
CMS Next Generation ACO Model

Payment Models Work Group
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Why is there a new ACO model?

- To address concerns about certain design elements of the existing Pioneer Program and the MSSP
- CMS has the goal of moving ACOs towards greater risk assumption
- HHS seeking to have 85 percent of Medicare fee-for-service payments linked to a quality component by 2016 and 90 percent by 2018

What were the previous concerns?

- Earning savings is increasingly difficult with every additional performance year (ACOs need to outperform themselves)
- There is a high turnover in beneficiary alignment* which may reduce the effectiveness of care interventions and limit the gains for these investments
- Limited flexibility in adjusting the experience trend in response to price changes that impact the ACO

*also referred to as attribution



Key Changes in Next Generation ACO Model

- Utilizes a fixed benchmark (known by providers before the start of the year) rather than rolling benchmarks based on an ACO's historical expenditures
- The ability to choose from 4 payment mechanisms from FFS to capitation (capitation option available after first PY)
- Financial arrangements with higher levels of risk **and** reward
- Increased access to home visits, telehealth services, and skilled nursing facilities
- Improvements in communication with beneficiaries about the characteristics and potential benefits of their ACO
- Larger beneficiary population

*See attached ACO matrix for additional differences

Application Process

- Letter of Intent due May 1, 2015 for all organizations interested in applying to Next Generation ACO Model for the January 1, 2016 start date.
 - Only organizations that submit an LOI will be able to complete an application.
- Applications will then be due June 1, 2015.
- Information about the 2017 start date will be released in spring 2016.



Qualifications

- CMS requires each Next Generation ACO to have at least 10,000 beneficiaries
- Those deemed Rural ACOs will be permitted to have only 7,500 Medicare beneficiaries
- ACOs may not simultaneously participate in the Next Generation ACO Model and the Medicare Shared Savings Program or the Pioneer ACO Model
 - ACOs may leave current model to join Next Generation

Duration

- The Next Generation ACO Model Agreement will have an initial term that consists of three performance periods for ACOs entering in 2016 and two performance periods for ACOs entering in 2017.
- There will be the potential for two additional one-year extensions regardless of entry year.
- Both tracks will end in 2020

Evaluation Criteria

- CMS will evaluate applications in accordance with specific criteria in five key domains:
 - (1) organizational structure;
 - (2) leadership and management;
 - (3) financial plan and experience with risk sharing;
 - (4) patient centeredness; and
 - (5) clinical care model
- CMS estimates selecting 15 to 20 applicants

Participants in Next Generation ACOs

- Provider/Suppliers:
 - Physicians or other practitioners in group practice arrangements
 - Networks of individual practices of physicians/practitioners
 - Partnerships between hospitals and physicians/practitioners
 - FQHCs, RHCs, CAHs
- Preferred Providers:
 - ACOs may contract with preferred providers to offer applicable benefit enhancements to aligned beneficiaries (ex: provide expanded telehealth services, post-discharge home visits, etc— see later slides for information on benefit enhancement)
 - Role based on benefit enhancements, therefore these providers will not be associated with alignment/quality reporting through the ACO.

Participants in Next Generation ACOs (cont'd)

■ Next Generation Affiliates:

- Next Generation ACOs may contract with other individuals and organizations to advance ACO cost and quality goals
- Two types of Next Generation Affiliates:
 - Capitation Affiliates - Medicare providers/suppliers with whom the ACO contracts to participate in capitation with regards to Next Generation Beneficiaries
 - SNF Affiliates - SNFs to which Next Generation Providers/Suppliers or Preferred Providers may admit Next Generation Beneficiaries according to the SNF 3-Day Rule benefit enhancement (see later slides).

	Alignment	Quality Reporting Through ACO	Population-Based Payments	Capitation	Coordinated Care Reward	3-Day SNF Rule ³	Telehealth	Post-Discharge Home Visit
Provider/Supplier ²	●	●	●	●	●	●	●	●
Preferred Provider					●	●	●	●
SNF Affiliate					●	●		
Capitation Affiliate				●	●			

Financial Benchmark

- Prospective Benchmark:

