

Next Generation ACO Model



Open Door Forum

January 31, 2017

Agenda

- **Model Overview**
- Application and Selection Timeline
- Participants and Preferred Providers
- Beneficiary Alignment
- Financial Model
- Benefit Enhancements
- Letter of Intent - Section Overview and Description

Next Generation ACO Model Overview

- The Next Generation ACO Model (NGACO or the Model) is an initiative developed by the CMS Innovation Center for ACOs experienced in managing the health of populations of patients.
- The Model seeks to test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for original Medicare beneficiaries.
- The Model offers more predictable financial targets and greater opportunities to coordinate care coupled with tools to help ACOs better engage beneficiaries.

Model Principles

There are six basic principles of the Model:

- Protect Medicare Fee-for-Service (FFS) beneficiaries' freedom of choice;
- Allow beneficiaries a choice in their alignment with the ACO;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care; and
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.

Current Model Status

- NGACO is a five year initiative that began on January 1, 2016 and will end on December 31, 2020.
- The Model is structured as an initial agreement period and two option years.
- ACOs that enter the Model on January 1, 2018 will have an initial agreement period of one year before the two option years.
- There are 45 Next Generation ACOs (NGACOs) participating in the Model as of the start of CY 2017.

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Preliminary 2018

Application and Selection Timeline

Milestone	Date
Application Open	March 2017*
LOI Due Date	May 4, 2017
Application Due	May 18, 2017
Next Generation Participant List Due	June 9, 2017
Finalists Identified	August 2017
Next Generation Preferred Provider List Due	Fall 2017
Participation Agreements Signed	Late Fall 2017
Start of Performance Year	January 1, 2018

**The text of the application is currently available in Appendix G of the RFA. The application portal is anticipated to open in March 2017 and will be available via <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.*

Upcoming Open Door Forums

Date	Topic
Tuesday, February 14, 2017	Overview and LOI Information
Tuesday, February 28, 2017	Next Generation ACO Financial Methodology Overview
Tuesday, March 14, 2017	Overview of the Next Generation ACO Model Application and Participant List Process
Tuesday, March 28, 2017	Next Generation ACO Model Benefit Enhancements Overview
Tuesday, April 11, 2017	Overview of Population-Based Payments and All-Inclusive Population-Based Payment
Tuesday, April 15, 2017	Deep Dive: Completing Your Next Generation ACO Model Participant List

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Next Generation Participants and Preferred Providers

- The Model defines two categories of Medicare providers/suppliers with respect to the ACO:
 - Next Generation Participants
 - Next Generation Preferred Providers
- Next Generation Participants are the core providers/suppliers in the Model.
 - Used for beneficiary alignment.
 - Report quality through the ACO.
 - Commit to beneficiary care improvement objectives.
- Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO.
 - May participate in certain benefit enhancements and payment mechanisms.
 - Not used in alignment and do not report quality through the ACO.

Next Generation Participants

- NGACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
 - Physicians or others in group practice arrangements;
 - Networks of individual practices of physicians;
 - Hospitals employing physicians or other practitioners;
 - Partnerships or joint venture arrangements between hospitals and physicians or other practitioners;
 - Federally Qualified Health Centers (FQHCs);
 - Rural Health Clinics (RHCs); and
 - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers or suppliers, except Durable Medical Equipment (DME) suppliers and any other Prohibited Provider (as defined in the RFA), may participate in an ACO formed by one or more of the entities listed above.

Next Generation Preferred Providers

- Contribute to Next Generation goals by extending and facilitating valuable care relationships:
 - Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO;
 - May participate in benefit enhancements (as applicable);
 - May participate in PBP and AIPBP;
 - Services delivered to Next Generation beneficiaries count toward the coordinated care reward calculation (direct payments made to beneficiaries by CMS); and
 - Preferred Providers will NOT be associated with beneficiary alignment or used for quality reporting by the ACO.

Types of Next Generation Entities and Associated Functions^{1,2}

Provider Type	Alignment	Quality Reporting Through ACO	Eligible for ACO Shared Savings	PBP	All-Inclusive PBP	Coordinated Care Reward	Telehealth	3-Day SNF Rule	Post-Discharge Home Visit
Next Generation Participant	X	X	X	X	X	X	X	X	X
Preferred Provider			X	X	X	X	X	X	X

¹ This table is a simplified depiction of key design elements with respect to Next Generation Participant and Preferred Provider roles. It does not necessarily imply that this list of capabilities is exhaustive with regards to possible ACO relationships and activities.

