

December 2023

Evaluation of the Next Generation Accountable Care Organization Model

Visual Appendix

The Innovation Center selected NORC at the University of Chicago (NORC) to conduct an independent evaluation of the Next Generation Accountable Care Organization (NGACO) Model.

This report is the sixth and final evaluation report to emerge from the evaluation. As such, it summarizes and synthesizes findings across all six performance years (PYs) to provide a comprehensive story of how the participating entities responded to the model and how they achieved or did not achieve the model's goals.

Key Findings



Improvements over Time

Increased impact on spending and utilization outcomes may reflect improvements over time, retention of higher-performing NGACOs, or larger savings in the context of COVID-19.



Pathways to Spending Reductions

There were four pathways to spending reductions based on organization type, NGACO size, and implementation strategies.



Pathways to Lack of Reductions

There were six pathways to lack of spending reductions based on organization type, NGACO size, market factors, and provider factors.

Key Findings

Reducing Medicare spending involved addressing beneficiary needs across the care continuum.

91%

Expanded data analytic capacity to support population health management

Many reported that this was the most significant organizational change they made during the model.

2.6%

Reduced spending for beneficiaries with 8+ chronic conditions

Care management prioritized reducing avoidable (re)admissions and emergency department visits, closing gaps in care.

20%

Two-thirds of NGACOs had initiatives to increase annual wellness visits

PAC\$

Addressed through SNF partnerships

NGACOs that shared data, embedded staff, and standardized care management processes with SNFs had larger reductions in SNF days.

Key Findings



Spending

NGACOs reduced spending and utilization in high-cost settings.

Spending reductions grew over time, which may reflect improvements over time, but also a “survivor effect” of more successful NGACOs remaining in the model.

NGACOs reduced Medicare Parts A & B gross spending by \$1.7B cumulatively, but there were no cumulative net savings.

NGACOs had the greatest gross spending reductions in PY6 and achieved net savings in that year of 2.4%.

NGACOs reduced spending on acute care, professional services, outpatient, and post-acute care (PAC).



Utilization & Quality

NGACOs increased preventive care using prospective alignment lists and other model resources.

- NGACOs reduced utilization in the following categories:
- Acute care hospital stays, emergency department (ED) visits, and observation stays
- Skilled nursing facility (SNF) days, home health episodes
- Evaluation & management (E&M) visits, imaging services, procedures and tests

In PY 6, NGACOs also reduced unplanned 30-day readmissions and hospital readmissions from SNFs.



Explore Different Parts of the Study.

This document is interactive. Click on the chapter icons to learn more.

Use the links at the top to navigate through the document.

Click on the glossary to look up acronyms.





Background

NGACO launched in 2016 and offered greater risk-sharing opportunities, flexible payment arrangements, and benefit enhancements to promote value over volume in health care delivery.

The model included three cohorts of participants, one starting in each of the first three performance years of the model—2016 (PY 1), 2017 (PY 2), and 2018 (PY 3).

Click on each topic to learn more.

[NGACO Model Overview](#)

[NGACO Model Features](#)

[NGACO Model Participants, by Year](#)

[Characteristics of NGACO Participants](#)



NGACO Model Overview

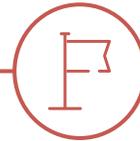


Basics

NGACO was an advanced alternative payment model (APM)

Built on CMS' previous ACO initiatives by offering greater risk-sharing opportunities, flexible payment arrangements, and benefit enhancements

Promoted value over volume in health care delivery



Goal

To assess the impact of strong financial incentives and tools to support patient engagement and care management

To improve the value of health services and reduce spending for Medicare fee-for-service (FFS) beneficiaries



Details

Three cohorts of participants over each of the first three performance years (PYs) of the model: 2016 (PY 1), 2017 (PY 2), and 2018 (PY 3)

The model lasted six years (2016-2021)

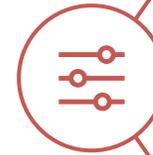
PY 5 and PY 6 overlapped with the COVID-19 public health emergency (PHE)



NGACO Model Features



Providers: Participant providers determined beneficiary alignment and cost and quality measures; preferred providers expanded networks



Alignment: Prospective alignment based on a plurality of qualified evaluation and management (QEM) visits or voluntary alignment



Benchmarks: Based on the NGACOs' historical and regional expenditures and projected spending in the PY



Payment Mechanisms: 1) Traditional FFS; 2) FFS with a fixed per-beneficiary infrastructure payment (ISP); 3) population-based payments (PBPs); or 4) all-inclusive PBPs (AIPBPs)



Risk-Sharing: 80% (partial) or 100% (full) risk for shared savings/losses and risk caps between 5% and 15% of benchmark expenditures



Benefit Enhancements: Six options, including waiver of 3-day hospital stay rule for skilled nursing facility (SNF) stays and waiver of telehealth requirements



NGACO Model Participants, by Year

Number of NGACOs, by Year & Cohort





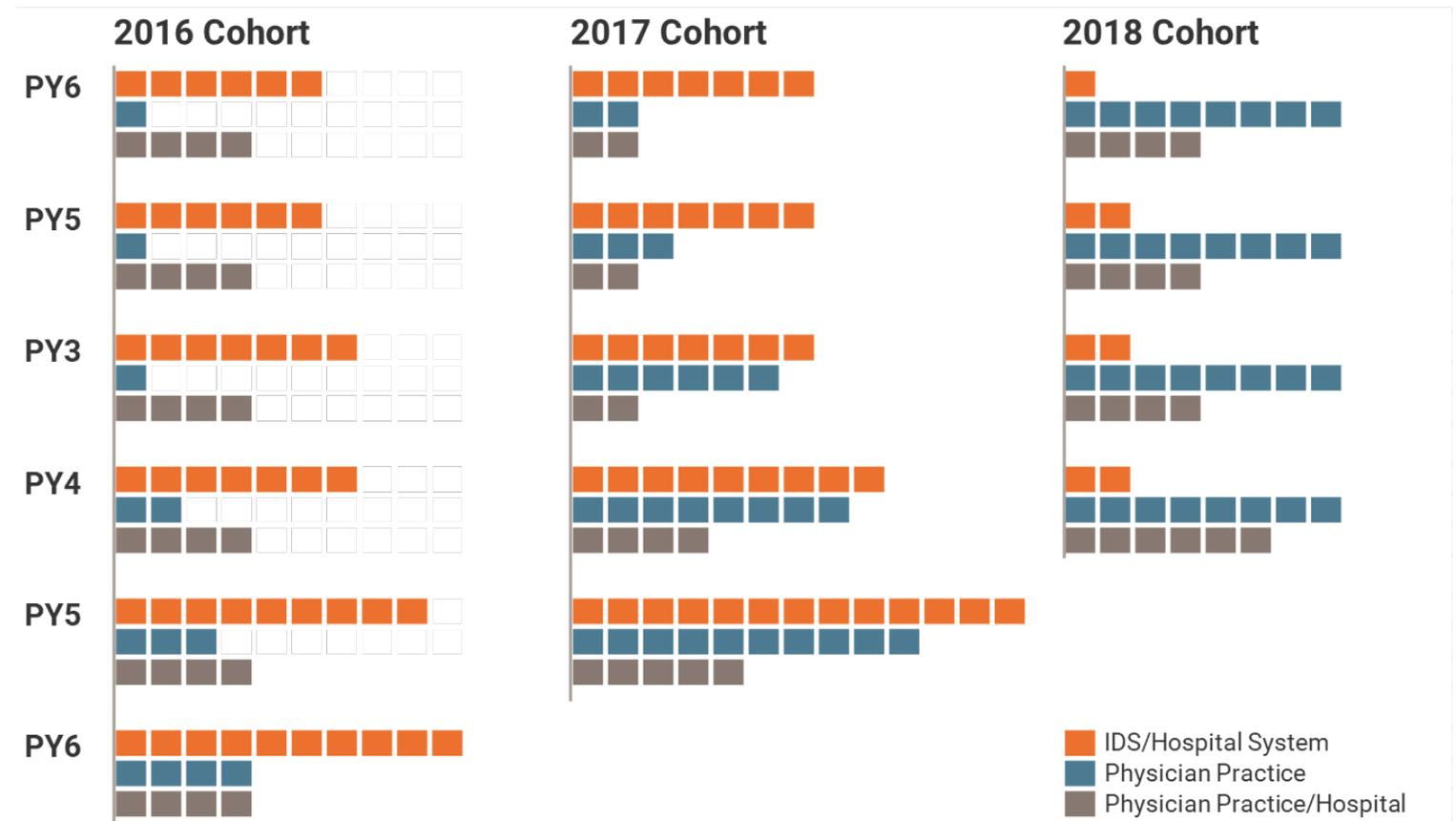
Characteristics of NGACO Participants

Hospital System & Integrated Delivery System (IDS): Hospital system with tightly linked providers/facilities offering a continuum of care

Physician Practice: A medical group practice or network of individual practices that is not affiliated with a hospital system

Physician Practice/Hospital Partnership: Physician practice(s) & hospital system partnership

Cohort Composition, by Organization Type





Theory & Methods

NORC conducted a mixed-methods evaluation of the implementation and impact of the NGACO Model to assess:

- Impact on Medicare spending, utilization, and quality
- Factors associated with spending outcomes
- Implementation strategies

This involved developing the following items, which will be discussed further in each section.

Click on each topic to learn more.