- In contrast with the MSSP and Pioneer approaches, under the Next Generation financial model, CMS will calculate the ACO's expenditure benchmark* prior to the start of each performance year using the following four steps:
 - 1.) Baseline – calculate using one year of historic baseline expenditures
 - 2.) Trend – trend the baseline forward using a regional projected trend
 - 3.) Risk Adjustment – using full prospective HCC risk score, applied to both baseline and performance year populations, with annual 3% cap on increase-decrease
 - 4.) Discount – derived from quality/efficiency adjustments and applied to benchmark (See Appendix A for discounting methodology)

* Further information about benchmark calculation and other details of financial methodology to be released by CMS at a later date

Risk Arrangements

- A Next Generation ACO may choose between two risk arrangements:
 - 1) Increased Shared Risk - 80% sharing rate for performance years 1 to 3 and 85% for performance years 4 and 5, and with a 15% savings/loss cap in all years
 - 2) Full Performance Risk -100% risk for Part A and Part B expenditures in each year with a 15% savings/loss cap
- The 80%, 85% and 100% provide much greater rewards and risk than in the MSSP or Pioneer ACO program.

Payment Mechanisms

- The Next Generation Model will test the effectiveness of four payment options
 - 1.) Normal Fee-For-Service (FFS):** The first payment arrangement provides normal FFS payments (represents no change from Original Medicare)
 - 2.) Normal FFS + Monthly Infrastructure Payment**
 - 3.) Population-Based Payments (PBP)**
 - 4.) Capitation (beginning in 2017)**
- ACOs can elect any payment option regardless of performance year (not a progression through the different payment mechanisms)
- Reconciliation will be done at end of each performance year
- None of the payment mechanisms will affect beneficiary out-of-pocket expenses.

Savings and Loss Calculation

- Determined by comparing total Parts A and B spending for Next Generation beneficiaries to the benchmark (with individual expenditures capped at the 99th percentile)
- Risk arrangement is then applied to determine the ACO's share of savings or losses.
 - Savings or loss will be determined annually following a year-end financial reconciliation
- Additionally, CMS will account for monthly payments made through PBP, infrastructure payments, or capitation, which may result in monies owed from CMS to ACOs (or vice versa), that are separate from shared savings or losses.

*See Appendix C for example savings and loss calculation

Beneficiaries

- Beneficiary eligibility
 - During the performance year, beneficiaries must:
 - Be enrolled in both Medicare parts A and B
 - Not be enrolled in a Medicare Advantage plan or other managed care plan
 - Not have Medicare as a secondary payer
 - Be a resident of the U.S.
 - Must live in a county in the Next Generation ACO's service area
 - Not have received more than 50% of their Evaluation and Management services ("E&M Services") from practitioners in counties outside of the Next Generation ACO's service area during base or performance years.
- At least 50% of the new ACOs' patients have to be covered under outcomes-based contracts by the end of year one



Beneficiaries (cont'd)

- Alignment:
 - Claims-based: Next Generation Model will use the Pioneer methodology to prospectively align beneficiaries in a two-step alignment algorithm. (See Appendix D for alignment algorithm)
 - Voluntary (supersedes claims based): At beginning of each Performance Year, beneficiaries may confirm/deny their care relationships with specific Next Generation Providers/Suppliers, which will affect alignment for subsequent year.

Benefit Enhancement

- CMS will make direct payments to each Next Generation beneficiary who receives at least 50% of Medicare services from Next Generation Provider/Suppliers, Preferred Providers, and Affiliates.
 - Approximately \$50 PBPY, paid semi-annually.
- CMS will conditionally waive certain Medicare payment requirements as part of the Next Generation ACO Model.
 - **3-Day SNF Risk Waiver.** CMS will waive the requirement of a three-day inpatient hospital stay before admission to a skilled nursing facility.
 - **Telehealth Expansion.** CMS will waive, under certain circumstances, the requirement that beneficiaries be located in a rural area and at a specified type of originating site to be eligible for telehealth services.
 - **Post-Discharge House Visits.** CMS will make available waivers to allow incident-to claims for home visits for non-homebound beneficiaries by licensed clinicians under general (not direct) supervision.

Quality and Performance

- The Next Generation Model will adopt the MSSP quality measure set, except for the electronic health record (EHR) measure for a total of 32 measures

Performance Year	Initial Benchmark	Quality Score Used in Initial Benchmark	Benchmark Update	Quality Score Used in Update
PY1 (2016)	Late Fall 2015	100%	N/A	N/A
PY2 (2017)	Late Fall 2016	Approximated mean quality score.	Summer 2017	Actual quality score for 2016 service dates.
PY3 (2018)	Late Fall 2017	Actual quality score for 2016 service dates.	Summer 2018	ACO to elect either: 1) Keep actual quality score for 2016 service dates; OR 2) Actual quality score for 2017 service dates (if higher).

