CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Findings at a Glance

Next Generation Accountable Care Organization (NGACO) Model

Evaluation of the First Four Performance Years (2016-2019)

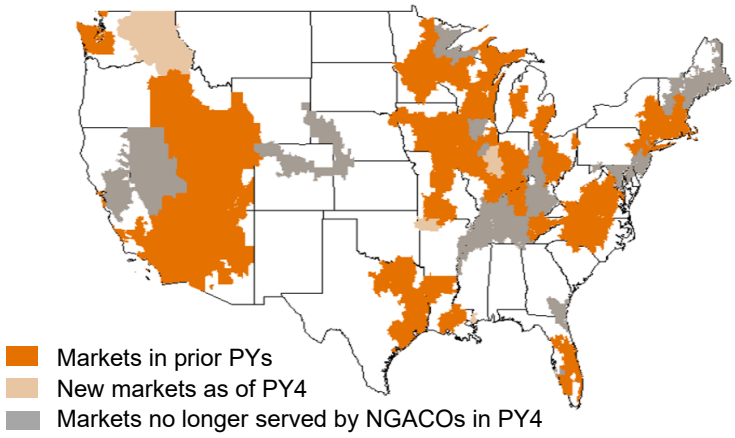
MODEL OVERVIEW

The NGACO Model tests whether strong financial incentives, flexible payment options, and tools to support care management improve value and lower expenditures for aligned populations of Medicare fee-for-service (FFS) beneficiaries. Participating ACOs assume 80% or 100% up- and down-side financial risk and select from one of four payment mechanisms that allow for FFS or prospective payments. The Model began in 2016 and was scheduled to run through 2020; due to the COVID-19 pandemic, it has been extended through 2021. ACOs joined the Model in one of three cohorts (2016, 2017, or 2018). This summary covers the Model's results over its first four performance years—2016 (performance year one [PY1]), 2017 (PY2), 2018 (PY3), and 2019 (PY4).

PARTICIPANTS

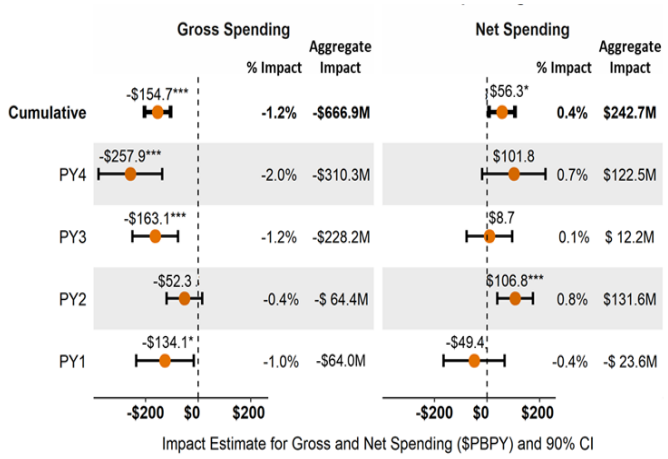
In PY4, there were 41 NGACOs across 29 states.

- Since PY1, 25 NGACOs exited; no new NGACOs in PY4
- NGACO markets (hospital referral regions) had more FFS beneficiaries, higher Medicare ACO and Medicare Advantage penetration, and fewer rural populations



EFFECTS ON TOTAL SPENDING

- **Gross Medicare spending reductions** for Parts A & B cumulatively and in PY1, PY3, and PY4
- **Net spending increased** after accounting for CMS payouts cumulatively and in PY2



NOTE: Estimated impacts significant at p<0.1*, p<0.05**, p<0.01***

ORGANIZATIONAL TYPE INFLUENCED NGACO SPENDING REDUCTIONS

On average, total gross spending reductions did not differ by NGACO organizational affiliation. However, physician practice NGACOs were more likely to reduce spending in acute care hospital and outpatient facility settings, while hospital-affiliated NGACOs were more likely to reduce spending on professional services.

	Acute Care Hospitals	Professional Services	Outpatient Facilities	Other*
Physician Practice	-37.5%	1.7%	-19.2%	-45.0%
Physician Hospital Partnership	-9.2%	-39.7%	1.6%	-52.7%
Integrated Delivery System/ Hospital System	-16.8%	-12.5%	-14.9%	-55.8%

NOTES: Percentages are relative contributions of care settings to average gross Medicare spending reduction, by NGACO organizational affiliation. Negative value (darker shade) indicates a relative spending reduction and positive value (lighter shade) a relative spending increase. Percentages sum to -100% by organizational affiliation. *Skilled nursing facilities (SNFs), other post-acute care, home health, and hospice.

This document summarizes the evaluation report prepared by an independent contractor. For more information about this Model and to download the 4th annual evaluation report, visit https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model.

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FACTORS EXPLAINING VARIATIONS IN SPENDING IMPACTS

NGACOs operating in different contexts and with different structures reduced Medicare spending. From PY1 through PY4, spending reductions associated with NGACOs were related to market characteristics, NGACO type, prior Medicare ACO experience, and the size and complexity of NGACOs' aligned beneficiary populations. Specific combinations of these factors explain nearly half of the cases associated with reduced spending. No single factor was necessary to reduce spending.

Spending reductions occurred mostly among ACOs in markets with high per capita FFS Medicare spending.

However, some NGACOs in markets with lower per capita spending also achieved more modest reductions.

	Average Gross Spending Reduction
Highest per capita spending (top quintile in spending)	-2.6%***
Lower per capita spending	-0.1% to -1.2%***

Estimated impacts significant at p<0.1*, p<0.05**, p<0.01***

Beneficiary health and social needs influenced spending reductions.

- The Model was associated with larger spending reductions for beneficiaries with multiple chronic conditions and those with prior hospitalizations.
- NGACOs with lower proportions of beneficiaries who were dually eligible or had disabilities were associated with larger average spending reductions.

Both physician practice and hospital-affiliated NGACOs reduced spending.

Physician practice NGACOs that reduced spending tended to have smaller provider networks and no acute care capacity.

- Those with smaller beneficiary populations often operated in less competitive hospital markets.
- Those with smaller beneficiary populations had prior experience in managed care and risk-based contracting.
- Smaller physician practice NGACOs reduced spending across all four years of the Model.

Hospital-affiliated NGACOs that reduced spending tended to have more prior Medicare ACO experience, larger beneficiary populations, and larger provider networks with many specialists than did other NGACOs.

- Hospital-affiliated NGACOs often realized spending reductions in the Model's later years.

NGACOs electing full risk or population-based payments were associated with larger spending reductions on average.

- Full financial risk or population based payments were not required to reduce spending.
- Larger and more experienced NGACOs with lower financial risk were also associated with reduced spending.

KEY TAKEAWAYS

As of PY4, the NGACO Model was associated with $667 million in gross Medicare savings (Parts A and B spending). After factoring in $909 million in shared savings and other payouts to NGACOs, the Model was associated with $243 million in net losses. On average, NGACOs located in markets with higher per capita Medicare expenditures achieved higher spending reductions, as they had more opportunities to improve efficiency. Some NGACOs operating in markets with lower Medicare expenditures also had pathways to spending reductions. The size of the total spending reductions was similar for physician practice ACOs and for hospital-affiliated ACOs, but there were differences in spending reductions by care setting: NGACOs reduced spending primarily in settings other than in their own organizational setting.