[Theory of Action](#)

[Difference-in-Differences Design](#)

[Configurational Comparative Methods](#)

[Primary Data Collection Approach](#)



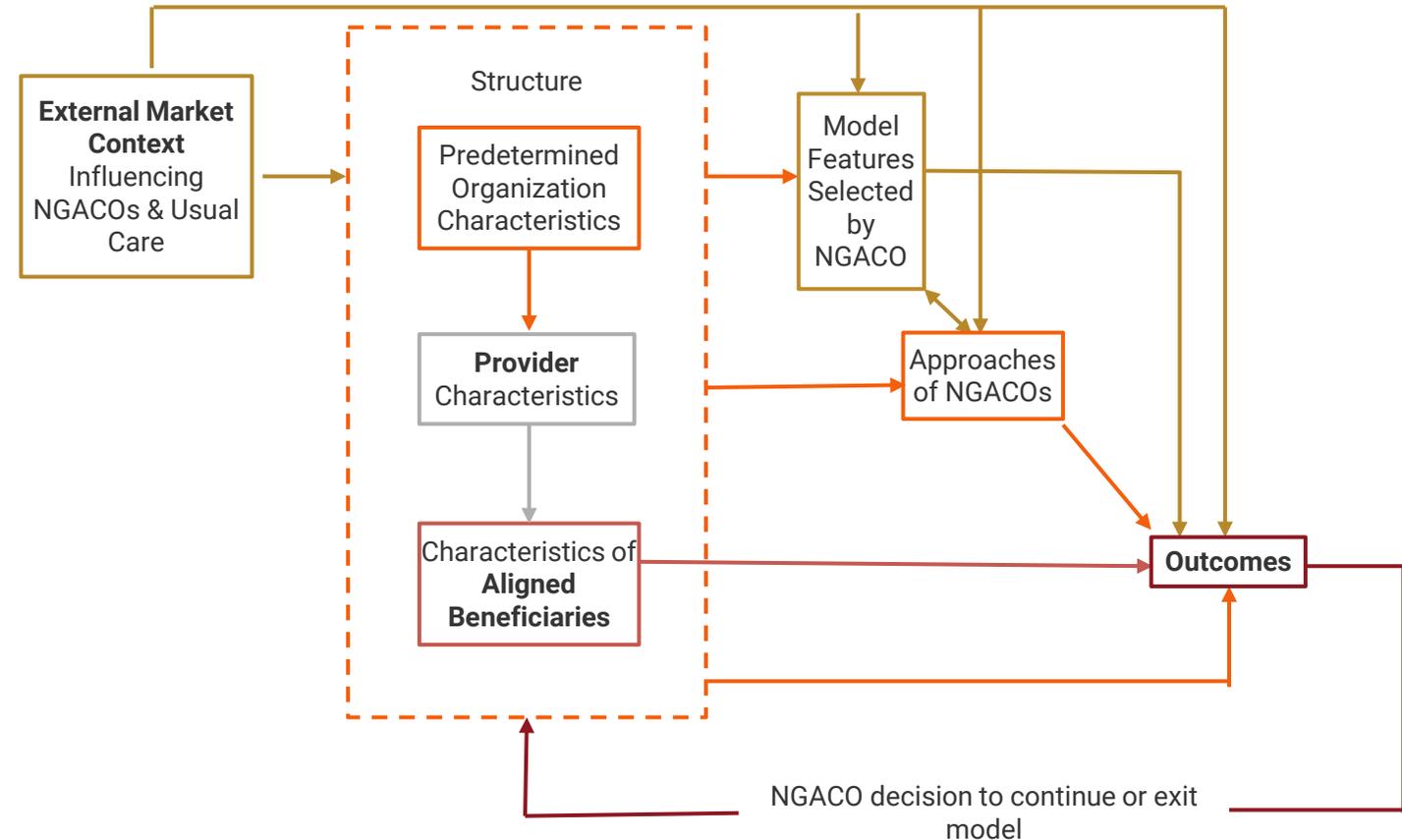
Theory of Action

The Theory of Action depicts how external market conditions may influence NGACOs' model feature selections as well as their performance.

These external factors may affect NGACOs in different ways based upon their structural characteristics, which include organizational, provider, and aligned beneficiary characteristics.

Structural characteristics, along with the external factors, in turn influence NGACO Model feature selections and implementation approaches. These decisions may then affect outcomes of interest.

These outcomes ultimately influence NGACOs' decisions as to whether to continue in the model or withdraw.



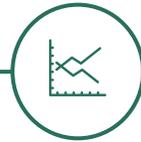


Difference-in-Differences Design (DID)

Click on each box to learn more.



**Design for Each Cohort
& ACO**



**Comparison Group & NGACO
Beneficiaries**



**Parallel Trends
Assumption**



DID Design for Each Cohort & ACO: We estimated both cohort and ACO-level models.

Measurement elements for DID analyses

ELEMENT	DETAILS
Data source	100% Medicare FFS claims & enrollment data
Analytic approach	Propensity-weighted DID analysis to estimate impact in each Performance Year
Pre-period	3 baseline years prior to Model entry for each cohort or ACO
Primary outcome	Total Medicare Parts A & B spending
Secondary outcomes	8 measures of Medicare spending for care settings; 11 measures of utilization; 3 measures of quality
Propensity score weighting	Comparison group weighted to be like ACO in baseline/performance year for balance on observed demographics, disease burden, ZIP-code level socio-economic characteristics, and county-level COVID rates in 2020-2021
Difference-in-Differences estimation	Fixed effects for cohort, years, hospital referral regions (HRRs), beneficiary covariates in PS model, treatment effect for cohort or ACO in performance year



We compared comparison group and NGACO beneficiaries from the same markets.

Composition of NGACO & comparison groups for performance & baseline years

		PERFORMANCE YEAR (PY)		BASELINE YEARS (BYs)	
NGACO GROUP	 ACO	1	ACO may be or may not be present in BYs	1	
	 ACO's Participant Providers in PY	3	ACO's PY Participant Providers in BYs	3	
	 Beneficiaries Attributed Prospectively to ACO's Participant Providers in PY	7	Beneficiaries Attributed Prospectively to ACO's PY Participant Providers in BYs	6	
COMPARISON GROUP FOR EACH NGACO	 Comparison* Providers in PY	4	Comparison* Providers in BYs	4	
	 Beneficiaries in NGACO's Hospital Referral Regions Attributed Prospectively to Comparison Providers in PY	9	Beneficiaries in NGACO's Hospital Referral Regions Attributed Prospectively to Comparison Providers in BYs	9	

NOTE: Baseline years for each NGACO includes three years prior to ACO starting the model in one of three Cohorts in 2016, 2017, & 2018. Comparison* providers are non-NGACO providers. They exclude NGACO Model's PY participant & preferred providers, & providers in other Medicare ACOs. Over half of the NGACO providers & beneficiaries in the baseline years were in SSP & Pioneer ACOs

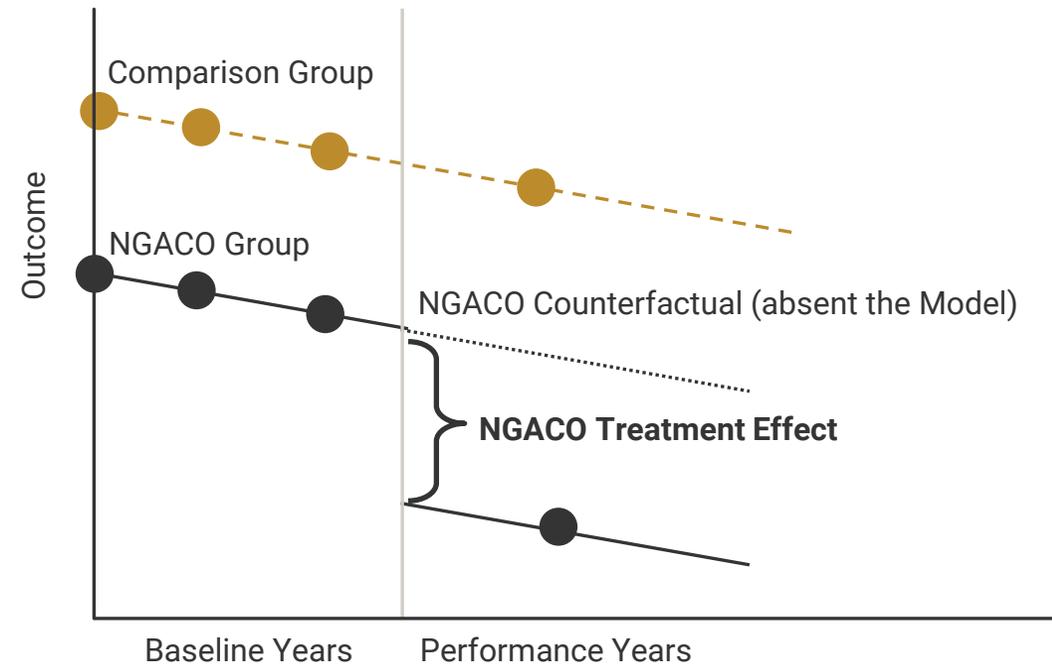


We tested the parallel trends assumption for the DID models for each cohort and ACO.

A key assumption of our difference-in-difference design is that of parallel trends, namely, that changes in outcomes from the BYs to the PY would have been similar in the NGACO and comparison groups in the absence of the NGACO Model.

We tested this assumption across the BYs by comparing the NGACO group's trend in BY 1 to BY 3 against the trend in the comparison group for all outcomes, noting where the assumptions passed and failed for each cohort and model-wide.

Illustration of Parallel Trends



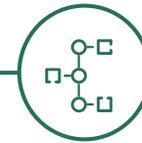


Configurational Comparative Methods (CCM)

Click on each box to learn more.



Details of the CCM



Two CCM Approaches



Details of the CCM

CCM was applied to qualitative and quantitative data to understand different pathways to similar outcomes as it:

Uses **Set-Theory** to identify overlap between conditions and outcomes

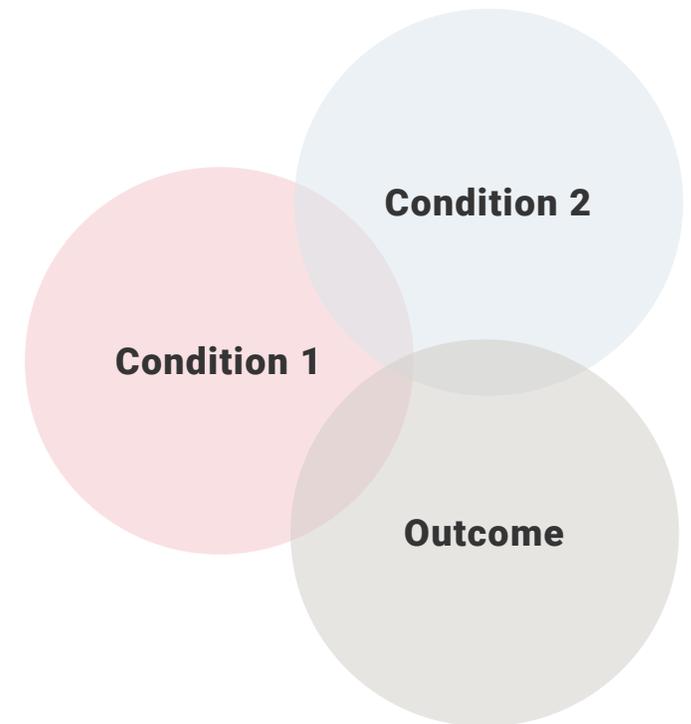
- Set membership vs. correlations

Handles situations of complex causality

- Different and multiple **pathways** to the same outcome vs. average treatment effects
- Outcome's occurrence relies on a combination of factors
- Yields different configurations of conditions (recipes) that are **necessary** and/or **sufficient** for outcome of interest

Complements regression outcomes

- Systematically groups cases with outcome of interest based on shared characteristics
- Identifies multiple ways NGACO can affect Medicare spending





We applied two CCM Approaches.