Appendix

A: Discount Methodology

B: Payment Mechanisms

C: Savings and Loss Calculation

D: Claims-Based Alignment

Appendix A: Discount Methodology

- Discount
 - Unlike MSSP, the Next Generation ACO model will not use an MSR, instead it will apply a discount once the baseline has been calculated, trended and risk-adjusted.
 - 3 factors included in the discount:
 - 1.) Quality score: ranges from 2.0--3.0%**
 - Utilizes the following formula: $[2.0\% + (1 - (\text{quality score}))]$.
 - Ex: an ACO with 100% quality score would have a discount of 2.0%; an ACO with a 0% quality score would have a quality discount of 3.0%
 - In PY1, a quality score of 100% will be applied to all Next Generation ACOs.
 - 2.) Regional efficiency: range from -1—1%**
 - Compares ACO's risk-adjusted historical per-capita baseline to risk-adjusted regional FFS per capita baseline (determined by ACO beneficiaries' counties of residence).
 - 3.) National efficiency: range from -0.5—0.5%**
 - Compares the risk-adjusted county FFS baseline to risk-adjusted national FFS per capita spending.

Appendix A: Discount Methodology

Example: ACO A

Calculating the Discount	Illustrative Amount
1. Quality	
<i>Quality Score</i>	100%
Quality Component	2.0%
2. Regional Efficiency	
<i>ACO Risk-Adjusted Baseline</i>	\$8,000
<i>Regional FFS Risk-Adjusted Baseline</i>	\$8,500
<i>Regional Efficiency Ratio</i>	0.94
Regional Efficiency Discount Component	-0.6%
3. National Efficiency	
<i>Regional FFS Risk-Adjusted Baseline</i>	\$8,500
<i>National FFS Risk-Adjusted Baseline</i>	\$10,500
<i>National Efficiency Ratio</i>	0.81
National Efficiency Discount Component	-0.5%
Example ACO A Discount	0.9%

- In PY1, 100% will be used as the quality score for all Next Generation ACOs:
 - $[2.0 + (1-1.0)]\%$
- Example ACO A's historic baseline expenditures are 6% less expensive than regional FFS—ACO is rewarded for this attainment by having the discount reduced by 0.6%.
- ACO is in a very low cost region (19% below national FFS)—ACO is rewarded with 0.5% discount reduction (the maximum regional-to-national FFS discount reduction).



Appendix A: Discount Methodology

Example: ACO B

Calculating the Discount	Illustrative Amount
1. Quality	
<i>Quality Score</i>	100%
Quality Component	2.0%
2. Regional Efficiency	
<i>ACO Risk-Adjusted Baseline</i>	\$12,000
<i>Regional FFS Risk-Adjusted Baseline</i>	\$13,000
<i>Regional Efficiency Ratio</i>	0.92
Regional Efficiency Discount Component	-0.8%
3. National Efficiency	
<i>Regional FFS Risk-Adjusted Baseline</i>	\$13,000
<i>National FFS Risk-Adjusted Baseline</i>	\$11,500
<i>National Efficiency Ratio</i>	1.13
National Efficiency Discount Component	0.4%
Example ACO B Discount	1.6%

- In PY1, 100% will be used as the quality score for all Next Generation ACOs:
 - $[2.0 + (1-1.0)]\%$
- Example ACO B's historic baseline expenditures are 8% less expensive than regional FFS—ACO is rewarded for this attainment by having the discount reduced by 0.8%.
- ACO is in a region whose spending is 13% higher than national FFS—ACO's discount is increased by 0.4% to reflect this regional-to-national FFS differential.

$$2.0 + (-0.8) + 0.4 = 1.6$$

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Appendix B: Payment Mechanisms

- Normal FFS + Monthly Infrastructure Payment
 - Next Generation Providers/Suppliers receive normal FFS reimbursement and ACO receives from CMS an additional per-beneficiary per month (PBPM) payment unrelated to claims.
 - No more than \$6 PBPM
 - Infrastructure payments will be recouped in full from ACO during reconciliation regardless of savings/loss.
 - ACOs electing this track required to have sufficiently large financial guarantee (as compared to other payment mechanisms) to assure repayments to CMS
 - Goal: to facilitate investments in infrastructure to support ACO activities
 - Offer a stable and predictable payment option throughout the performance year

