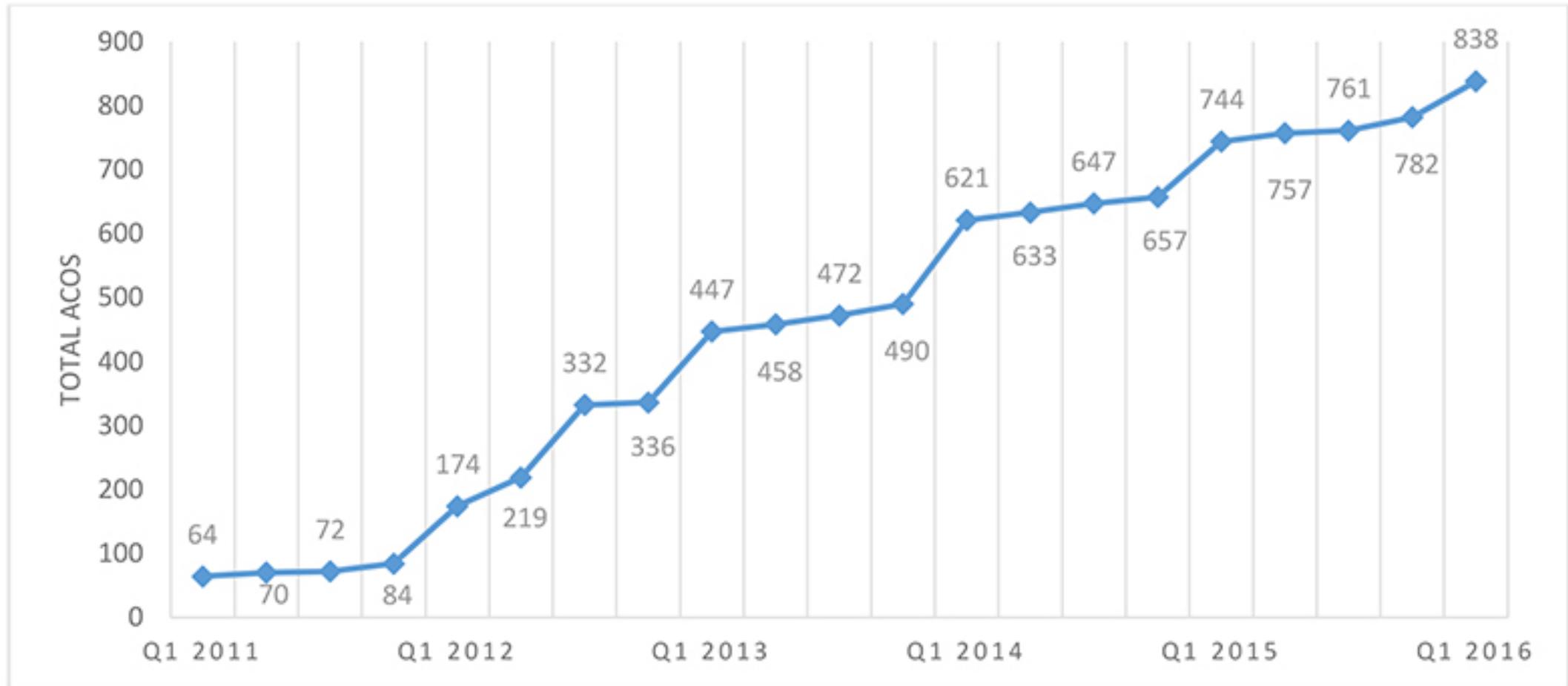
ACOs and The Rapidly Changing Payment Reform Landscape

Seventh National ACO Summit
Focus Session

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Principal and National Leader
Center for Healthcare Regulatory Insight
KPMG, LLP

June 9, 2016

Growth of ACOs Over Time



Muhlestein, David and Mark McClellan. "Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion" *Health Affairs* blog. April 21, 2016

HHS Payment Reform Goals

In January 2015, the Department of Health and Human Services announced **new goals for value-based payments and APMs in Medicare**