Coincidence Analysis

- Question for analysis: Which population health management strategies led to improved spending and quality outcomes?
- Bottom-up approach
- Chains of minimally sufficient conditions to an outcome
- Accommodates large number of conditions
- Allows causal order specification

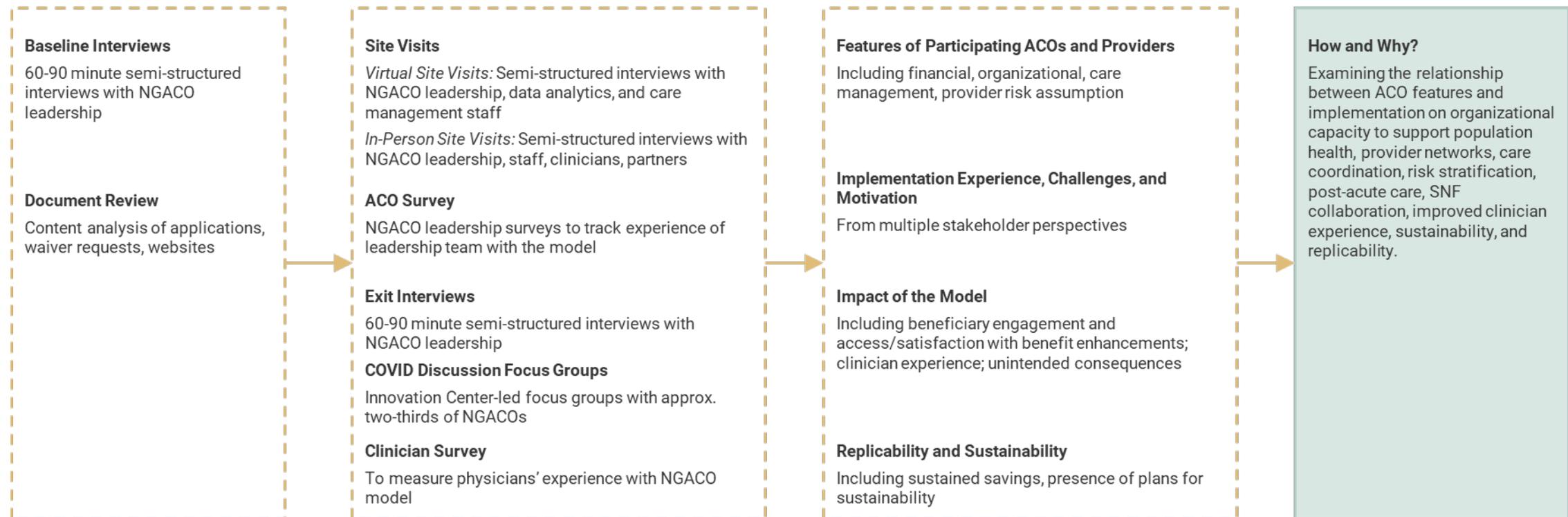
Qualitative Comparative Analysis

- Question for analysis: What structural and contextual characteristics contribute to NGACOs' failure to reduce Medicare spending?
- Top-down approach
- Considers all conditions to build pathways
- Mirrors methodology used in Fourth Report



Primary Data Collection Approach

Population Health Strategies: Methodology



Team coordinated and incorporated input from CMMI and contractors in the design of schedules, protocols, and instructions



Findings

This section is presented in chapters based on the overall finding.

Each chapter has the accompanying charts with more details.

Click on each topic to learn more.

Impacts on Spending, Utilization, and Quality of Care

Differences in Outcomes by Factors in the Theory of Action

Population Health Strategies

Pathways to Spending Reductions and Lack of Spending Reductions



Impacts on Spending, Utilization, and Quality of Care

Click on each finding to learn more & see charts.

Model-Wide

Gross spending declined cumulatively—with larger declines in later PYs. Net spending did not decline cumulatively but declined in PY 6.

NGACOs reduced spending and utilization in the most intensive care settings.

The Model had no cumulative impact on selected quality of care measures, but PY 6 saw lower readmissions.

Most NGACOs had concordance between financial results relative to benchmark and evaluation impacts; those with shared losses tended to exit the model.

ACO & Providers

NGACOs that remained in the model, and their retained providers had greater gross spending reductions.

Beneficiaries

Gross spending reductions were greater over time for retained beneficiaries.

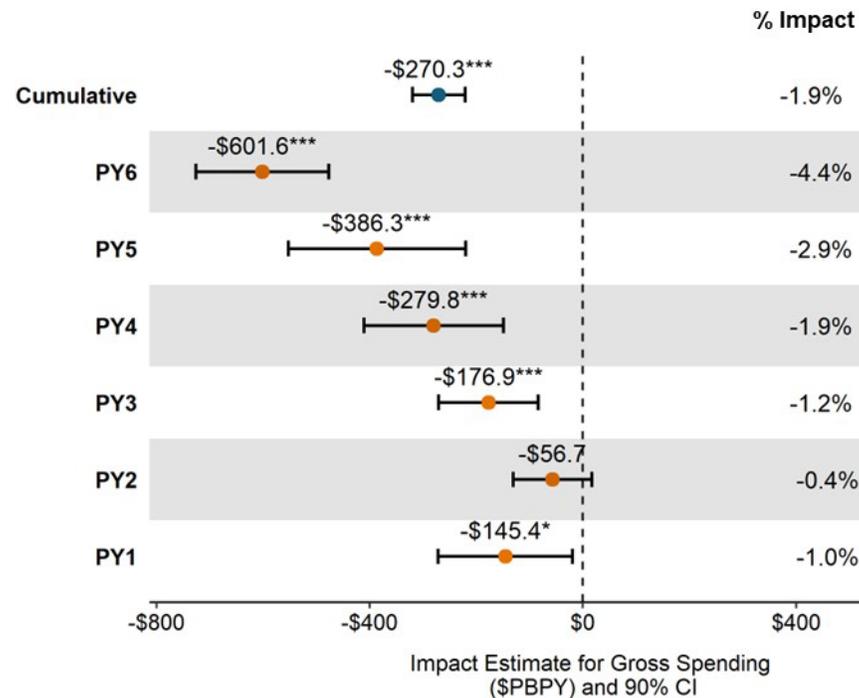


Model-Wide: Gross spending declined cumulatively—with larger declines in later PYs. Net spending did not decline cumulatively but declined in PY 6.

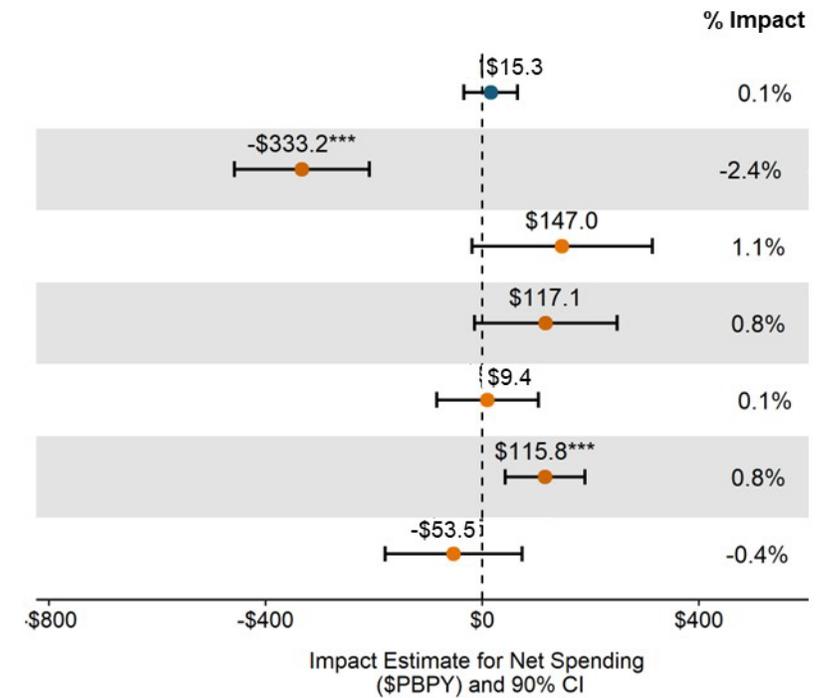
The model's gross spending reductions increased annually from a nonsignificant increase of 0.4% in PY 2 (\$56.7 PBPY) to 4.4% in PY6 (\$601.6 PBPY, $p < 0.01$).

Cumulatively, net spending did not decline; the estimated increase of 0.1% (\$15.3 PBPY or \$96.7M in aggregate) was not statistically significant.

Gross spending impacts



Net spending impacts





Model-Wide: NGACOs reduced spending and utilization in the most intensive care settings.

These findings are consistent with NGACOs' strategies to risk-stratify and manage care for aligned beneficiaries, and to partner with skilled nursing facilities to manage post-acute care.

Changes in spending & utilization by care setting

	Cumulative	
	Spending	Utilization
Acute care hospital	↓	↓
Outpatient facility	↓	↓
Professional services	↓	↓
Home health	↓	↓
Skilled nursing facility	↓	↔
Hospice	↓	
Other post-acute care	↓	



Model-Wide: The Model had no cumulative impact on selected quality of care measures, but PY 6 saw lower readmissions.

NGACO implementation strategies:

- Care management for patients at risk of hospitalization
- Initiatives focused on reducing readmissions,
- Partnerships with skilled nursing facilities to manage post-acute care.

Changes in selected quality of care measures, cumulatively & in PY 6

	CUMULATIVE	PY6
Unplanned 30-Day Readmissions		
30-Day Hospital Readmission from skilled nursing facilities		
Hospitalizations for ambulatory care sensitive conditions (ACSCs)		

NOTE: Solid fill denotes statistical significance at p<0.1 or lower.



