The Next Generation ACO Model

On March 10, 2015, the Center for Medicare & Medicaid Services (CMS) announced a new classification of Accountable Care Organizations (ACO), known as the Next Generation model, which is aimed at providing coordinated, efficient, and high quality care to patients and reimbursing providers for the quality of care they provide rather than the quantity of care they provide to patients. Toward that end, the Next Generation model is designed to build upon the successes of previous ACO models, while making some significant modifications. Eligibility for participation in the Next Generation ACO program is conditioned on: (1) having at least 10,000 beneficiaries, or 7,500 beneficiaries if located in a rural area; (2) demonstrating compliance with applicable state and federal laws; (3) having a majority of the total patient population covered under an outcomes-based contract; and, (4) not simultaneously participating in the Pioneer ACO model or the Medicare Shared Savings Program (MSSP).

One aim of the Next Generation model is to set predictable financial targets that enable providers and beneficiaries to coordinate high quality care. To do this, CMS has modified how they establish and operate Next Generation ACO financial benchmarks. Specifically, Benchmarks for Next Generation ACOs will utilize a 4-step hybrid approach that still uses the performance adjustments for risk characteristics of the ACO’s population; but also incorporates projected expenditure trends into that adjustment. Further, the minimum savings rate (MSR) used by the original ACO models will be replaced by a new discounting rate system that will continue to permit shared savings and loss for amounts beyond the benchmark but will allow the benchmark to be calculated prospectively. Specifically, the discounting rate system will begin with the historical benchmark and discount it between 0.5% and 4.5% based on the Next Generation ACO’s performance on quality metrics, expenditures relative to regional fee for service expenditures, and expenditures relative to national fee for service expenditures.

In addition to the changes to the benchmarking system, CMS also announced that the Next Generation ACOs will have a have the option of selecting from four different payment options including: (1) a fee for service (FFS) payment in which the ACO is paid by CMS for services through the normal FFS channels; (2) a fee for service payment plus a per beneficiary per month (PBPM) payment infrastructure, unrelated to claims, that can be used to help provide stability and support investment but is recouped by CMS during reconciliation regardless of savings or losses; (3) a population-based payment in which the ACO receives a pre-determined reduced FFS payment through the normal FFS channels, in addition to a monthly payment from CMS that is based upon the projected aggregate annual reduction in FFS payments; or, (4) a capitation method of payment, beginning in 2017. The aim of these four payment plan options is to permit CMS to measure the effectiveness of each of these alternative payment mechanisms without affecting the beneficiary’s out of pocket expenses.

While the Next Generation model will use the same two-step algorithm as the Pioneer ACO model to determine beneficiary alignment, it will also offer the opportunity for the beneficiary to voluntarily align with a particular ACO. In an attempt to fix a common complaint of the Pioneer ACO model, Next Generation ACOs will be able to control and predict their costs by building a guaranteed attributable patient base and engaging beneficiaries through the voluntary alignments that supersede the claims-based attribution assignment the beneficiary may have been designated by the algorithm. Prior to each benefit year, the Next Generation ACOs will be required to send a letter, approved by CMS, to beneficiaries with information about voluntary alignment and the potential benefit enhancements that are associated with it. Some of these benefit enhancements will include financial rewards, improved access to home visits and skilled nursing facilities, and use of telehealth services. Even if a beneficiary aligns themselves with an ACO, they can remove or change their voluntary alignment, as long as it is before the official development of the ACO’s alignment list.

Even with all the proposed changes contained in the Next Generation ACO model, there remain fears that it still has not addressed some of the other ACO related issues, including the models’ long term viability. For example, many of the personalized medical treatments that are revolutionizing the diagnostics, pharmaceutical, and biotechnology markets tend to fall outside the scope of the ACO’s alternative payment models as the quality

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benchmark metrics typically do not capture the quality value that these treatments add to patient care. Additionally, the fact that Pioneer ACOs generated only a third of the savings in their second year of operation, as compared to the savings they generated in their first year of operation, has advanced the fear that ACOs cannot actually develop better processes to improve the efficiency and quality of care provided, but instead act as a way to control costs by cutting the waste from the healthcare system. Regardless of the fears and concerns held by industry stakeholders, CMS remains optimistic that the Next Generation ACO model will be the right step in ensuring long-term sustainability of these coordinated care and alternative payment models.

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2 Ibid.
3 Ibid.
4 Ibid.
13 Ibid.
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