² More information on the benefit enhancement may be found in Section VI.C.2 of the Request for Applications.

Program Overlap

- **With other Medicare models and programs:**
 - NGACOs are *NOT allowed* to simultaneously participate in other Medicare shared savings initiatives (e.g., Shared Savings Program);
 - Next Generation Participant Taxpayer Identification Numbers (TINs) *may NOT* overlap with Shared Savings Program participant TINs; and
 - Preferred Provider TINs *may* overlap with Shared Savings Program participant TINs.
- **Within the Model:**
 - Next Generation Participants that are primary care providers may participate in only one NGACO;
 - Next Generation Participants that are specialists may participate in more than one NGACO (serve an equivalent role in any other model or program in which non-primary care specialists are not required to be exclusive to one entity); and
 - Preferred Providers are not required to be exclusive to any one NGACO.

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Beneficiary Alignment

- NGACOs will earn savings or accrue losses and receive quality scores with regards to an aligned population of Medicare beneficiaries.
- Claims-based Alignment
 - Next Generation uses a two-stage beneficiary alignment methodology to prospectively align beneficiaries based on plurality of evaluation and management services.
- Voluntary Alignment
 - Enhances the claims-based alignment by allowing beneficiaries to decide on their alignment to an ACO voluntarily.
 - Available to currently- or previously-aligned beneficiaries, as well as certain other categories of beneficiaries.
 - During each performance year (PY), beneficiaries will have the opportunity to voluntarily align for the subsequent PY.
 - ACOs may select the mode(s) of beneficiary confirmation.
 - Direct provider-beneficiary communication about voluntary alignment allowed.

Beneficiary Eligibility

- During the base or performance year, the beneficiary must:
 - Be covered under Part A in January of the base or performance year and in every month of the base or performance year in which the beneficiary is alive;
 - Have no months of coverage under only Part A;
 - Have no months of coverage under only Part B;
 - Have no months of coverage under a MA or other Medicare managed care plan;
 - Have no months in which Medicare was the secondary payer; and,
 - Be a resident of the United States.
- Beneficiaries are also not eligible for inclusion in financial settlement (i.e., will be excluded from the aligned population) if:
 - The Next Generation beneficiary was a resident of a county that was part of the ACO's service area in the last month of the 2-year alignment period but was a resident of a county that was not part of the ACO's service area in the performance-year.
 - During the base- or performance-year (respectively, for base-year and performance-year aligned beneficiaries) at least 50% of Qualified Evaluation and Management (QEM) services used by the Next Generation beneficiary were from providers practicing outside the ACO's service area.