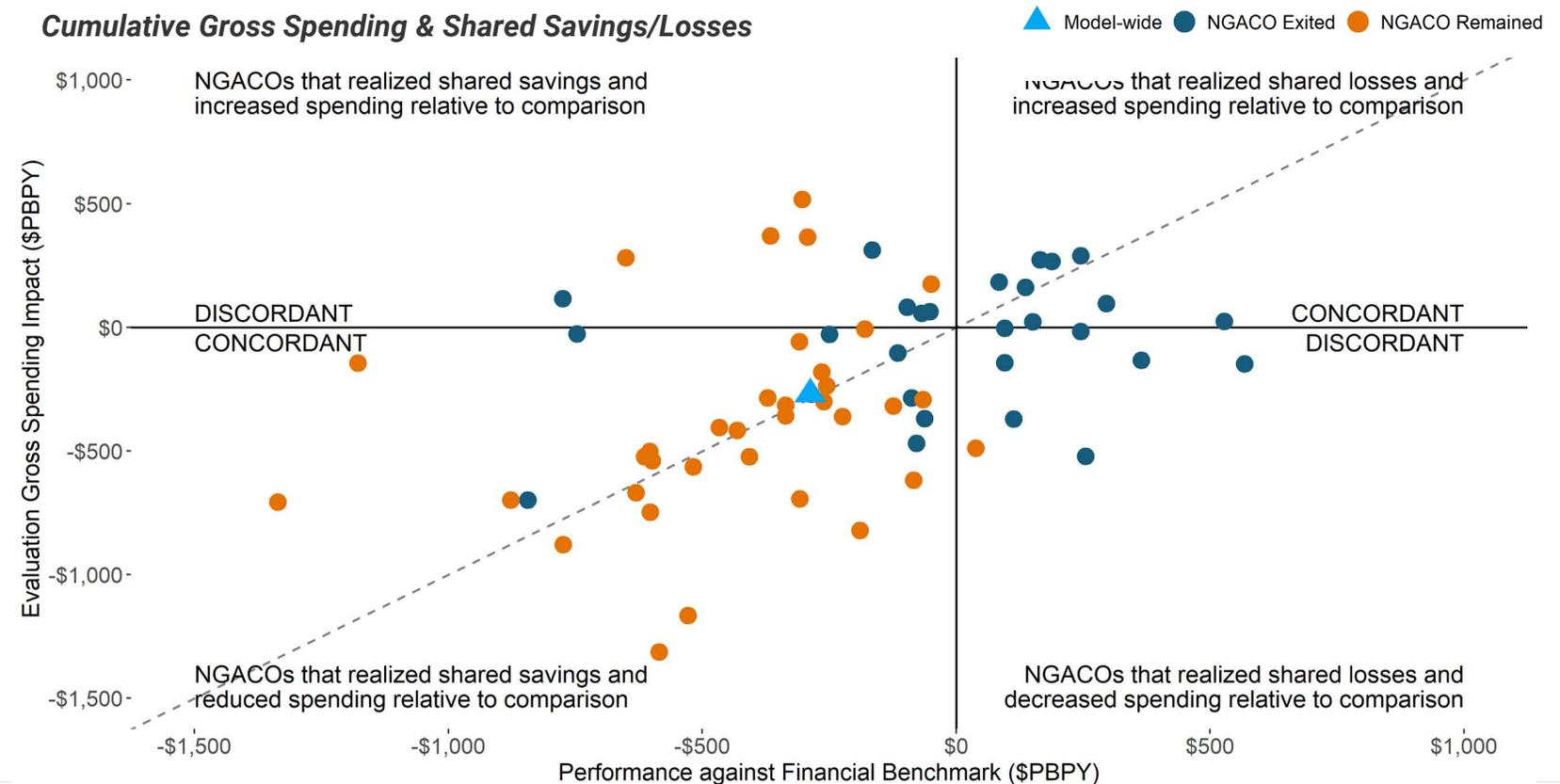
Model-Wide: Most NGACOs had concordance between financial results relative to benchmark and evaluation impacts; those with shared losses tended to exit the model.

We saw concordance between the evaluation and financial results for over 70% of NGACOs (44 out of 62), including those that remained in the model and those that withdrew (quadrants 1 and 3, respectively).

Fewer than 30% of NGACOs (18 out of 62) showed discordance between the two results (quadrants 2 and 4).

Most NGACOs that remained in the model reduced gross Medicare spending and realized shared savings, and most NGACOs that withdrew from the model increased gross Medicare spending and incurred shared losses.

Cumulative Gross Spending & Shared Savings/Losses



NOTE: The cumulative point estimate PBPY for gross spending impacts (relative to the comparison group) is shown on the vertical axis, & shared savings & losses (relative to financial benchmark) on the horizontal axis. Each point's distance from the dashed line indicates the magnitude & direction of net Medicare spending. NGACOs above the dashed line increased net spending, while those below it decreased net spending.

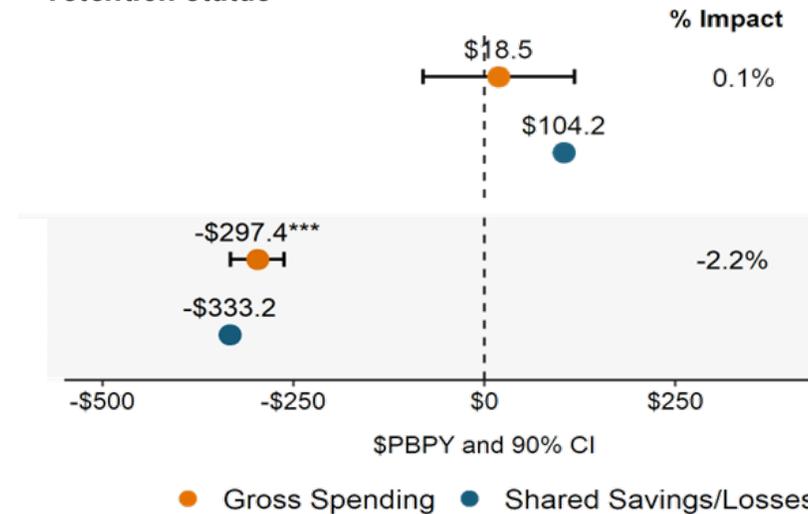


ACO & Providers: NGACOs that remained in the model, and their retained providers had greater gross spending reductions.

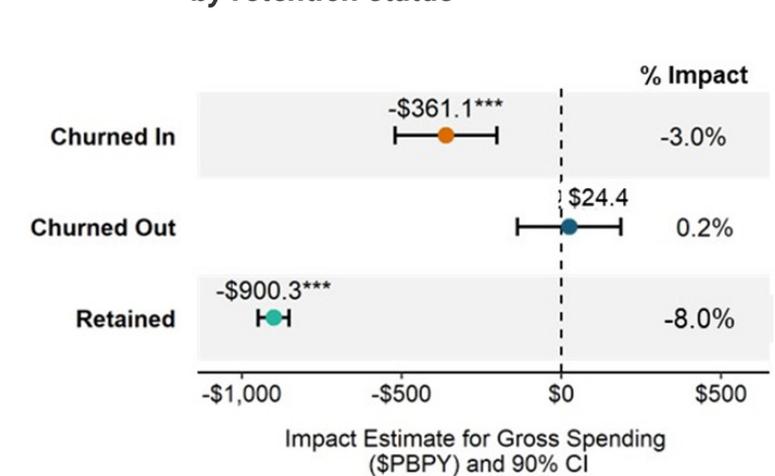
NGACOs that remained in the model significantly reduced gross spending relative to a comparison group and earned greater shared savings.

The NGACO Model had the largest reductions in gross spending for beneficiaries of providers who remained in the model for at least three years (two years for providers of newly entering NGACOs).

NGACO impact on gross spending & shared savings by retention status



Provider impact on gross spending by retention status



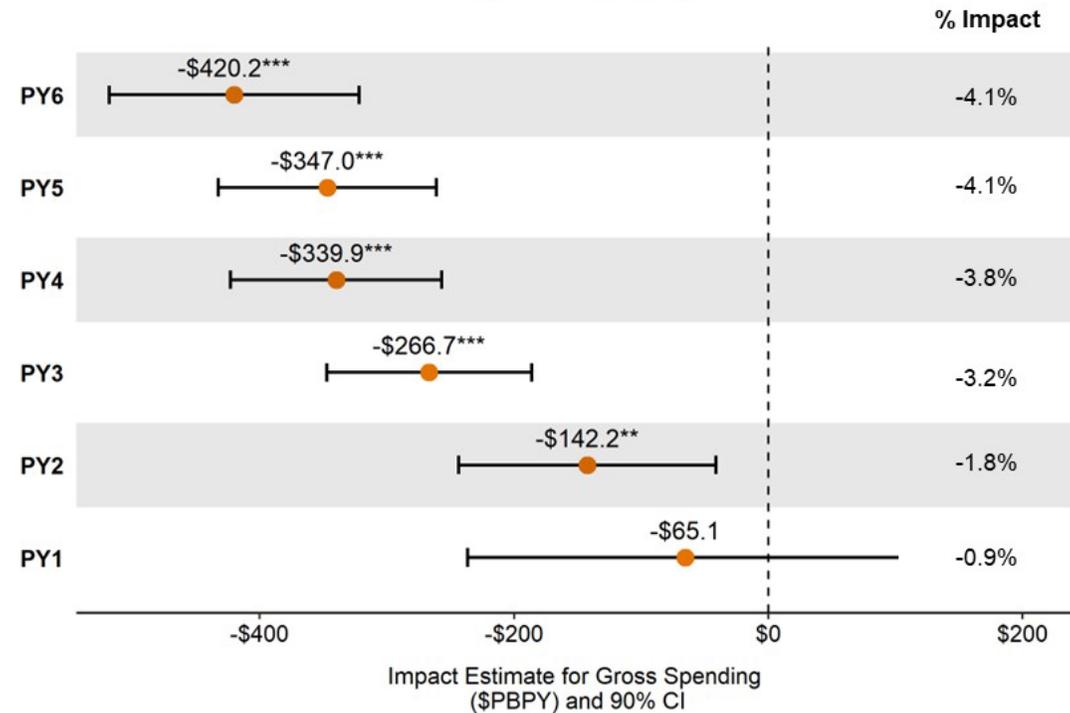


Beneficiaries: Gross spending reductions were greater over time for retained beneficiaries.

Gross spending reductions grew over time for NGACO beneficiaries who remained in the model continuously, relative to comparison beneficiaries with continuous years of observation, across all PYs.

