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Todd A. Zigrang, MBA, MHA, ASA, FACHE, Publisher • Jessica L. Bailey, Esq., Editor ©

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[1] and reimbursing providers for the quality of care they provide rather than the quantity of care they provide to patients.[2] Toward that end, the *Next Generation* model is designed to build upon the successes of previous ACO models, while making some significant modifications.[3] 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).[4]

One aim of the *Next Generation* model is to set predictable financial targets that enable providers and beneficiaries to coordinate high quality care.[5] To do this, CMS has modified how they establish and operate *Next Generation ACOs* 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.[6] 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.[7] 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.[8]

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.[9] 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.[10] In an attempt to fix a common complaint of the *Pioneer ACO* model,[11] *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.[12] 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.[13] Some of these benefit enhancements will include financial rewards, improved access to home visits and skilled nursing facilities, and use of telehealth services.[14] 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.[15]

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.[16] 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.[17] 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.[18]

1 "Next Generation Accountable Care Organization (ACO) Model Fact Sheet" Centers for Medicare & Medicaid Services, March 10, 2015, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-03-10.html (Accessed 5/8/15).

2 *Ibid.*

3 *Ibid.*

4 *Ibid.*

5 "Building on the Success of the ACO Model" By Patrick Conway, The CMS Blog, March 10, 2015, http://blog.cms.gov/2015/03/10/building-on-the-success-of-the-aco-model/ (Accessed 5/8/15).

6 "Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program" CMS, April 2014, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf (Accessed 5/8/2015), p. 3-4; "Next Generation ACO Model: Request for Applications" CMS, Accessed 5/8/2015, p. 11-12.

7 "Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program" CMS, April 2014, p. 3-4; "Next Generation ACO Model: Request for Applications" CMS, Accessed 5/8/2015, p. 11-13.

8 "Next Generation ACO Model: Request for Applications" CMS, Accessed 5/8/2015, p. 11-13.

9 *Ibid*, p. 14-16.

10 *Ibid*, p. 18-19.

11 "CMS Preps 'Next Generation' ACO Model" By Melanie Evans, Modern Healthcare, March 10, 2015, http://www.modernhealthcare.com/article/20150310/NEWS/150319994?template=print (Accessed 5/8/15).

12 "Next Generation ACO Model: Request for Applications" CMS, Accessed 5/8/2015, p. 18-19.

13 *Ibid.*

14 *Ibid*, p. 20-23.

15 *Ibid*, p. 18-19.

16 "PMC Paper Asks Policymakers to Consider Impact of Alternative Payment Models on Personalized Rx" By Turna Ray, GenomeWeb, May 1, 2015, https://www.genomeweb.com/molecular-diagnostics/pmc-paper-asks-policymakers-consider-impact-alternative-payment-models (Accessed 5/8/15).

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18 "CMS Announces the Next Generation of Accountable Care Organizations Aimed at Increased Risk Sharing and Program Sustainability" By Richard Church, Steven Pine, & Trevor Presler, K&L Gates LLP, JD Supra Business Advisor, April 13, 2015, http://www.jdsupra.com/legalnews/cms-announces-the-next-generation-of-acc-21011/ (Accessed 5/8/15).

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*Accountable Care Organizations: Value Metrics and Capital Formation*" [2013 - Taylor & Francis, a division of CRC Press], "*The Adviser's Guide to Healthcare*" – Vols. I, II & III [2010 – AICPA], and "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books]. His most recent book, entitled *"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services"* was published by John Wiley & Sons in 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the author of the soon-to-be released "*Adviser's Guide to Healthcare – 2nd Edition*" (AICPA, 2014), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC). Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.

Jessica L. Bailey, Esq., is the Director of Research of **HEALTH CAPITAL CONSULTANTS** (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.

Richard W. Hill, III, Esq. is Senior Counsel of **HEALTH CAPITAL CONSULTANTS** (HCC), where he manages research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services, and conducts analyses of contractual relationships for subject enterprises. Mr. Hill is a member of the Missouri Bar and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law.