Medicare Fee-for-Service

GOAL 1: **30%** 

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2: **85%** 

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



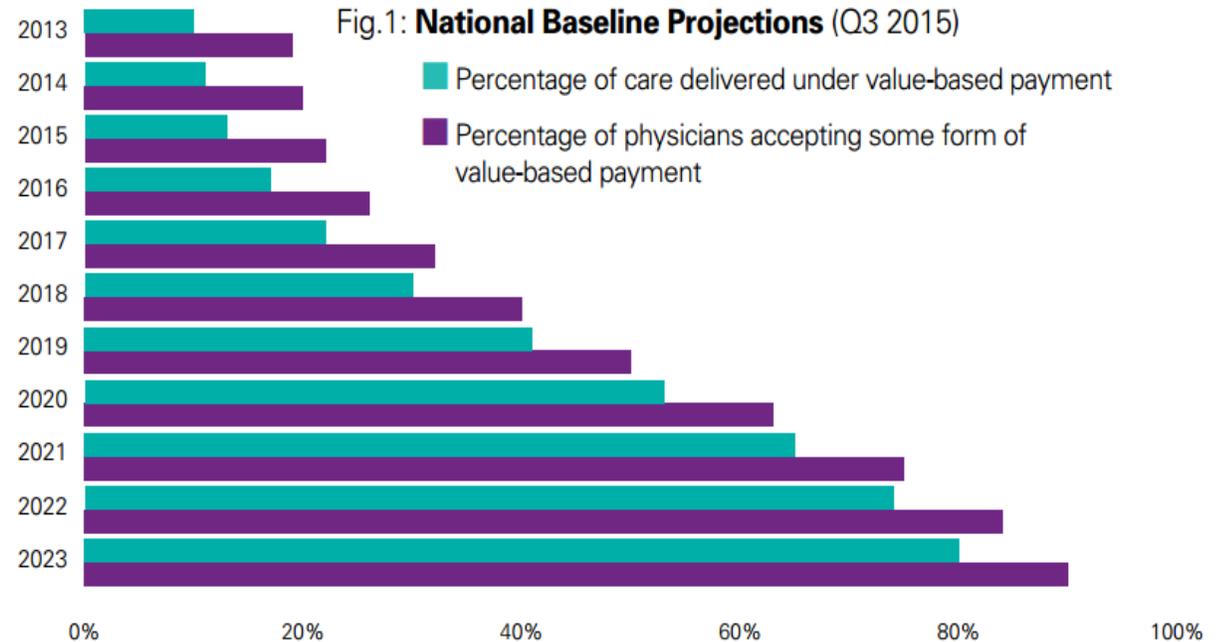
Set **internal goals** for HHS



Invite **private sector payers** to match or exceed HHS goals

Source: Centers for Medicare and Medicaid Services

Value-Based Care Will Continue to Grow

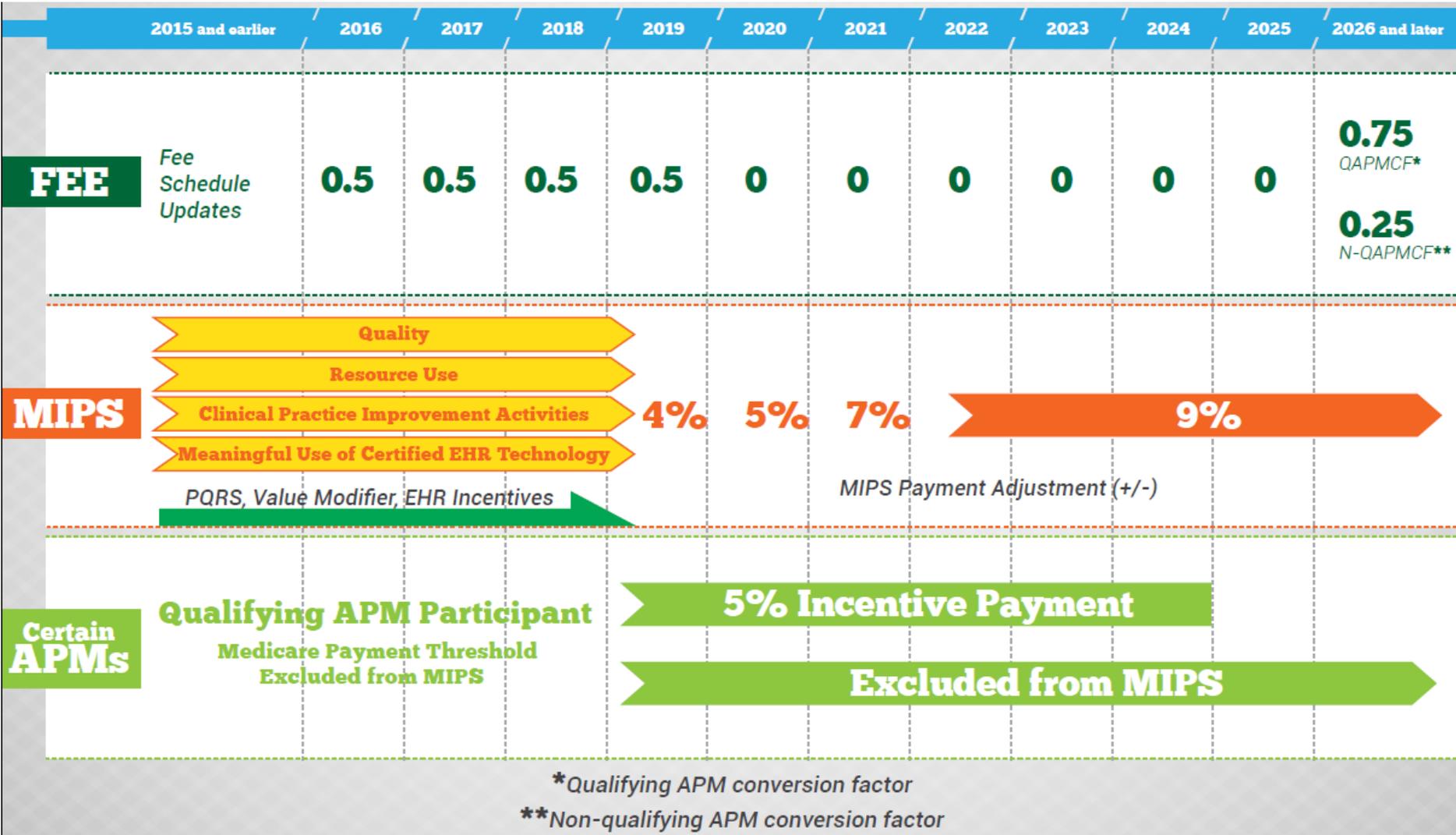


Medicare Access and CHIP Reauthorization Act

Repeals SGR and replaces it with a 0.5% payment increases for doctors each year through 2019, when the Quality Payment Program takes effect

- Provides 5 percent bonus to qualifying participants (QPs) receiving significant proportion of revenue from Advanced Alternative Payment Models (APMs)
 - Must be at least 25% of revenue (or 20% of patients) through Advanced APM and increases over time
 - Recently released proposed rule suggests only a few may qualify as Advanced APMs: MSSP Track 2 and 3, Next Generation ACO, Comprehensive ESRD (large dialysis organizations), CPC+, oncology care (two-sided risk arrangement)
- Clinicians not meeting QP standard will participate in Merit-Based Incentive Payment System (MIPS)
 - Incentives/penalties for quality and efficiency measure reporting
 - Four performance reporting categories: quality, resource use, advancing care information and clinical practice improvement activities (replaces PQRS, VBM and MU)
 - Clinicians in an APM, but not one certified as “advanced,” have less burdensome reporting requirements and more favorable scoring in certain categories

MACRA Payment Update Timeline (2015-2026)