The magnitude of significant spending reductions increased from 1.8% (\$142.2 PBPY, $p < 0.05$) in PY 2 to 4.1% (\$420.2 PBPY, $p < 0.01$) in PY 6, suggesting that both Medicare and NGACOs may benefit from continuous beneficiary engagement over time, or that beneficiaries who have been continuously aligned maybe healthier.

Gross spending impacts for retained beneficiaries over time



NOTE: Impact estimates significant at $p < 0.1^*$, $< 0.05^{**}$, or $< 0.01^{***}$



Differences in Outcomes by Factors in the Theory of Action

Click on each finding to learn more & see charts

Model Features

NGACOs selecting higher risk levels and caps and those selecting population-based payments had greater spending reductions.

The percentage of NGACOs choosing 100% risk varied by year.

Providers

Over the course of the model, NGACOs increasingly favored primary care providers over specialty providers as Participant Providers.

Certain strategies for engaging physicians were associated with quality and cost outcomes.

Beneficiaries

NGACO beneficiaries were more likely to be White and eligible for Medicare only compared to Medicare FFS beneficiaries in their market.

By PY 6, NGACOs had limited impact on addressing health disparities.

Majority of NGACO aggregate spending reductions were not from overlap with episodic initiatives.

Organizations

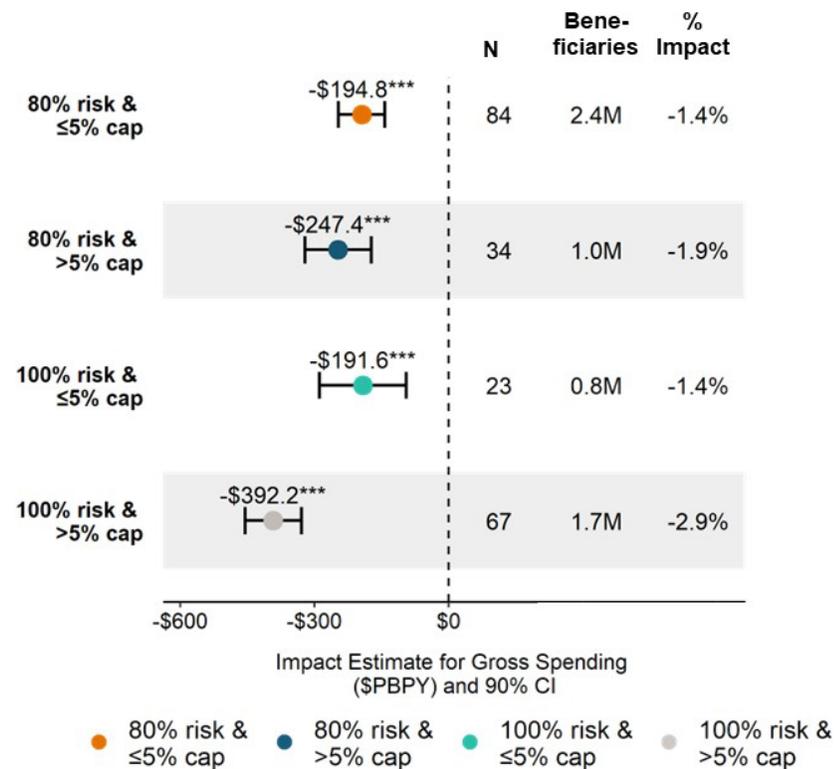
Physician practice NGACOs had the largest gross spending reductions as of PY 6, driven by larger spending reductions during COVID-19 PHE.

Impacts on spending and utilization categories differed by organization type.

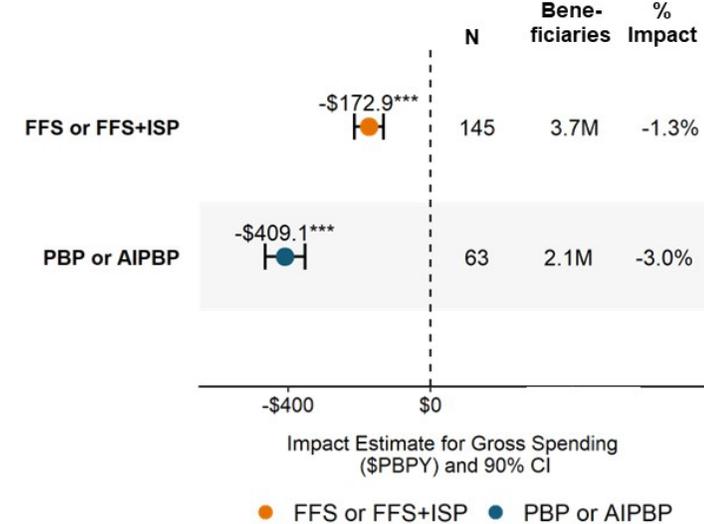


Model Features: NGACOs selecting higher risk levels and caps and those selecting population-based payments had greater spending reductions.

Impact of risk selection on gross spending



Impact of payment mechanism on gross spending





Model Features: Risk over Time

The percentage of NGACOs choosing 100% risk varied by year.

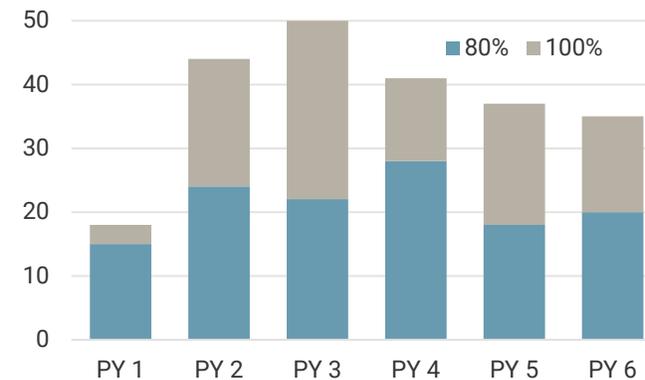
More NGACOs elected higher risk caps over time, with one exception being an uptick in NGACOs electing 5% risk caps in PY 5; this exception likely reflected the 5 percent risk limits for those that signed the COVID-19 amendment.

NGACOs primarily chose FFS-based payment mechanisms. The percentage of NGACOs electing population-based payment (PBPs) increased over time.

Uptake of most benefit enhancements remained low over the course of the model.

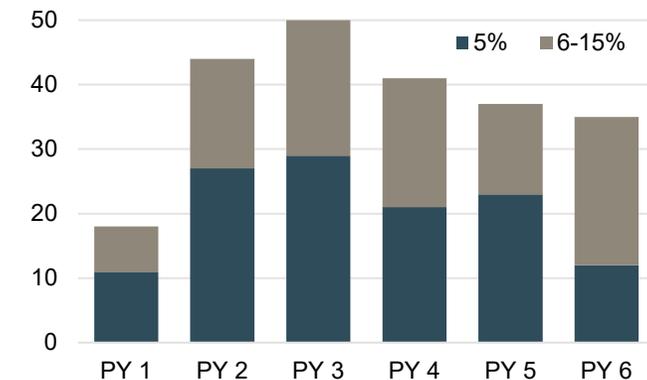
Risk Levels Selected, PY1-PY6

of NGACOs



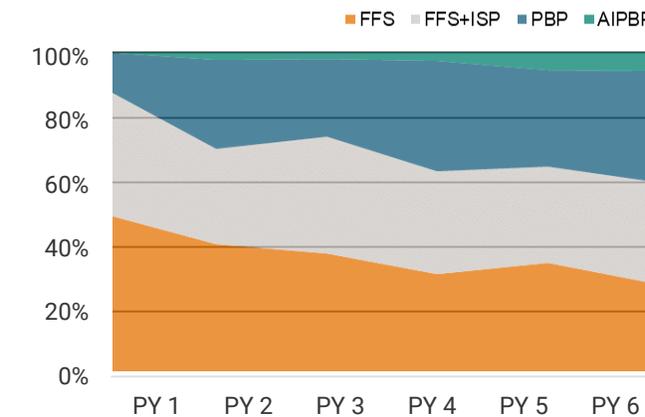
Risk Caps Selected, PY1-PY6

of NGACOs



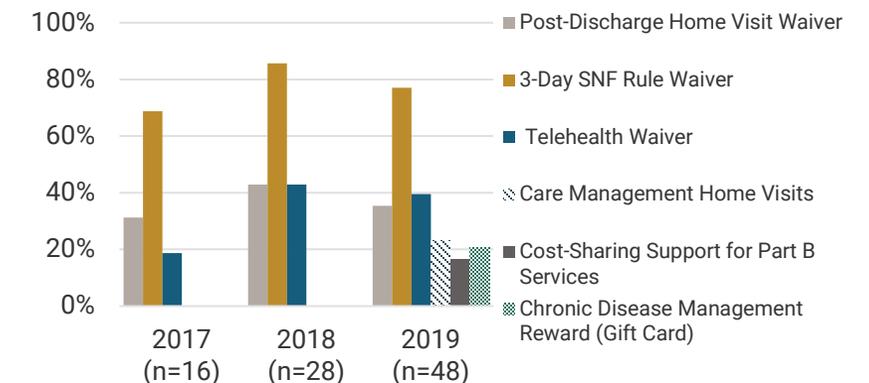
Payment Mechanisms Selected, PY1-PY6

% of NGACOs



Waiver Elections, PY1-PY6

% of NGACOs that fully implemented or were in the process of implementing each benefit enhancement