Agenda

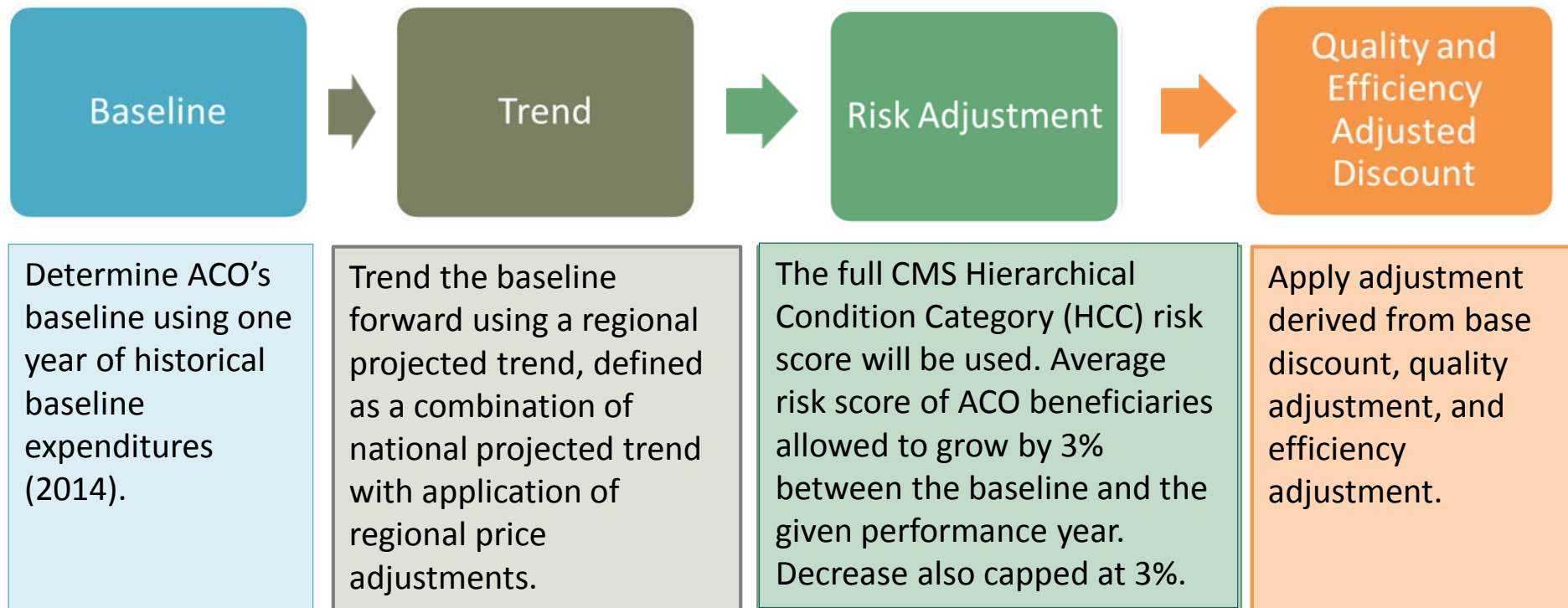
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Financial Goals and Opportunities

- Financial Goals
 - Increased ACO financial risk;
 - Long-term fiscal sustainability; and
 - Benchmark predictability and stability.
- ACO Opportunities
 - Greater financial risk coupled with a greater portion of savings; and
 - Flexible payment options that support ACO investments in care improvement infrastructure to provide high-quality care to patients.

Components of the NGACO Benchmark

The benchmark will be **prospectively set prior to the performance year** using the following four steps¹:



¹ Benchmark will be prospectively set with retrospective adjustments based on final risk adjustment and quality score information.

Baseline

- NGACO model uses a **one-year baseline** (2014).
- **Shared Savings Program** uses (and former Pioneer ACO Model used) a three-year baseline, trending the first two baseline year expenditures to the third baseline year.¹
- NGACO one-year baseline **significantly reduces complexity** of savings/loss calculation by eliminating multi-year baseline trending.

¹ In these models/programs, Baseline Year 1 and Baseline Year 2 are trended to Baseline Year 3 by factors accounting for the change in state expenditures, risk scores, and (for the Pioneer ACO model in Performance Years 4 and 5) regional price adjustments (the Pioneer model sometimes refers to the latter as “locality price adjustments”

Trend

The baseline will be trended forward using a regional projected trend:

- National projected trend similar to that currently used in Medicare Advantage (MA).
- Regional prices applied to the national trend.
- Under limited circumstances, CMS may adjust the trend in response to payment changes with substantial expected impact (negative or positive) on ACO expenditures.

Risk Adjustment

- Key background concept: NGACO benchmark is **cross-sectional**, which means that:
 - Alignment algorithm applied to baseline year, and **then separately** to performance year¹
 - **Populations in these two time periods will overlap but be different** – some beneficiaries will be aligned in baseline year but not performance year, while some beneficiaries will be aligned in performance year but not baseline year (e.g., because of changes in utilization patterns, changes in provider/market landscape, etc.)
- Risk adjustment is meant to **adjust for the difference** between the baseline and performance-year populations²
- **CMS HCC model** used to determine average risk score of baseline year population and average risk score of performance-year population²
- Increase in average risk score **capped** at 3% cap. Decrease in HCC risk score will also be **capped** at 3%
 - PY3: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2018
- **Risk adjustment initially set prospectively, but retrospectively adjusted** for final reconciliation when "final risk scores" become available after the performance year³

¹ In contrast, a "cohort methodology" aligns beneficiaries once to the performance year and looks at expenditures for this same group of beneficiaries in the baseline year (i.e. this cohort is followed over time). The Pioneer ACO model used a cohort methodology from Performance Years 1 – 3 (2012 – 2014). A cross-sectional methodology is used by the Pioneer ACO model in Performance Years 4 – 5 (2015 – 2016) and the Shared Savings Program.

