HEALTH CAPITAL Topics
Volume 14
Issue 6
June 2021
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, CVA, ASA, FACHE, Publisher

Next Generation ACO Model to End in 2021

Many accountable care organizations (ACOs) received disappointing news on May 21, 2021, when the Centers for Medicare & Medicare Services (CMS) announced that it would not be extending the Next Generation ACO (NGACO) model for 2022.[1] After five years and a dwindling number of participating ACOs, experts were split on whether or not CMS should keep the model in place for another year.[2] On one hand, stakeholders have argued for the NGACO model's extension until it can be replaced with or integrated into another program; however, others asserted that resources could not be properly invested with only one more year left in the program.[3] This *Health Capital Topics* article will review the background of the NGACO model, its effect on value-based care, thoughts from stakeholders, and plans among these stakeholders moving forward.

Background

The NGACO model was established under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA), and launched by CMS in January 2016.[4] With 18 initial participating ACOs, the NGACO model built on past ACO experience from the Pioneer Model and Medicare Shared Savings Program (MSSP) and sought to set predictable financial targets, give providers more opportunities to coordinate care to beneficiaries, and ensure high quality care.[5] The number of participating NGACOs increased from its inception until its peak in 2018, with 51 participating ACOs, and has slowly declined over the past few years, to 35 participating ACOs in 2021.[6] In prior years, health systems reported pulling out of the NGACO model due to unachievable savings metrics, such that health systems were unable to earn shared savings payments.[7]

CMS's Center for Medicare & Medicaid Innovation Center (CMMI) created the NGACO model to test if financial incentives and an innovative payment system would provide sustainable utilization of resources, while enhancing quality and coordination of care.[8] The NGACO model is an Advanced Alternative Payment Model (APM) that sought to incentivize eligible physicians to participate in a high risk/high reward system.[9] While it is generally similar to the MSSP, some of the significant differences in the NGACO model include, first, the required risk-sharing arrangements. Under the NGACO model, the shared savings and losses are greater than the MSSP. Second, NGACOs must have at least 10,000 beneficiaries, in contrast to the MSSP's minimum of 5,000 beneficiaries.[10] Third, NGACOs are responsible for the first dollar above or below the discounted benchmark, while the MSSP has a minimum savings rate (MSR) and minimum loss rate (MLR), which provides a buffer for participants, i.e., they are not responsible for the first dollar of savings or losses.[11]

The goal of this approach to pay providers based on quality, rather than quantity, of care attempted to improve health outcomes and lower healthcare expenditures from the original fee-for-service (FFS) Medicare reimbursement model with the following core principles in mind:

> *(1)* "*Protect Medicare fee-for-service beneficiaries' freedom to seek covered items and services from the Medicare-enrolled providers and suppliers of their choice;*
>
> *(2) Engaged beneficiaries in their care through benefit enhancements designed to improve the patient experience and reward seeking appropriate care from providers and suppliers participating in ACOs;*
>
> *(3) Create a financial model with long-term sustainability;*
>
> *(4) Utilize a prospectively-set benchmark that: (1) rewards quality; (2) rewards both improvement in and attainment of efficiency; and (3) ultimately transitions away from using an ACO's recent expenditures for purposes of setting and updating the benchmark;*
>
> *(5) Mitigate fluctuations in aligned beneficiary populations and respect beneficiary preferences by supplementing a prospective claims-based alignment process with a voluntary alignment process; and*
>
> *(6) Smooth ACO cash flow and support investment in care improvement capabilities through alternative payment mechanisms*."[12]

Despite these high standards, NGACOs did not deliver as expected. The first three cohorts of ACOs contributed greatly to spending reduction, but after 2017, the model saw no appreciable declines in spending.[13] Meanwhile, in

(Continued on next page)

the past five years, quality remained constant with no significant improvements or declines.[14]