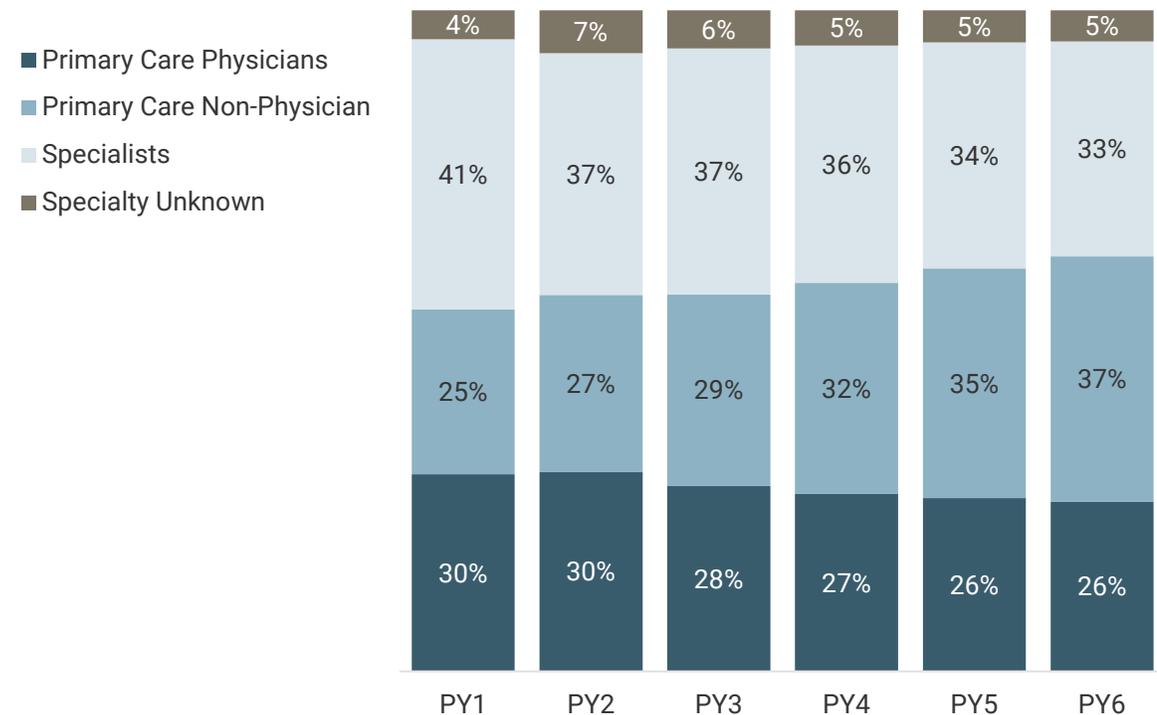




Provider-level factors: Over the course of the model, NGACOs increasingly favored primary care providers over specialty providers as Participant Providers.

Concurrently, the proportion of specialist Participant Providers decreased over time, while primary care physicians were more likely to remain. This trend continued through the final year of the model.

Percentage of provider participants by specialty





Provider-level factors: Certain strategies for engaging physicians were associated with quality and cost outcomes.



Sharing Savings

Reduced ACSC hospitalizations & readmissions



Sharing Upside & Downside Risk

Reduced inpatient spending & ACSC hospitalizations



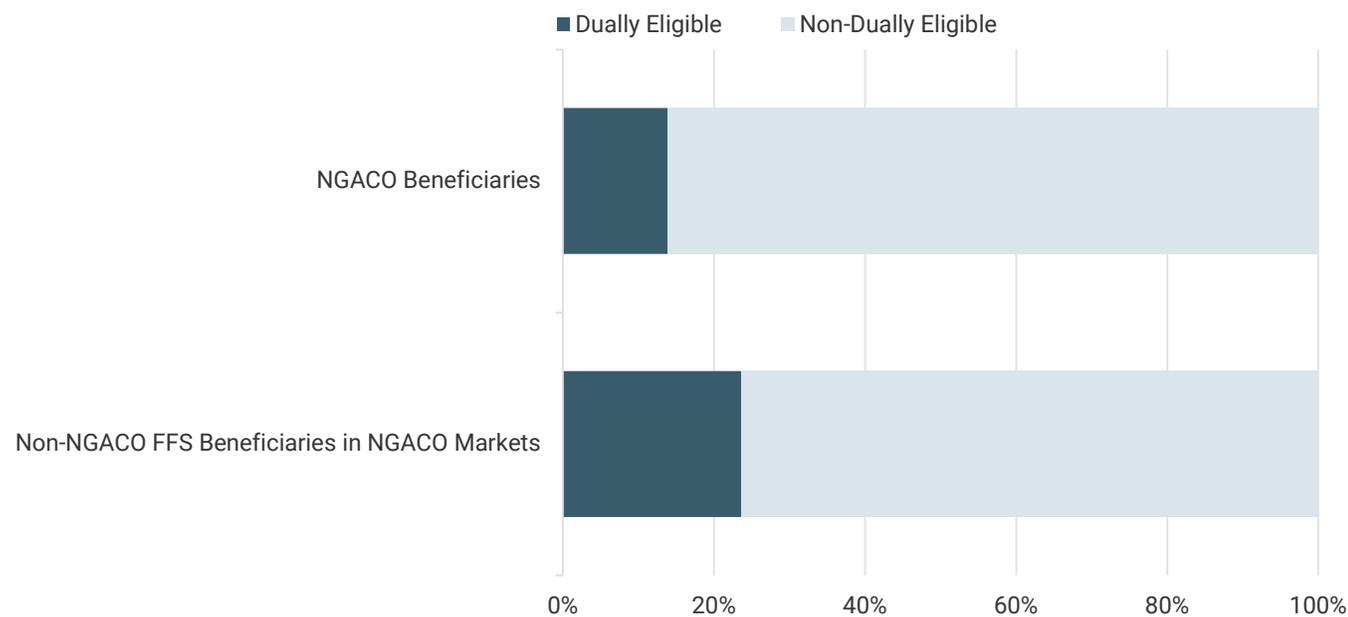
Sharing Cost Data

Reduced ACSC hospitalizations

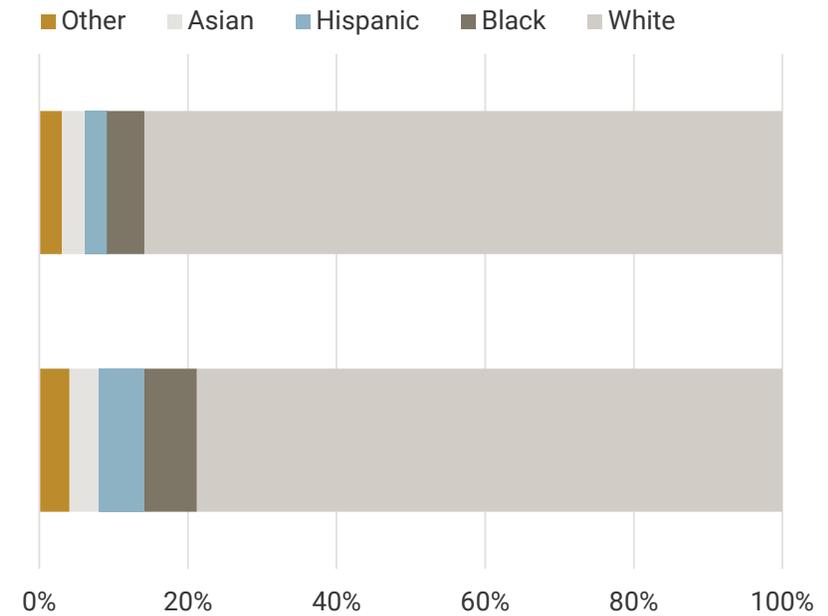


Beneficiary-level factors: NGACO beneficiaries were more likely to be White and eligible for Medicare only compared to Medicare FFS beneficiaries in their market.

Dually eligible vs. non-dually eligible participants



Beneficiary race





Beneficiary-level factors: By PY 6, NGACOs had limited impact on addressing health disparities.

71% of NGACOs had implemented initiatives to address social needs.

Only one third reported this was high priority.

NGACOs reduced spending for beneficiaries who were White in all PYs but only in PY 6 for beneficiaries who were Black.

Lower spending may not be a desirable outcome if beneficiaries had challenges accessing care or avoided health care services in the baseline.

ACSC hospitalizations declined for Black beneficiaries in PY 6.

But the rates continued to be higher than for White beneficiaries.



Beneficiary-level factors: Majority of NGACO aggregate spending reductions were not from overlap with episodic initiatives.

Variation in results may be due to timing of overlap, complexity of episodes, or providers initiating them.

Beneficiaries with **Oncology Care Model episodes: Spending reductions for NGACO > comparison group**

Later overlap timing: 2018 cohort, PYs 3-6

Limited focus on chemotherapy episodes initiated in oncology practices

Beneficiaries with **Bundled Care for Payment Initiative episodes: Spending reductions for NGACO < comparison group**

Earlier overlap timing: PYs 1-3, all three cohorts

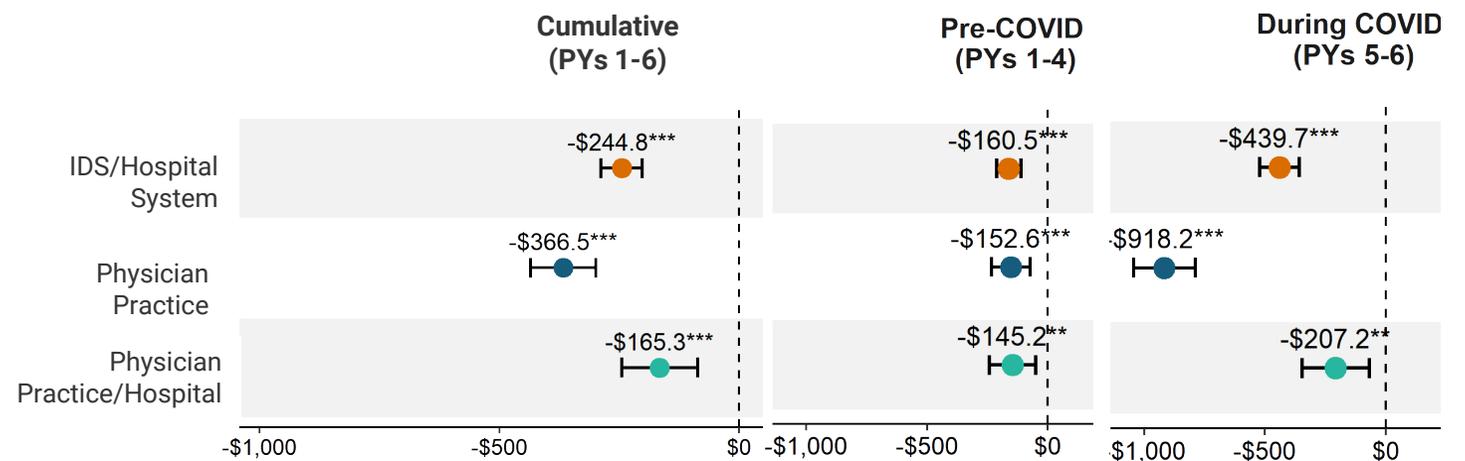
Multiple medical and surgical episodes initiated by acute care hospitals, SNFs, physician practices, home health agencies, IRFs/LTCHs



Organization-level factors: Physician practice NGACOs had the largest gross spending reductions as of PY 6, driven by larger spending reductions during COVID-19 PHE.

During the COVID-19 PHE, physician practice-affiliated NGACOs saw their greatest spending reductions, which exceeded the cumulative reductions achieved by other NGACO organization types.