² The "baseline year population" and the "performance year population" are also referred to as the "baseline year panel" and the "performance panel" in certain Pioneer / Shared Savings Program documents – a panel here simply refers to a group of beneficiaries which may overlap with other panels

³ Note that HCC scores are based on diagnoses in claims for the year prior to the performance year. As an example, consider Performance Year 2 (2017). Performance year risk scores are based on prior-year claims (i.e. claims incurred in 2016). The HCC methodology does not allow for final calculation of these performance year risk scores until early-to-mid 2018. The benchmark, however, will be prospectively set based on currently available information at the time, and CMS is exploring options for updating benchmark based on interim risk score information available prior to the final scores becoming available.

Quality- and Efficiency-Adjusted Discount

- The NGACO benchmark will be calculated by applying to the trended, risk-adjusted benchmark an efficiency- and quality-adjusted discount. The adjusted discount is the sum of four components:
 - A standard discount of -2.25%.
 - A quality adjustment to the standard discount of up to +1.0%
 - A regional efficiency adjustment of $\pm 1.0\%$
 - A national efficiency adjustment of $\pm 0.5\%$
- The quality- and efficiency-adjusted discount for an NGACO thus can vary from -0.0 to -3.75% **(assuming a +1.0% quality adjustment for an ACO's first year in the Model, range is from -0.0 to -2.75%)**
- A separate quality-adjusted and efficiency-adjusted discount will be calculated for Aged/Disabled and ESRD beneficiaries.
- The efficiency adjustments will be calculated separately for Aged/Disabled and End Stage Renal Disease (ESRD) beneficiaries and may differ. The same quality adjustment will apply to each entitlement category however.

Alternative Benchmark Methodology (2019-2020)

- Principles for alternative benchmark methodology:
 - Eliminate or further de-emphasize the role of recent ACO cost experience when updating the baseline;
 - Take into account public comments received in response to the Shared Savings Program Notice of Public Rulemaking (NPRM) from January 2016 on alternative benchmark approaches;
 - Shift to valuing attainment more heavily than year-over-year improvement;
 - Consider the use of a normative trend;
 - Continue to refine risk adjustment for beneficiary characteristics that balances changes in disease burden against more complete coding;
 - Consider adjustments reflecting geographic differences in utilization or price changes.
- CMS intends to provide additional detail by the end of 2017.

Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
<p>Parts A and B Shared Risk</p> <ul style="list-style-type: none">• 80% sharing rate (PY1-3, 2016-2018)• 85% sharing rate (PY4-5, 2019-2020)• 5-15% savings/losses cap (elected annually by each ACO)	<p>100% Risk for Parts A and B</p> <ul style="list-style-type: none">• 5-15% savings/losses cap (elected annually by each ACO)

- Benchmarks calculated the same way for both arrangements.
- Different sharing rates affect ACO risk.
- For both arrangements, individual beneficiary expenditures capped at the 99th percentile of expenditures to moderate outlier effects.

Payment Mechanisms

Payment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: All-Inclusive Population-Based Payments
Medicare payment through usual FFS process.	Medicare payment through usual FFS process plus additional per-beneficiary per-month (PBPM) payment to ACO.	Medicare payment redistributed through reduced FFS and monthly payment to ACO.	Medicare payment redistributed through 100% FFS reduction and monthly payment to ACO; Next Generation responsible for paying claims for participating Next Generation Participants and Preferred Providers.

- Goals of payment mechanisms:
 - Offer ACOs the opportunity for stable and predictable cash flow; and
 - Facilitate investment in infrastructure and care coordination.
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.

Infrastructure Payments

- All claims paid through normal FFS reimbursement.
- The ACO chooses an additional per-beneficiary per-month (PBPM) payment unrelated to claims.
- Maximum payment rate: \$6 PBPM
- All infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses.

Population Based Payments (PBP)

- ACO determines a percentage reduction to the base FFS payments of Next Generation Participants and/or Preferred Providers.
- ACO may opt to apply a different percentage reduction to different subsets of PBP-participating providers (reductions may vary by TIN).
- Next Generation Participants and Preferred Providers with PBP must agree in writing to the percentage reduction.
- CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments.