Effects on Value-Based Care

While some industry stakeholders are critical of the NGACO model, participating providers have generally been successful operating under the model. First, the NGACO model achieved approximately five times higher savings per beneficiary than MSSP ACOs.[15] Second, the NGACO model has reduced inpatient admissions, reduced total medical expenditures with care management programs, and increased beneficiaries' likelihood to participate in annual wellness visits.[16] Ultimately, NGACOs are fond of the model's high-risk/high-rewards reimbursement structure, in which they can reduce gross beneficiary spending, maintain quality of care, and implement benefit enhancement tools.[17] Specifically, ACOs are attracted to the opportunity to assume 80% to 100% risk of the difference from the calculated benchmark, with caps spanning from 5% to 15% for losses and savings.[18]

Conversely, a report from the National Opinion Research Center (NORC) at the University of Chicago found that the NGACO model's $348.6 million in spending reductions in its first three years was overstated.[19] The NORC report concluded that while the model did have Medicare spending reductions of 0.9%, it actually increased net spending by 0.3% after accounting for shared savings payments.[20] The NORC report also found that the NGACO model had minimal impact in reducing acute care hospital spending and stays, which account for the largest part of Medicare Part A and B spending.[21] Additionally, many of the NGACO model participants were originally participants in the Pioneer Model or MSSP (i.e., had prior ACO experience).[22] NORC asserts that these reported spending improvements are modest in consideration of the amount of time these providers have participated in ACO models; in other words, these more mature ACOs should be able to generate more savings and achieve higher quality metrics than they actually did in the NGACO model.[23]

Thoughts from Stakeholders

Many organizations were extremely upset about the decision to end the program a year early. However, this news should not have come as a surprise. NGACOs were reportedly told in early 2020 that the model would be discontinued at the end of that year.[24] Not long after, the COVID-19 pandemic struck and in June 2020, CMS decided to extend the program for an additional year to reduce the burden on healthcare providers, who were responding to the public health crisis.[25] In April 2021, 14 industry stakeholders wrote to the Secretary of the U.S. Department of Health & Human Services (HHS) urging HHS to extend and reevaluate the NGACO model.[26] Notable healthcare provider associations, such as the Association of American Medical Colleges, American Hospital Association, and American Medical Group Association, as well as other industry players, claimed that the NGACO model had been successful in lowering Medicare spending and improving quality for beneficiaries over the past several years.[27] Further, these organizations asserted that it would be unfair to end the program suddenly, as many organizations have invested greatly in the program over the past five years, and because ACOs needed to apply to other ACO payment models a year ago to be eligible for the 2022 performance year.[28] Organizations have subsequently had to scramble to demonstrate that they meet qualifications for CMS's other risk-based models, such as the Global and Professional Direct Contracting (GPDC) Model, by June 14, 2021, or be moved into the MSSP, both of which models provide less flexibility than the NGACO model to adjust downstream payments.[29]

ACOs Moving Forward

In ending the NGACO model, CMS wants these ACOs to leverage their experience and operational capabilities in the GPDC model, which began in 2020 with an "implementation period" (where participants could begin aligning beneficiaries prior to the start of the first performance year) and commenced its first participation year on April 1, 2021.[30] GPDC is a risk-sharing model that focuses less on quality measures and more on outcomes and beneficiary experience.[31] Additionally, direct contracting entities (DCEs)[32] will focus their value-based plans on beneficiaries with complex chronic conditions.[33] DCEs have two voluntary risk-sharing options under the GPDC Model:

(1) Professional, which offers a low risk-sharing arrangement (50% savings/losses) and provides payment through a capitated, risk-adjusted, monthly plan for primary care services provided by the DCE called Primary Care Capitation (PCC).[34]

(2) Global, which offers the high risk-sharing option (100% savings/losses) and has two payment options available: PCC, as described above, and Total Care Capitation, where payment is provided through a capitated, risk-adjusted, monthly plan for all services provided by the DCE.[35]

The NGACO model was a program built on the lessons learned from previous attempts by CMS to transition healthcare payments away from volume-based, FFS reimbursement to payments based on high-quality, cost-effective care. While the NGACO model has had notable improvements over previous ACO model iterations, the program has its own shortcomings. CMS's decision to end the NGACO model is simply the next step in CMS's journey from *volume*-based to *value*-based reimbursement, wherein the agency continues to test and tweak various payment models to find a sufficient balance between high-quality and low-cost care while giving providers a sufficient number of value-based payment model choices in which to participate.

