

Next Generation ACO Model



Open Door Forum

March 8, 2016

Agenda

- Model Overview
- Financial Model
- ACO Entities and Participation
- Beneficiary Engagement
- Application and Selection Timeline
- Questions

Next Generation ACO Model Overview

- The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients.
- It is a new opportunity in accountable care, differentiated from other models by:
 - More predictable financial targets;
 - Greater opportunities to coordinate care; and
 - High quality standards consistent with other Medicare programs and models.
- It seeks to test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for original Medicare beneficiaries.

Model Principles

There are six basic principles of the Next Generation ACO Model:

- Protect Medicare Fee-for-Service (FFS) beneficiaries' freedom of choice;
- Allow beneficiaries a choice in their alignment with the ACO;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care; and
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.

Contents

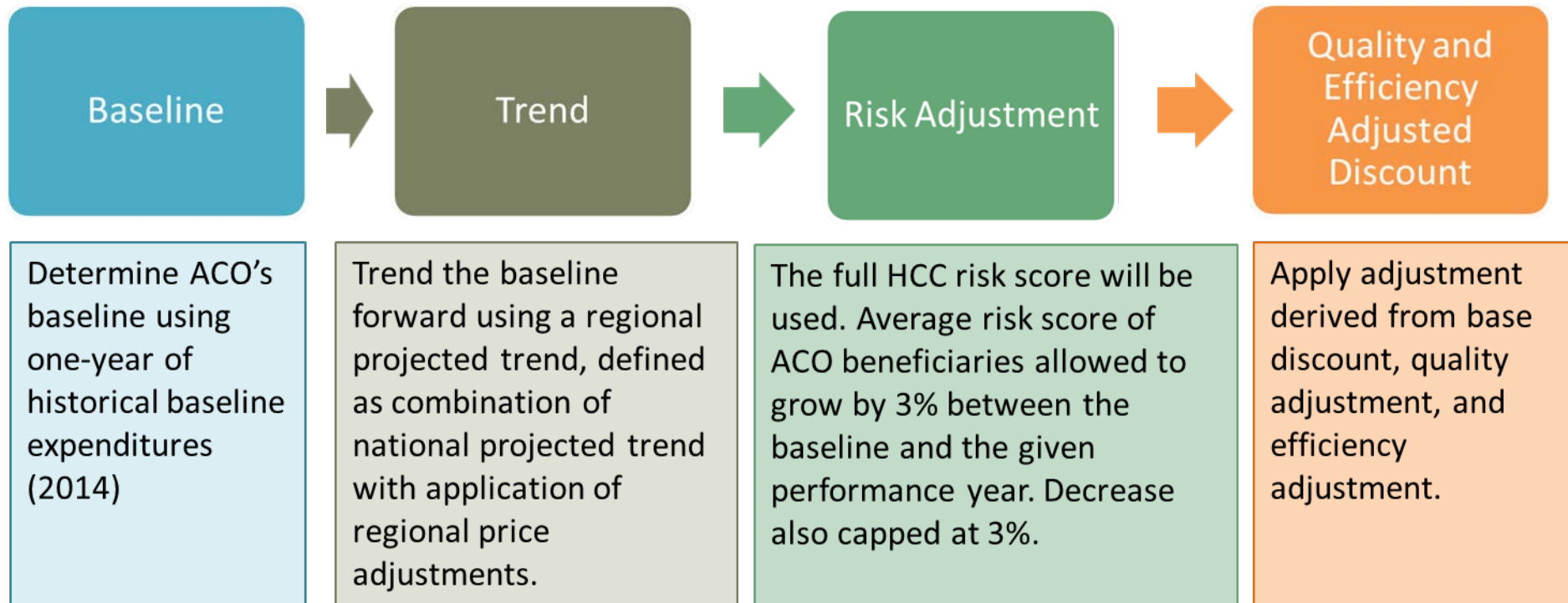
- Model Overview
- **Financial Model**
- ACO Entities and Participation
- Beneficiary Engagement
- Application and Selection Timeline
- Questions

Financial Goals and Opportunities

- Financial Goals
 - Increased ACO financial risk;
 - Long-term fiscal sustainability; and
 - Benchmark predictability and stability.
- ACO Opportunities
 - Greater financial risk coupled with a greater portion of savings; and
 - Flexible payment options that support ACO investments in care improvement infrastructure to provide high quality care to patients.