All-Inclusive Population-Based Payments

- ACOs elect to participate in AIPBP and Next Generation Participants and/or Preferred Providers agree to receive 100 percent FFS reduction.
- ACO is responsible for paying claims for Next Generation Participants and Preferred Providers receiving reduced FFS.
- Claims process:
 - All participants submit claims to CMS as normal.
 - CMS sends ACOs claims information for those services.
 - ACOs are responsible for making payments.
- CMS will continue to pay normal FFS claims for care furnished to Next Generation beneficiaries by Next Generation Participants and Preferred Providers not participating in AIPBP (as well as care furnished by all other Medicare providers and suppliers).

Financial Reconciliation

- Savings or losses determined by comparing total Parts A and B spending for aligned beneficiaries to the benchmark.
 - Individual expenditures capped at the 99th percentile.
- Risk arrangement determines ACO's share of savings or losses.
- Annual savings payment or losses recoupment occurs following a year-end financial reconciliation.
- Additional accounting for monthly payments that occurred during the performance year through PBP, infrastructure payments, or AIPBP.
 - May result in monies owed from CMS to the ACO, or vice versa.

Financial Guarantees

- NGACOs are required to have in place a financial guarantee, equivalent to 2% of baseline expenditures.
- NGACOs are required to comply with all applicable state laws and regulations regarding provider-based risk-bearing entities.

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Benefit Enhancements

- Medicare payment rule waivers are designed to improve care coordination and cost-saving capabilities:
 - [Telehealth expansion](#);
 - [Post-discharge home visit](#); and
 - [3-Day SNF rule waiver](#).
- ACOs may decide which benefits to implement, if any.
- For each, ACOs will submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

3-Day SNF Rule Waiver Overview

- Eliminates the requirement of a 3-day inpatient stay prior to SNF (or swing-bed CAH) admission.
 - Available to aligned beneficiaries of Next Generation Participants or Preferred Providers.
 - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing/rehab need.

Telehealth Expansion Overview

- Elimination of geographic (rural) component of originating site requirements.
- Beneficiaries may receive telehealth services from place of residence.
- Telehealth services including Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes remain unchanged.

Post-Discharge Home Visits Overview


- A licensed clinician under the *general supervision* – instead of direct – of a Next Generation Participant or Preferred Provider may bill for “incident to” services at an aligned beneficiary’s home.
- Such services may be furnished not more than one time in the first 10 days following discharge from an inpatient facility (hospital, CAH, SNF, IRF) and not more than one time in the subsequent 20 days.

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Letter of Intent


Next Generation ACO Model
Letter of Intent



Organizations interested in applying to the Next Generation ACO Model must submit a Letter of Intent (LOI). LOIs will be used only for planning purposes, and the content of the LOI will not be binding. CMS will not consider applications from organizations that do not submit a timely LOI.

Uploading the signature certification page prior to submission of the LOI is required. Please download the signature certification page prior to filling out the LOI to avoid losing any information you may have entered in the event of internet connectivity or power issues.

***[CLICK HERE TO DOWNLOAD Signature Certification](#)

 DO NOT use your browser's back page function or navigate away from this page while completing your LOI. Doing so will cause you to lose information that you have entered into your LOI. If you navigate away from this page, all information that you entered will be lost.

- In order to apply for the NGACO Model, interested organizations must first submit a [Letter of Intent](#) (LOI).
- The LOI will take about 10-15 minutes to complete.
- Contents of the LOI are not binding and will only be used for planning purposes.

Letter of Intent

- The LOI cannot be saved while in progress—do not press the back button or navigate away from a page.
 - Applicants should have all information and supporting documents ready before starting the LOI.
 - Download the [Signature Certification PDF](#) prior to beginning the LOI.
- Once the LOI has been submitted, the primary contact will receive a confirmation e-mail with a unique LOI number.
- The LOI number can be used to access the full application.

Sections of the LOI

- Section A. Organization and Contact Information
- Section B. Letter of Intent
- Section C. Supplemental Survey (Optional)
- Section D. [Signature Certification](#) and Submission

Section A. Organization and Contact Information

- Includes basic questions on applicant organization contact information and organization TIN.

Section A. Organization and Contact Information

All fields in **bold** are required.