Impact Estimates for Gross Spending (\$BPY) & 90% CI by Organization Type





Organization-level factors: Impacts on spending and utilization categories differed by organization type.

Physician practice NGACOs had the greatest impacts across most settings, with the exception of intensive PAC

Physician practice NGACOs may have more incentive to reduce hospitalizations since it would not affect their revenue

IDS/hospital NGACOs may have had more control over post-acute discharges

Impacts on cost (\$BPY) & utilization (per 1,000 BPY) by setting & by organization type

	IDS/Hospital System NGACOs	Hospital-Physician Partnerships NGACOs	Physician Practice NGACOs
Acute care hospital spending	-49.0 ***	-25.9	-93.6 ***
Acute care hospital stays	-2.6 ***	0.9	-4.3 ***
Skilled nursing facility days	-34.8 ***	-22.4	-55.7 ***
Outpatient facility spending	-43.9 ***	30.2 *	-49.9 ***
Evaluation & management visits	-311.0 ***	-159.4 ***	-322.6 ***
Home health spending	-21.7 ***	14.7 ***	-35.2 ***
Ambulatory care sensitive conditions (ACSC) hospitalizations	0.3 *	-0.3	-0.4 **
Other post-acute care spending	-28.4 ***	-15.2 **	-11.6 **

NOTE: Impact estimates significant at p<0.1*, <0.05**, or <0.01***



Population Health Strategies

Click on each finding to learn more & see charts.

**Data
Analytics**

**Care Coordination
& Management**

**Annual Wellness
Visits**

**Post-acute Care
Coordination**



Population Health Strategies: Data Analytics

Improving data analytic capacity was a key focus of NGACOs.

NGACOs leveraged prospective alignment lists to stratify beneficiaries by risk and target resources.

By the end of the model, more than two-thirds of NGACOs reported data analytic resources and activities were the most significant changes during the model.

“During the time we participated in the NGACO Model the most significant changes came about by advances made in understanding and utilizing data...This allowed for advances in many of our programs like PAC, care management, provider outreach, and education, etc. Data is the lifeblood of any value-based care organization. Understanding and leveraging your data to help inform all activities is paramount to success.”

– NGACO Leader



Population Health Strategies: Care Coordination & Management

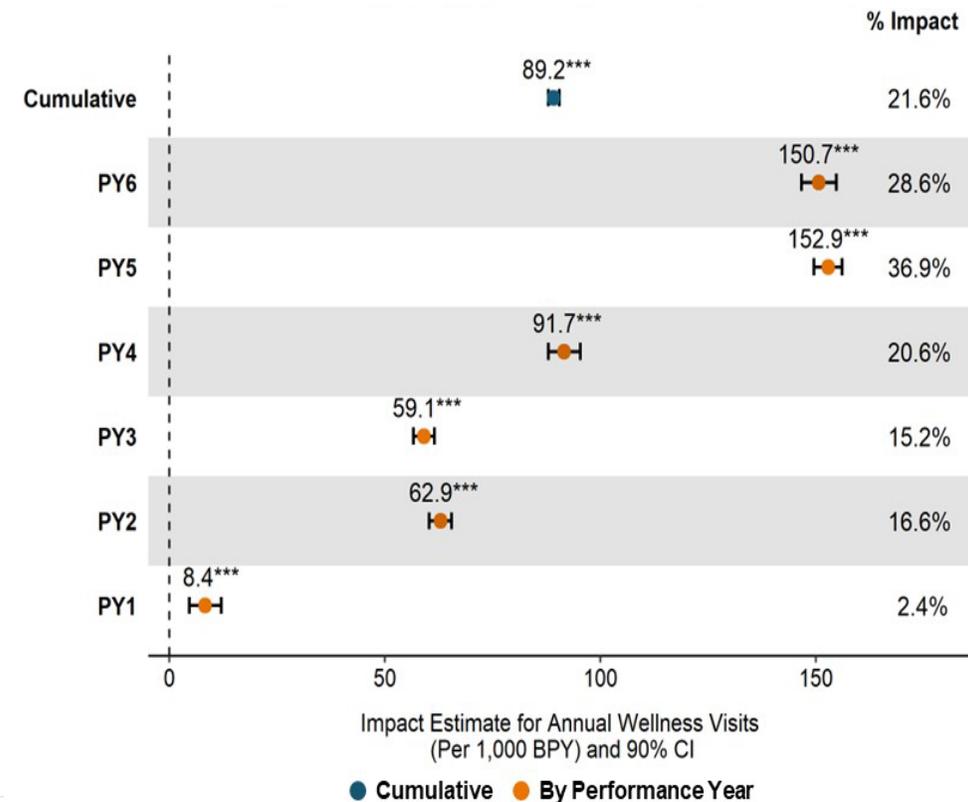
Spending declines for beneficiaries with 8+ chronic conditions were larger in magnitude than model-wide impacts.

NGACOs emphasized proactive care management as a means of reducing unnecessary health care utilization.

70% or more of NGACOs implemented initiatives in priority areas:

- Closing gaps in preventive care
- Preventing readmissions
- Reducing avoidable ED visits
- Reducing avoidable inpatient admissions

Impact on Annual Wellness Visits by Performance Year



Source: NGACO Leadership Survey, 2021; Medicare Claims Data, 2016-2021



Population Health Strategies: Annual Wellness Visits

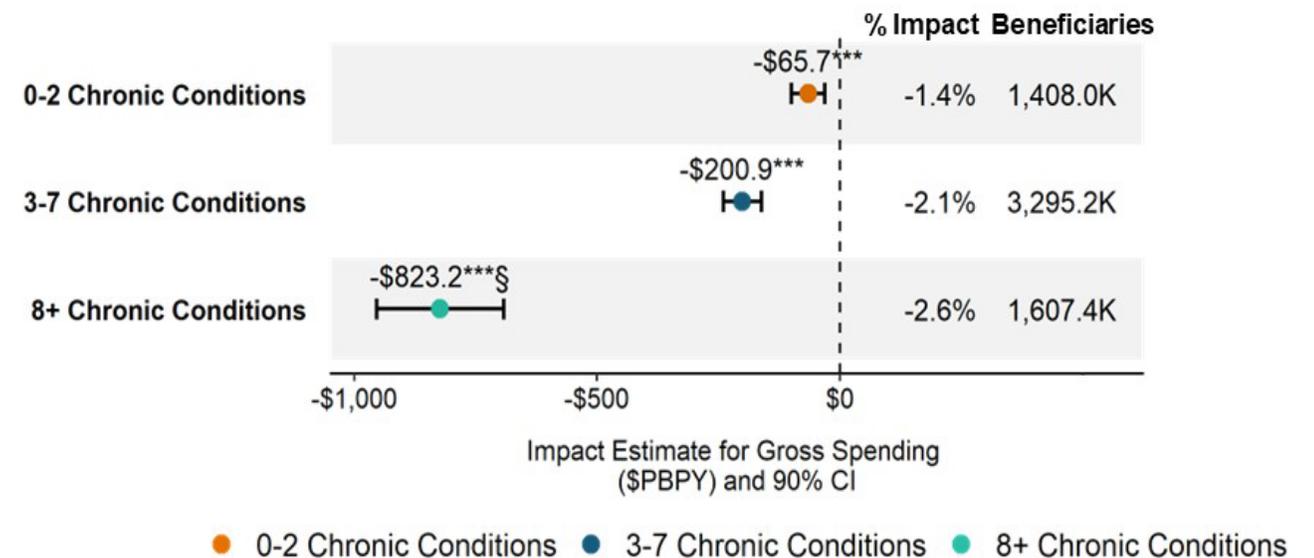
NGACOs viewed AWVs as a way to engage aligned beneficiaries and identify gaps in care.

66% of NGACOs reported that they fully implemented initiatives to increase AWVs among aligned beneficiaries.

“We think that when we can get folks in for the annual wellness visit, we’re more likely to make sure that we’ve accurately assessed all of their health conditions.”

– NGACO Leader

Gross spending by beneficiary number of chronic conditions





Population Health Strategies: Post-acute Care Coordination

There were successes and missed opportunities.

NGACOs identified PAC as an area of inefficient spending and formed partnerships with SNFs to share information and better manage care.

60% of NGACOs reported that they had fully implemented initiatives to manage PAC spending and quality.

66% of NGACOs felt they had gotten “a lot better” at coordinating and managing the care of beneficiaries admitted to PAC settings over the course of the model.

NGACOs that had larger reductions in SNF days:

- Prioritized PAC spending and quality
- Shared performance data with SNFs
- Had fully standardized care management processes and staff

“We surely have connected the various SNFs together in a quality improvement program...And we're communicating more actively with the people involved with the discharge planning in the hospital, trying to stand up some information...And I think the Next Gen program helped impel us to do that work.”

– NGACO Representative



Pathways to Spending Reductions & Lack of Spending Reductions

Click on each finding to learn more & see charts.