Components of the NGACO Benchmark

The benchmark will be **prospectively set prior to the performance year** using the following four steps¹:



¹ Benchmark will be prospectively set with retrospective adjustments based on final risk adjustment and quality score information

Baseline

- Next Generation ACO (NGACO) model uses a **one-year baseline** (2014)
- **Pioneer ACO model and Shared Savings Program** use a three-year baseline, trending the first two baseline year expenditures to the third baseline year¹
- NGACO one-year baseline **significantly reduces complexity** of savings / loss calculation by eliminating multi-year baseline trending

¹ In these models/programs, Baseline Year 1 and Baseline Year 2 are trended to Baseline Year 3 by factors accounting for the change in state expenditures, risk scores, and (for the Pioneer ACO model in Performance Years 4 and 5) regional price adjustments (the Pioneer model sometimes refers to the latter as “locality price adjustments”

Trend

The baseline will be trended forward using a regional projected trend:

- National projected trend similar to that currently used in Medicare Advantage (MA).
- Regional prices applied to the national trend.
- Under limited circumstances, CMS may adjust the trend in response to payment changes with substantial expected impact (negative or positive) on ACO expenditures.

Risk Adjustment

- Key background concept: Next Generation ACO benchmark is **cross-sectional**, which means that:
 - Alignment algorithm applied to baseline year, and **then separately** to performance year¹
 - **Populations in these two time periods will overlap but be different** – some beneficiaries will be aligned in baseline year but not performance year, while some beneficiaries will be aligned in performance year but not baseline year (e.g., because of changes in utilization patterns, changes in provider/market landscape, etc.)
- Risk adjustment is meant to **adjust for the difference** between the baseline and performance-year populations²
- **CMS Hierarchical Condition Category (HCC) model** used to determine average risk score of baseline year population and average risk score of performance-year population²
- Similar to the Pioneer ACO model and Shared Savings Program, **average risk scores will be “re-normalized” to the average risk score of the national population** (i.e. for the purposes of financial reconciliation, HCC risk scores are adjusted in any given year such that the average risk score nationally is 1)³
- Increase in average risk score **capped** at 3% cap. Decrease in HCC risk score will also be **capped** at 3%
 - PY1: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2016
 - PY2: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2017
 - PY3: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2018
- **Risk adjustment initially set prospectively, but retrospectively adjusted** for final reconciliation when “final risk scores” become available after the performance year⁴

1 In contrast, a “cohort methodology” aligns beneficiaries once to the performance year and looks at expenditures for this same group of beneficiaries in the baseline year (i.e. this cohort is followed over time). The Pioneer ACO model used a cohort methodology from Performance Years 1 – 3 (2012 – 2014). A cross-sectional methodology is used by the Pioneer ACO model in Performance Years 4 – 5 (2015 – 2016) and the Shared Savings Program.

2 The “baseline year population” and the “performance year population” are also referred to as the “baseline year panel” and the “performance panel” in certain Pioneer / Shared Savings Program documents – a panel here simply refers to a group of beneficiaries which may overlap with other panels

3 The “national population” here refers to the national population of beneficiaries eligible to be aligned to a Next Generation ACO

4 Note that HCC scores are based on diagnoses in claims for the year prior to the performance year. As an example, consider Performance Year 2 (2017). Performance year risk scores are based on prior-year claims (i.e. claims incurred in 2016). The HCC methodology does not allow for final calculation of these performance year risk scores until early-to-mid 2018. The benchmark, however, will be prospectively set based on currently available information at the time, and CMS is exploring options for updating benchmark based on interim risk score information available prior to the final scores becoming available.

Quality- and Efficiency-Adjusted Discount

- The NGACO benchmark will be calculated by applying to the trended, risk-adjusted benchmark an efficiency- and quality-adjusted discount. The adjusted discount is the sum of four components:
 - A standard discount of -3.0%.
 - A quality adjustment to the standard discount of up to +1.0%
 - A regional efficiency adjustment of $\pm 1.0\%$
 - A national efficiency adjustment of $\pm 0.5\%$
- The quality- and efficiency-adjusted discount for an NGACO thus can vary from -0.5 to -4.5% (**assuming a +1.0% quality adjustment for an ACO's first year in the Model, range is from -0.5 to -3.5%**)
- A separate quality- and efficiency-adjusted discount will be calculated for Aged/Disabled and ESRD beneficiaries.
- The efficiency adjustments will be calculated separately for Aged/Disabled and ESRD beneficiaries and may differ. The same quality adjustment will apply to each entitlement category however.

Alternative Benchmark Methodology (2019-2020)

- Principles for alternative benchmark methodology :
 - Eliminate or further de-emphasize the role of recent ACO cost experience when updating the baseline;
 - Take into account public comments received in response to the Shared Savings Program Notice of Public Rulemaking (NPRM) on alternative benchmark approaches;
 - Shift to valuing attainment more heavily than year-over-year improvement;
 - Consider the use of a normative trend;
 - Continue to refine risk adjustment for beneficiary characteristics that balances changes in disease burden against more complete coding;
 - Consider adjustments reflecting geographic differences in utilization or price changes.
- CMS intends to provide additional detail by the end of 2017.

Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Parts A and B Shared Risk <ul style="list-style-type: none">• 80% sharing rate (PY1-3, 2016-2018)• 85% sharing rate (PY4-5, 2019-2020)• 15% savings/losses cap	100% Risk for Parts A and B <ul style="list-style-type: none">• 15% savings/losses cap

- Benchmarks calculated the same way for both arrangements.
- Different sharing rates affect ACO risk.
- For both arrangements, individual beneficiary expenditures capped at the 99th percentile of expenditures to moderate outlier effects.

Payment Mechanisms

Payment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: All-Inclusive Population-Based Payments (April 2017)
Medicare payment through usual FFS process.	Medicare payment through usual FFS process plus additional per-beneficiary per-month (PBPM) payment to ACO.	Medicare payment redistributed through reduced FFS and PBPM payment to ACO.	Medicare payment redistributed through 100% FFS reduction and PBPM payment to ACO; Next Generation responsible for paying claims for participating Next Generation Participants and Preferred Providers.

- Goals of payment mechanisms:
 - Offer ACOs the opportunity for stable and predictable cash flow; and
 - Facilitate investment in infrastructure and care coordination.
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.

Infrastructure Payments

- All claims paid through normal FFS payment.
- The ACO chooses an additional per-beneficiary per-month (PBPM) payment unrelated to claims.
- Maximum payment rate: \$6 PBPM
- All infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses.

Population Based Payments (PBP)

- ACO determines a percentage reduction to the base FFS payments of Next Generation Participants and/or Preferred Providers.
- ACO may opt to apply a different percentage reduction to different subsets of PBP-participating providers.
- Next Generation Participants and Preferred Providers with PBP must agree in writing to the percentage reduction.
- CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments.

All-Inclusive Population-Based Payments (available in April 2017)

- ACOs elect to participate in AIPBP and Next Generation Participants and/or Preferred agree to receive 100 percent FFS reduction.
- ACO is responsible for paying claims for Next Generation Participants and Preferred Providers receiving reduced FFS.
- Claims process:
 - All participants submit claims to CMS as normal.
 - CMS sends ACOs claims information for those services.
 - ACOs are responsible for making payments.
- CMS will continue to pay normal FFS claims for care furnished to Next Generation beneficiaries by Next Generation Participants and Preferred Providers not participating in AIPBP (as well as care furnished by all other Medicare providers and suppliers).

Financial Reconciliation

- Savings or losses determined by comparing total Parts A and B spending for aligned beneficiaries to the benchmark.
 - Individual expenditures capped at the 99th percentile.
- Risk arrangement determines ACO's share of savings or losses.
- Annual savings payment or losses recoupment occurs following a year-end financial reconciliation.
- Additional accounting for monthly payments that occurred during the performance year through PBP, infrastructure payments, or AIPBP.
 - May result in monies owed from CMS to the ACO, or vice versa.

Financial Guarantees

- Next Generation ACOs are required to have in place a financial guarantee, equivalent to 2% of baseline expenditures.
- Next Generation ACOs are required to comply with all applicable state laws and regulations regarding provider-based risk-bearing entities.

Contents

- Model Overview
- Financial Model
- **ACO Entities and Participation**
- Beneficiary Engagement
- Application and Selection Timeline
- Questions

Eligible Participants

- Next Generation ACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
 - Physicians or others in group practice arrangements;
 - Networks of individual practices of physicians;
 - Hospitals employing physicians or other practitioners;
 - Partnerships or joint venture arrangements between hospitals and physicians or other practitioners;
 - Federally Qualified Health Centers (FQHCs);
 - Rural Health Clinics (RHCs); and
 - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers or suppliers, except Durable Medical Equipment (DME) suppliers and any other Prohibited Provider (as defined in the RFA), may participate in an ACO formed by one or more of the entities listed above.

Next Generation Preferred Providers

- Contribute to Next Generation goals by extending and facilitating valuable care relationships:
 - Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO;
 - May participate in benefit enhancements (as applicable);
 - May participate in PBP and AIPBP;
 - Services delivered to Next Generation beneficiaries count toward the coordinated care reward calculation (direct payments made to beneficiaries by CMS);
 - Preferred Providers will NOT be associated with beneficiary alignment or used for quality reporting by the ACO;

Types of Next Generation Entities and Associated Functions¹

Provider Type	Alignment	Quality Reporting Through ACO	Eligible for ACO Shared Savings	PBP	All-Inclusive PBP	Coordinated Care Reward	Telehealth	3-Day SNF Rule	Post-Discharge Home Visit
Next Generation Participant	X	X	X	X	X	X	X	X	X
Preferred Provider			X	X	X	X	X	X	X

¹ This table is a simplified depiction of key design elements with respect to Next Generation Participant and Preferred Provider roles. It does not necessarily imply that this list of capabilities is exhaustive with regards to possible ACO relationships and activities.