1. Applicant's Name

Organization Name **Doing Business as (If applicable)**

Organization Type

Organization TIN/EIN

Street Address

City **State** **Zip Code**

Website (if applicable)

2. Applicant's Primary Contact

Primary Contact's First Name **Primary Contact's Last Name**

Title/Position **Email Address**

Business Phone Number **Business Phone Number Extension** **Alternative Phone Number (e.g. cell phone)**

Section B. Letter of Intent

- Applicants are asked to identify:
 - Initiatives they are currently participating in or have applied to in the past;
 - Medicare ACO name and number, if applicable;
 - Anticipated transition of the Applicant ACO to the NGACO Model (entire transition or partial transition);
 - Participation in an ACO with a payer other than Medicare, if applicable;
 - Number of rural counties the proposed ACO will serve; and
 - Expected number of aligned Medicare beneficiaries.

Estimating Number of Aligned Medicare Beneficiaries

- If available, the applicant should use the most recent count of aligned beneficiaries that it has from its current ACO initiative or program.
- If the ACO is new, the applicant can use an estimate based on Medicare beneficiaries treated by the ACO's primary care physicians.
- During the application review period, CMS will perform a minimum beneficiary count for all applicants.
 - This count will determine whether beneficiaries are eligible for alignment under this Model, based on qualifying services received from participants included in the application for the NGACO.

Rural ACOs

- Rural ACO is defined in Appendix B of the Request For Application (RFA).
- Applicant ACOs are considered rural if any of its primary service areas are located in a rural county.
 - More information on primary service area:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Calculations.html>
- Counties not designated as parts of metropolitan areas by the Office of Management and Budget, census tracts with Rural Urban Commuting Area Codes (RUCA) 4 through 10, and micropolitan areas will be considered rural for the purposes of the Next Generation Model.
 - More information on RUCA codes: <http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx>

Section C. Supplemental Survey (Optional)

Section C. Optional Supplemental Survey

CMS is seeking to understand the characteristics of provider organizations interested in participating in the Next Generation ACO Model. The information gathered through questions S1-S6 below will help CMS understand the conditions under which the initiative can be implemented and the extent to which interventions are applicable to the general provider community. Your participation is strictly voluntary. Your eligibility for participating in the initiative will not be affected by your answers or decision to respond to any of the questions below. Further, your response(s) or decision to respond will not be known to application reviewers nor will information from this survey be added to your application file.

S1. This question asks about the relative importance of the following factors in your interest in participating in the Next Generation ACO Model. On a scale ranging from 1 to 5 where 1 is “not relevant” and 5 is “highly relevant,” rate each of the following factors with regards to your decision to participate. List additional factors as applicable.

To drive improvements in population-based care.

Please Select

To be market-leading or to remain competitive in the market place.

Please Select

To gain experience operating in an outcome-based revenue arrangement.

Please Select

To expand upon efforts led by non-Medicare payers or entities.

Please Select

To accelerate provider integration (e.g., between physicians and hospitals).

Please Select

To improve or maintain financial performance within the next 3-5 years.

Please Select

- Applicants are asked to identify the relevance of specific factors that impact organizations’ decisions and interest in participating in the NGACO Model.
- Questions use a scale from 1 to 5, where 1 is “not relevant” and 5 is “highly relevant.”
- Participation is strictly voluntary. Eligibility for participation in the initiative will not be affected by applicants’ answers or the decision to respond to any of the questions.

Section D. Signature Certification and Submission

Section D. Signature Certification and Submission

All fields in **bold** are required.

Please download, complete, and then upload the Signature Certification per the instructions provided below.

- Print the Signature Certification, fill in the requested information, and sign the document;
- Scan and save the executed Signature Certification;
- Select the "Upload and Submit" button to upload the executed Signature Certification to the LOI.
- When complete, select "Save and Submit LOI". This will complete the LOI submission process.

*****CLICK HERE TO DOWNLOAD [Signature Certification](#)**

Please click below to upload the Signature Certification and then submit your LOI.

Upload and Submit

- The certificate must be signed by someone in the organization with the authority to submit the LOI.
- Organizations should download and fill out the [Signature Certification PDF](#) prior to beginning the LOI.
- The LOI submission process is complete once the certificate has been uploaded and submitted.

Questions?

Next Generation ACO Model Webpage:

<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

E-mail: NextGenerationACOModel@cms.hhs.gov

Technical Support: CMMIForceSupport@cms.hhs.gov