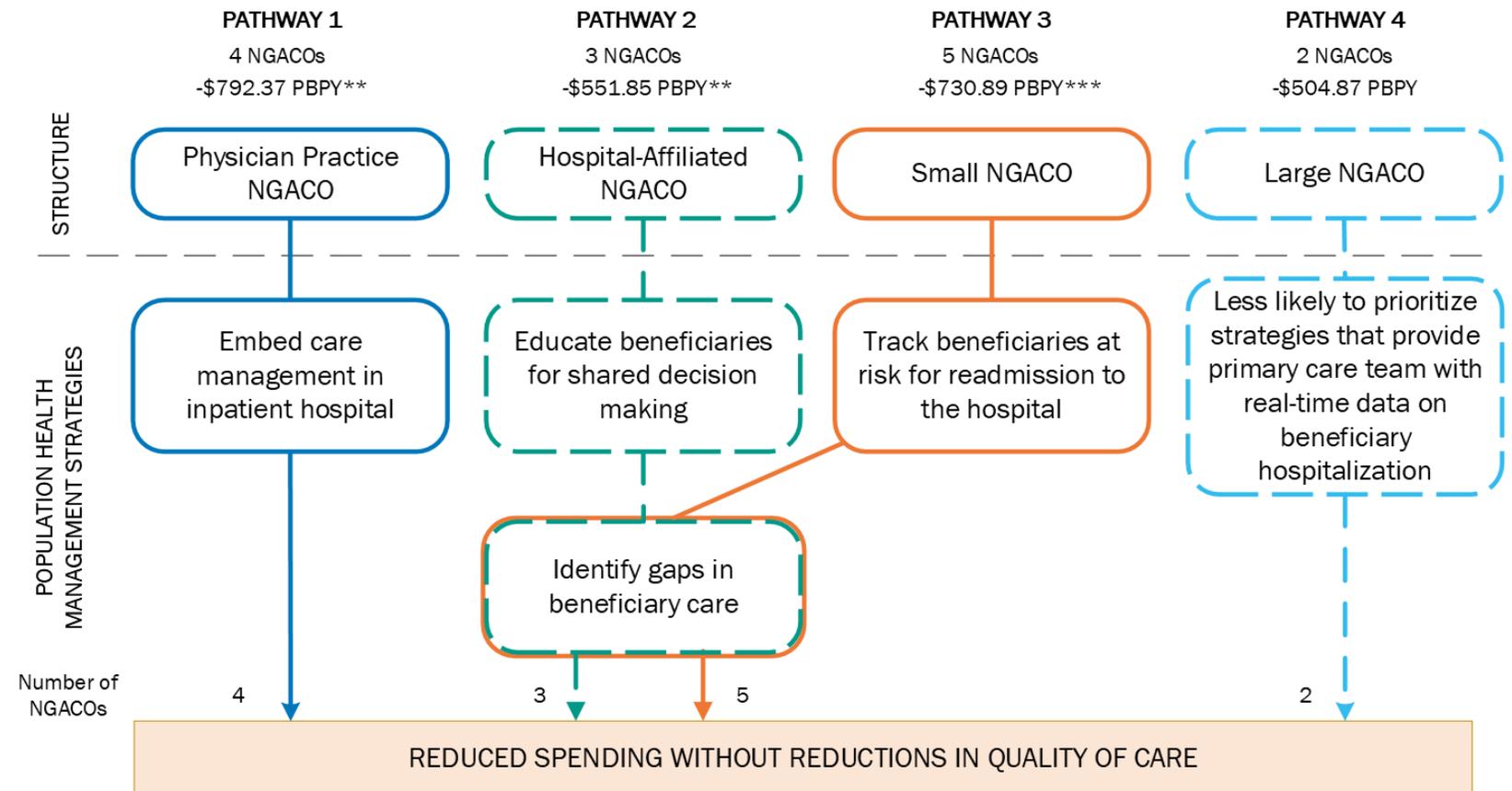
**Pathways to Spending
Reductions**

**Pathways to Lack of
Spending Reductions**



Pathways to Spending Reductions

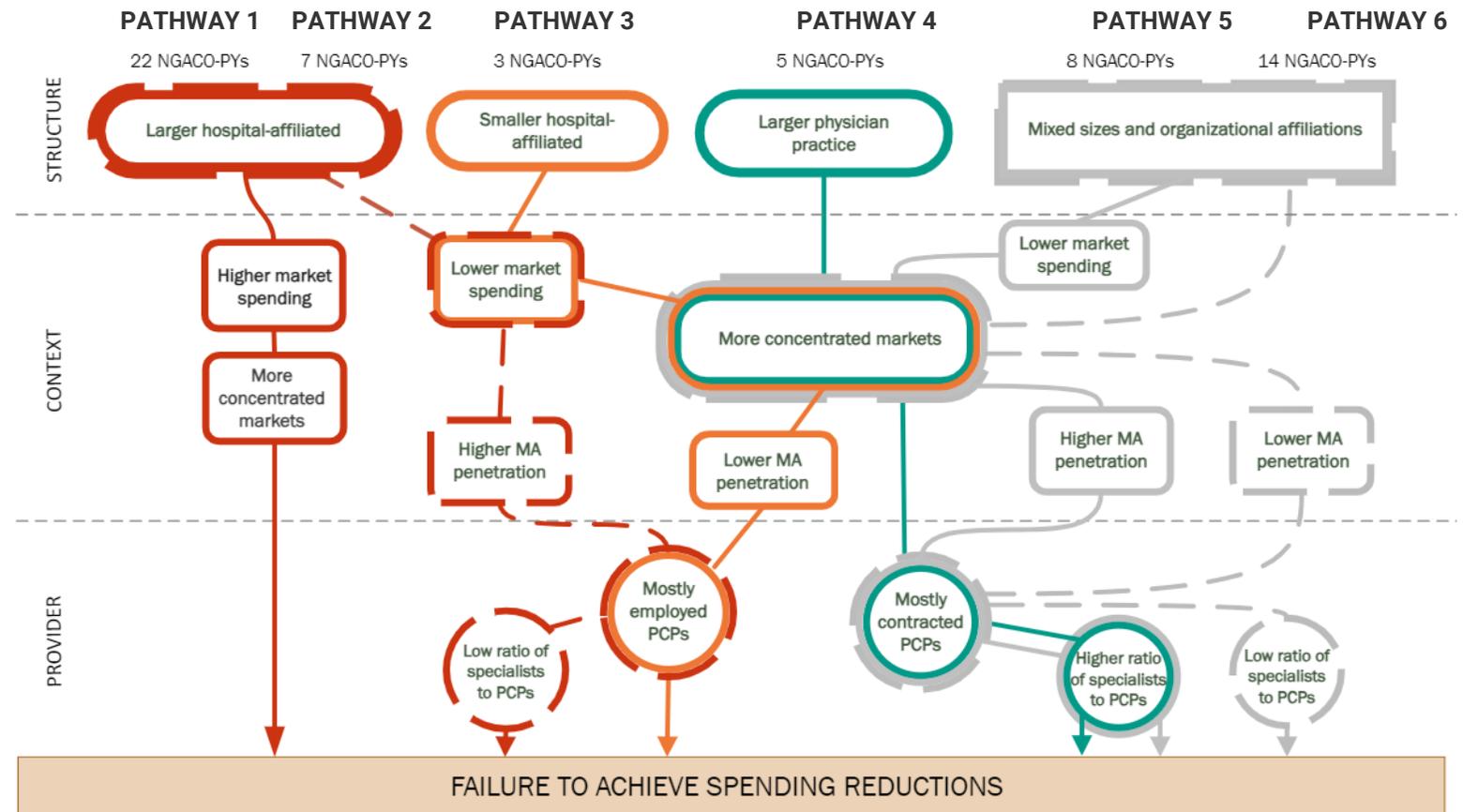
25 of 35 NGACOs reduced cumulative Medicare spending while maintaining ACSC hospitalizations, 30-day unplanned readmissions.





Pathways to Lack of Spending Reductions

Of the 225 NGACO-PYs in all years of the model, 126 failed to reduce spending.





Lessons Learned

This section summarizes what lessons we can take away from this study.

Click on each topic to learn more.

Overall Lessons

Evaluation Challenges

Model Challenges



Enabled by the model's resources and features, NGACOs reduced gross expenditures; we did not detect negative effects on quality.

NGACOs reduced spending and utilization in high-cost settings and increased preventive care using prospective alignment lists and other model resources.

Spending reductions grew over time, which may represent improvement over time but may reflect a survivor effect of more successful NGACOs remaining in the model.

Promising results for NGACO/OCM overlap suggest possible synergies with specialty care models.

There is no single pathway to reduced Medicare spending.

Success and failure in the model occurred among NGACOs in various market environments and with different organizational characteristics.



There are important challenges to consider at the evaluation level.

Most pronounced impacts during the final two PYs, which overlapped with the PHE.

This could be related to:

NGACOs building capacity in response to the model that put them in a better position to address the PHE.

Selection of higher-performing NGACOs remaining in the model.

Exit of beneficiaries aligned to GPDC from the comparison group in PY 6.

NGACOs that lowered spending, built on successes achieved in previous models.

It could also be related to:

Unmeasured differences between the NGACO and comparison groups that contributed to NGACO success.



There are important challenges to consider at the model level.

Data issues

Lack of real-time claims data

Variation in electronic health records

Beneficiary issues

Limited beneficiary awareness of the model

Leakage of beneficiaries to other models or organizations

Implementation issues

Administrative burden

Delays in receiving shared savings payments

Lack of financial predictability

[Home](#)

Glossary

This section is a collection of terms used in the study and their accompanying definitions.

Click on each box to learn more.

Definitions of Key Terms

List of Acronyms



Definitions of Key Terms

TERM	DEFINITION
Beneficiary	An individual who receives Medicare benefits.
Medicare Parts A & B	Medicare Parts A & B cover different services. Part A covers inpatient hospital stays, post-acute care (including skilled nursing facility stays & home health), & hospice care. Part B covers outpatient care, preventive services, emergency department visits that do not result in a hospital admission, & medical supplies.
Gross & net spending	Gross spending impacts represent the difference between an NGACO's effect on total Medicare spending for its beneficiaries, relative to the effect on total Medicare spending for the comparison group of beneficiaries that received usual care in their markets. Net spending is a modification of gross spending that takes into account payments distributed to an NGACO, either from shared savings or other incentive payments, & shared losses paid by NGACOs to CMS. (NGACOs received shared savings payouts from Medicare if Medicare spending for their beneficiaries was below their financial benchmarks.)
Acute hospital stay	A hospital stay to receive inpatient care for surgery, acute medical conditions, or injuries.
Population-based payment	Under a population-based payment structure, care providers are paid upfront based on the number of covered patients they serve. This is in contrast to the fee-for-service model, where providers are reimbursed after a service for each service they perform.



List of Acronyms

\$BPBY: \$ per beneficiary per year	CMMI: Center for Medicare & Medicaid Innovation	IDS: integrated delivery system	PHE: public health emergency
AAPM: advanced alternative payment model	CMS: Centers for Medicare & Medicaid Services	IRF: inpatient rehabilitation facility	PY: performance year
ACO: Accountable Care Organization	CNA: Coincidence Analysis	ISP: infrastructure payment	QCA: Qualitative Comparative Analysis
ACSC: ambulatory care sensitive conditions	DID: difference-in-differences	LTCH: long-term care hospital	QEM: qualified evaluation & management
AIPBP: all-inclusive population-based payment	E&M: evaluation & management	MA: Medicare ACO	SNF: skilled nursing facility
AWV: annual wellness visit	ED: emergency department	NGACO: Next Generation Accountable Care Organization	SSP: Shared Savings Program
BY: baseline year	FFS: fee-for-service	OCM: Oncology Care Model	
CCM: configurational comparative methods	GPDC: Global & Professional Direct Contracting	PAC: post-acute care	
CI: confidence interval	HRR: hospital reference region	PBP: population-based payment	

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