² More information on the benefit enhancement may be found in Section VI.C.2 of the Request for Applications.

Program Overlap

- **With other Medicare models and programs:**
 - Next Generation ACOs are *NOT allowed* to simultaneously participate in other Medicare shared savings initiatives (e.g., Shared Savings Program, Pioneer ACO Model);
 - Next Generation Participant TINs *may NOT* overlap with Shared Savings Program TINs; and
 - Preferred Provider TINs *may* overlap with Shared Savings Program TINs.
- **Within the Model:**
 - Next Generation Participants that are primary care providers may participate in only one Next Generation ACO;
 - Next Generation Participants that are specialists may participate in more than one Next Generation ACO (serve an equivalent role in any other model or program in which non-primary care specialists are not required to be exclusive to one entity); and
 - Preferred Providers are not required to be exclusive to any one Next Generation ACO.

Contents

- Model Overview
- Financial Model
- ACO Entities and Participation
- **Beneficiary Engagement**
- Application and Selection Timeline

Beneficiary Eligibility

- Next Generation ACOs will earn savings or accrue losses and receive quality scores with regards to an aligned population of Medicare beneficiaries.
- During the base or performance year, the beneficiary must:
 - Be covered under Part A in January of the base- or performance-year and in every month of the base- or performance-year in which the beneficiary is alive;
 - Have no months of coverage under only Part A;
 - Have no months of coverage under only Part B;
 - Have no months of coverage under a Medicare Advantage or other Medicare managed care plan;
 - Have no months in which Medicare was the secondary payer; and,
 - Be a resident of the United States.
- Beneficiaries are also not eligible for inclusion in financial settlement (i.e., will be excluded from the aligned population) if:
 - The Next Generation Beneficiary was a resident of a county that was part of the ACO's service area in the last month of the 2-year alignment period but was a resident of a county that was not part of the ACO's service area in the performance-year.
 - During the base- or Performance-Year (respectively, for base-year and performance-year aligned beneficiaries) at least 50% of Qualified Evaluation and Management (QEM) services used by the Next Generation Beneficiary were from providers practicing outside the ACO's service area.

Beneficiary Alignment

- **Claims-based Alignment**

- Next Generation uses a two-stage beneficiary alignment methodology to prospectively align beneficiaries based on plurality of evaluation and management services.

- **Voluntary Alignment**

- Enhances the claims-based alignment by allowing beneficiaries to decide on their alignment to an ACO voluntarily.
 - Available to currently- or previously-aligned beneficiaries, as well as certain other categories of beneficiaries.
 - During each performance year (PY), beneficiaries will have the opportunity to voluntarily align for the subsequent PY.
- ACOs may select the mode(s) of beneficiary confirmation.
- Direct provider-beneficiary communication about voluntary alignment allowed.

Benefit Enhancements

- Medicare payment rule waivers are designed to improve care coordination and cost-saving capabilities:
 - [Telehealth expansion](#);
 - [Post-discharge home visit](#); and
 - [3-Day SNF rule waiver](#).
- ACOs may decide which benefits to implement, if any.
- For each, ACOs will submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

3-Day SNF Rule Waiver Overview

- Eliminates the requirement of a 3-day inpatient stay prior to SNF (or swing-bed CAH) admission.
 - Available to aligned beneficiaries of Next Generation Participants or Preferred Providers
 - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing/rehab need.

Telehealth Expansion Overview

- Elimination of geographic (rural) component of originating site requirements.
- Beneficiaries may receive telehealth services from place of residence.
- Telehealth services (CPT and HCPCS codes) unchanged.

Post-Discharge Home Visits Overview

- A licensed clinician under the *general supervision* – instead of direct – of a Next Generation Participant or Preferred Provider may bill for “incident to” services at an aligned beneficiary’s home.
- Such services may be furnished not more than one time in the first 10 days following discharge from an inpatient facility (hospital, CAH, SNF, IRF) and not more than one time in the subsequent 20 days.

Contents

- Model Overview
- Financial Model
- ACO Entities
- Beneficiary Engagement
- **Application and Selection Timeline**
- Questions

Preliminary Round Two Application and Selection Timeline

Milestone	Date
Application Open	March 23, 2016
LOI Due Date	May 2, 2016
Application Due	May 25, 2016
Next Generation Provider List Due	June 3, 2016
Finalists Identified	August 2016
Agreements Signed	Late Fall 2016
Start of Performance Year	January 1, 2017

Contents

- Model Overview
- Financial Model
- ACO Entities
- Beneficiary Engagement
- Application and Selection Timeline
- Questions

Questions?

Next Generation ACO Model Webpage:

<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

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