(Continued on next page)

1 "Next Generation ACO Model" Centers for Medicare & Medicaid Services, May 28, 2021, https://innovation.cms.gov/innovation-models/next-generation-aco-model (Accessed 6/1/21).
2 *Ibid.*
3 "CMS won't extend the Next Generation ACO Model through 2022" By Michael Brady, Modern Healthcare, May 21, 2021, https://www.modernhealthcare.com/payment/cms-wont-extend-next-generation-aco-model-through-2022?utm_source=modern-healthcare-daily-finance-friday&utm_medium=email&utm_campaign=20210521&utm_content=article3-headline (Accessed 6/1/21).
4 "Next Generation Accountable Care Organization (ACO) Model Fact Sheet" Center for Medicare & Medicaid Innovation, May 28, 2021, https://innovation.cms.gov/files/fact-sheet/nextgenaco-fs.pdf (Accessed 6/1/21).
5 *Ibid.*
6 *Ibid.*
7 "Seven ACOs drop out of NGACO, but don't say why" By Susan Morse, Healthcare Finance News, March 26, 2018, https://www.healthcarefinancenews.com/news/seven-acos-drop-out-next-generation-program-dont-say-why (Accessed 6/2/21).
8 "Next Generation ACO Model" Centers for Medicare & Medicaid Services, May 28, 2021.
9 Under the APM, physicians may become Qualified APM Participants (QPs) by meeting specific criteria such as using certified electronic health record technology, and providing payment for covered professional services. When QPs achieve the specific criteria, they receive benefits such as exclusion from the Merit-Based Incentive Payment System (MIPS) reporting requirements, a 5% APM incentive payment adjustment, and other APM-specific awards. "Next Generation Accountable Care Organization (ACO) Model Fact Sheet"; "Advanced Alternative Payment Models (APMs)" Quality Payment Program, Centers for Medicare & Medicaid Services, 2021, https://qpp.cms.gov/apms/advanced-apms (Accessed 6/2/21).
10 "Next Generation Accountable Care Organization (ACO) Model Fact Sheet" Center for Medicare & Medicaid Innovation, May 28, 2021.
11 "This NAACOS ACO comparison chart details the main elements of the three tracks in the Medicare Shared Savings Program and the Next Generation ACO model." National Association of ACOs, https://www.naacos.com/assets/docs/news/revisedsummaryaco-comparisonchart.pdf (Accessed 6/9/21); "ACO minimum savings/(loss) rates: Less is more?" By Charlie Mils and Chris Smith, Milliman, February 2020, https://us.milliman.com/-/media/milliman/pdfs/articles/aco_minimum_savings_loss_rates-less_is_more.ashx (Accessed 6/17/21).
12 "Next Generation Accountable Care Organization (ACO) Model Fact Sheet" Center for Medicare & Medicaid Innovation, May 28, 2021.
13 "Next Generation Accountable Care Organization (NGACO) Model; Findings at a Glance" Center for Medicare & Medicaid Services, August 31, 2020, https://innovation.cms.gov/data-and-reports/2020/nextgenaco-thirdevalrpt-ataglance (Accessed 6/1/21).
14 "Third Evaluation Report: Next Generation Accountable Care Organization Model Evaluation" National Opinion Research Center at the University of Chicago, September 2020, https://innovation.cms.gov/data-and-reports/2020/nextgenaco-thirdevalrpt-fullreport (Accessed 6/1/21).
15 "Impact of the Next Generation ACO Model" The Health Care Transformation Task Force, January 22, 2021, https://hcttf.org/wp-content/uploads/2021/01/HCTTF-Assessment_Impact-of-the-Next-Generation-ACO.pdf (Accessed 6/1/21).
16 *Ibid.*
17 "No Extension for Next Generation ACO Model After This Year" By Jacqueline LaPointe, RevCycle Intelligence, May 24, 2021, https://revcycleintelligence.com/news/no-extension-for-next-generation-aco-model-after-this-year (Accessed 6/1/21).
18 National Opinion Research Center at the University of Chicago, September 2020.
19 *Ibid.*
20 "CMS' Next Generation ACO Model to end this year" By Anuja Vaidya, Med City News, May 24, 2021, https://medcitynews.com/2021/05/cms-next-generation-aco-model-to-end-this-year/?rf=1 (Accessed 6/1/21).
21 National Opinion Research Center at the University of Chicago, September 2020.
22 *Ibid.*
23 *Ibid.*
24 "ACOs warn future of Next Gen program appears bleak" By Robert King, Fierce Healthcare, February 4, 2020, https://www.fiercehealthcare.com/payer/future-next-gen-acos-appears-bleak-critical-report-emergence-direct-contracting (Accessed 6/2/21).
25 "CMS Extends Next Gen ACO Model for 2021" NextGen ACO Coalition, June 3, 2020, https://nextgencoalition.org/news/cms-extends-next-gen-aco-model-for-2021/ (Accessed 6/17/21).
26 "Re: Extending the Next Generation Accountable Care Organization Model" Association of American Medical Colleges et al., April 12, 2021, https://www.aha.org/system/files/media/file/2021/04/aha-others-urge-hhs-to-extend-next-generation-aco-model-letter-4-12-2021.pdf (Accessed 6/1/21).
27 *Ibid.*
28 *Ibid.*
29 Brady, May 21, 2021.
30 "Global and professional Direct Contracting (GPDC)" Centers for Medicare & Medicaid Services, April 8, 2021, https://innovation.cms.gov/innovation-models/gpdc-model (Accessed 6/2/21).
31 *Ibid.*
32 Under the GPDC model, a DCE is "an ACO-like organization, comprised of health care providers and suppliers, operating under a common legal structure, which enters into an arrangement with CMS and accepts financial accountability for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the entity." "Direct Contracting Model: Professional and Global Options Model Overview Webinar" Centers for Medicare & Medicaid Services and Center for Medicare and Medicaid Innovation, December 11, 2019, https://innovation.cms.gov/files/slides/dc-model-options-overviewalignment-slides.pdf (Accessed 6/17/21), p. 12.
33 Centers for Medicare & Medicaid Services, April 8, 2021.
34 *Ibid.*
35 *Ibid.*