Appendix B: Payment Mechanisms

- Population-based Payments (PBP)
 - Next Generation ACOs determine a percentage reduction in FFS payments to its Next Generation Provider/Suppliers, which is then paid to the ACO on a monthly basis.
 - ACO may apply a different percentage reduction to different subsets of Provider/Suppliers
 - Provider/Suppliers participating in PBP must agree to permit CMS to reduce their Medicare reimbursements by the specified percentage.
 - Aggregate monthly payments from CMS to the ACO may be updated periodically throughout the Performance Year
 - Provides Next Generation ACOs with a monthly payment to support ongoing ACO activities
 - Allows flexibility in types of arrangements ACO enters into with its Providers/Suppliers

Appendix B: Payment Mechanisms

Population-Based Payment Calculation

Example ACO	Amount	Description
# Aligned Beneficiaries	25,000	--
Benchmark (Projected Spending)	\$300,000,000 (\$12,000 PBPY = \$1,000 PBPM)	Benchmark calculated using model benchmark methodology.
Projected Spending by PBP participating providers/suppliers	75%	Using historic claims, CMS projects spending by providers participating in PBP.
FFS % Reduction	10%	Providers agree to reduction off base FFS rates.
PBPM to ACO	\$75	10% of 75% of \$1,000 PBPM
Monthly Payment to ACO	\$1,875,000	\$75 PBPM x 25,000 aligned beneficiaries
Annual Amount Paid to ACO	\$22,500,000	\$1,875,000 monthly payment x 12 months

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Appendix B: Payment Mechanisms

- Capitation (beginning in 2017)
 - Projected annual expenditures are paid to the Next Generation ACO in a PBPM payment with money withheld to cover anticipated care provided by non-ACO providers/suppliers.
 - Providers/suppliers submit claims to CMS as normal
 - ACOs are responsible for paying claims to its Provider/Suppliers and Capitation Affiliates
 - ACOs are not required to pay capitated providers 100% of FFS rates and may make other compensation arrangements
 - CMS will continue to pay normal FFS claims for care provided to beneficiaries from ACO providers and suppliers not covered by a Next Generation capitation agreement.
 - CMS may periodically update capitation amounts

Appendix B: Payment Mechanisms

Capitation Conceptual Design

Example ACO	Amount	Description
# Aligned Beneficiaries	25,000	--
Benchmark (Projected Spending)	\$300,000,000 (\$12,000 PBPY = \$1,000 PBPM)	Benchmark calculated using model benchmark methodology.
Projected Spending by ACO Providers and Capitation Affiliates	75%	Using historic claims, CMS projects spending by providers participating in capitation.
Capitation PBPM	\$750	75% of \$1,000 PBPM
Monthly Payment to ACO	\$18,750,000	\$750 capitation PBPM x 25,000 aligned beneficiaries
Annual Amount Paid to ACO	\$225,000,000	\$18,750,000 monthly payment x 12 months

Appendix C: Savings and Loss Calculation

Shared Savings/Loss Reconciliation	Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Illustrative Benchmark	\$100,000,000	\$100,000,000
Sharing Rate	80%	100%
Savings/Losses Cap	15%	15%
Maximum Savings/Losses	+/- \$12,000,000 [80% x (15% x \$100,000,000)]	+/- \$15,000,000 [100% x (15% x \$100,000,000)]
Actual PY Expenditures	\$97,000,000	\$97,000,000
Shared Savings Payment	\$2,400,000	\$3,000,000
Actual PY Expenditures	\$103,000,000	\$103,000,000
Shared Losses Owed	\$2,400,000	\$3,000,000

- Savings or losses determined by comparing total Parts A and B spending for aligned beneficiaries to the benchmark.
- Risk arrangement determines ACO's share of savings or losses.

Appendix D: Claims-Based Alignment

Claims based alignment following a two step process:

- 1) beneficiaries with a plurality of outpatient E&M services delivered by Next Generation Providers/Suppliers in select primary care specialties are aligned for the subsequent year
- 2) beneficiaries with less than 10% of their E&M services delivered by Next Generation ACO primary care providers but with determination that Next Generation provider/supplier in select subspecialty was central to beneficiary's care may result in alignment for subsequent year