Centers for Medicare and Medicaid Services, 2015



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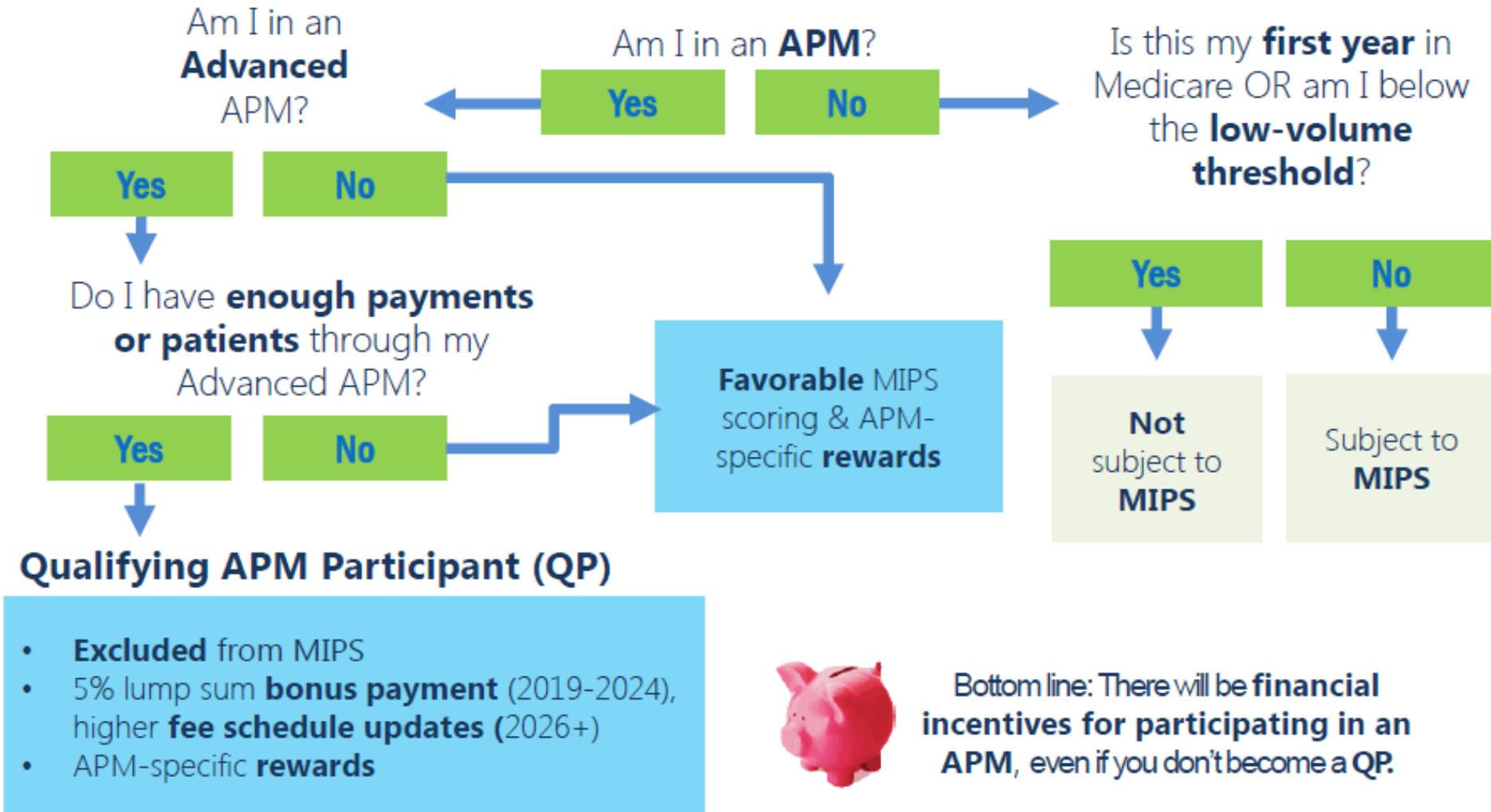
MIPS Compared to Prior Law