(Continued on next page)

HCC
HEALTH CAPITAL CONSULTANTS

(800)FYI - VALU

Providing Solutions in the Era of Healthcare Reform

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- HCC Home
- Firm Profile
- HCC Services
- HCC Experts
- Clients & Projects
- HCC News
- Upcoming Events
- Contact Us
- Email Us

HCC Services

- Valuation Consulting
- Commercial Reasonableness Opinions
- Commercial Payor Reimbursement Benchmarking
- Litigation Support & Expert Witness
- Financial Feasibility Analysis & Modeling
- Intermediary Services
- Certificate of Need
- ACO Value Metrics & Capital Formation
- Strategic Consulting
- Industry Research Services

Todd A. Zigrang, MBA, MHA, CVA, 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 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 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 co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], 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*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); 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).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of 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.

She serves on the editorial boards of NACVA's The Value Examiner and of the American Health Lawyers Association's (AHLA's) Journal of Health & Life Sciences Law. Additionally, she is the current Chair of the American Bar Association's (ABA) Young Lawyers Division (YLD) Health Law Committee and the YLD Liaison for the ABA Health Law Section's Membership Committee. She has previously presented before the ABA, NACVA, and the National Society of Certified Healthcare Business Consultants (NSCHBC).

Ms. Bailey-Wheaton 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 & Policy.

Daniel J. Chen, MSF, CVA, focuses on developing Fair Market Value and Commercial Reasonableness opinions related to healthcare enterprises, assets, and services. In addition he prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams. Mr. Chen holds the Certified Valuation Analyst (CVA) designation from NACVA.

Janvi R. Shah, MSF, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition he prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.