Prior Law			MACRA		
Year	P4P Penalties	Max Combined P4P Penalties	Max MIPS Penalties	Max MIPS Bonuses	Annual Updates
2017	MU -3% PQRS -2% VBM -4%	-9%	No change	No change	0.5%
2018	MU -4% PQRS -2% VBM -4% or more	-10% or more	No change	No change	0.5%
2019	MU -5% PQRS -2% VBM -4% or more	-11% or more	-4%	4% or more	0.5%
2020	MU -5% PQRS -2% VBM -4% or more	-11% or more	-5%	5% or more	0%
2021	MU -5% PQRS -2% VBM -4% or more	-11% or more	-7%	7% or more	0%
2022	MU -5% PQRS -2% VBM -4% or more	-11% or more	-9%	9% or more	0%

American Medical Association. "Understanding the Merit-Based Incentive Payment System (MIPS)" Available at <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-merit-based-incentive-program.page>



APMs or MIPS?



Centers for Medicare and Medicaid Services, 2016



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Headwinds for Rapid Progress in Payment Reform

- **Performance results suggest ACOs are still a work in progress**
 - Roughly half of MSSP ACOs reduced spending to-date; one-quarter enough to earn shared savings
 - About one-third of Pioneers had statistically significant savings in two consecutive years; one-third statistically significant savings in one year; one-third statistically insignificant savings/losses
 - MSSP and Pioneer ACOs improving quality overall
 - A mixture of MSSP, Pioneers, and new entrants started as Next Generation ACOs in January
- **How can we put this progress to work in MACRA implementation?**
 - MACRA charts a constructive course for value-based physician payment reform... how can the final rule be improved? What have ACOs taught us about physician led value based care... Are physicians ready for MACRA?
- **How will consolidation of payers and providers impact the movement from volume to value?**
 - What impact will insurance and hospital consolidation have on value-based payment models?
- **How will new payment models co-exist with fraud and abuse laws?**
 - How will enforcement priorities change to accommodate a new world order of payment and delivery models

Focus Session Agenda

9:10 am	Panel I: MACRA, MIPS, and APMs: Getting There from Here
10:10 am	Panel II: Impact of Market Consolidation: Providers and Payers
11:05 am	Panel III: How Will New Payment Models Co-exist with Old Fraud and Abuse Laws?
11:55 am	Wrap-Up
12:00 pm	Adjournment to Joint Luncheon with Patrick Conway, CMS

MACRA, MIPS, and APMs: Getting There from Here

Paul N. Casale, MD, MPH

Executive Director, New York Quality Care ACO; Former Chief, Division of Cardiology, Lancaster General Health

Harold D. Miller

President and Chief Executive Officer, Center for Healthcare Quality and Payment Reform

Frank Opelka, MD, FACS

Medical Director, Division of Advocacy and Health Policy, American College of Surgeons; Former EVP of Health Care and Medical Redesign, Louisiana State University System

Impact of Market Consolidation: Providers and Payers

Leigh Oliver, Esq.

Partner, Hogan Lovells LLP

Joshua H. Soven, Esq.

Partner, Gibson, Dunn & Crutcher LLP; Vice Chair, ABA Antitrust Section's Federal Civil Enforcement Committee; Former Chief, Litigation I Section, Antitrust Division, US Department of Justice

Christine White, JD, MPH

Vice President - Legal Affairs, Northwell Health; Chair, Antitrust Practice Group, American Health Lawyers Association; Former Senior Staff Attorney, Federal Trade Commission

How Will New Payment Models Co-exist with Old Fraud and Abuse Laws?

Vicki Robinson, Esq.

Senior Counselor for Policy, Office of the Inspector General (OIG), US Department of Health and Human Services

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Partner, Crowell & Moring; Former Director, Division of Technical Payment Policy, Center for Medicare and Medicaid Services; Former Program Integrity Group, CMS Division, Office of the General Counsel, US Department of Health and Human Services

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