"Next Generation" Accountable Care Organization: A New Model from CMS

On March 10, 2015, the Centers for Medicare and Medicaid Services ("CMS") announced the newest iteration of accountable care organization ("ACO") models. The "Next Generation" model continues CMS's efforts to incentivize Medicare providers, through shared savings opportunities, to redirect the care delivery system toward quality and value, not volume, of care.

The new model will build on the experience gleaned from the existing Pioneer and Medicare Shared Savings Program models. These models permit ACOs to retain a percentage of the Medicare savings generated through their coordinated care efforts. While the existing ACO models remain available, the Next Generation initiative is based on two central features that will differentiate it from its predecessors:

- The Next Generation model will allow an ACO to reap greater financial rewards, in exchange for assuming a larger share of financial risk, than under the Shared Savings or Pioneer models.
- Participating ACOs will be able to offer beneficiaries significant "benefit enhancements" designed to encourage more active engagement between the ACOs and the patients they serve.

In order to support the heightened risk and reward potential, the new ACOs will feature different financial terms than are available under the previous models. Next Generation ACOs will be able to choose between the following payments models:

- **Traditional Fee-for-Service ("FFS"):** Next Generation ACO providers can be paid through normal FFS channels at standard reimbursement levels, as in the standard ACO model.
- **FFS Plus a Monthly Infrastructure Payment:** In addition to receiving normal FFS reimbursements, Next Generation ACOs can receive a per-beneficiary per-month ("PBPM") payment allowing the ACO to invest in infrastructure to support its coordinated care activities. These payments will be no higher than $6 PBPM and will be recouped by CMS during reconciliation, irrespective of savings or losses realized by the ACO. In order to qualify for this payment model, an ACO will be required to maintain a financial guarantee large enough to ensure the repayment to CMS.
- **Population-Based Payments ("PBP"):** This payment model provides monthly payments to ACOs to support ongoing activities and allows greater flexibility in the types of arrangements the ACO can enter into with providers. ACOs and providers will agree on a percentage reduction to FFS payments that otherwise would be made. CMS will then pay the ACO the amount by which the full FFS rates have been reduced pursuant, essentially funding ACO capital in real time through reduced FFS payments.
- **Full Capitation:** Under the capitation model, CMS will estimate the total annual expenditures for the ACO's beneficiaries and will pay that amount to the ACO in monthly installments. The ACO then assumes the responsibility for paying its providers for the services they have provided to the ACO's beneficiaries at rates negotiated between the ACO and its providers. CMS will continue to pay normal FFS claims provided by providers and suppliers with whom the ACO does not have a capitation agreement.

The financial benchmark used to evaluate an ACO's success in reducing health care expenditures will change as well. The Next Generation model will use a more predictable, stable benchmark that is set prospectively by CMS at the start of each performance year, rather than at the end of each year, as with the Pioneer and Shared Savings Program models. The benchmark will also be amended to reflect the concerns of ACOs

under the previous models. Under those models, an ACO's success was measured in relation to its increased efficiency compared with its past performance. ACOs have expressed concerns that this measurement system penalized ACOs that had already achieved high levels of efficiency, as it is difficult to generate significant increases in cost savings year after year. Responding to these concerns, CMS will alter the Next Generation benchmark calculation by taking into account not only an ACO's historical performance, but also its regional and national efficiency compared to peers. This may allow historically efficient ACOs to continue to hit critical benchmarks despite decreased relative improvement over time. While the benchmark calculation methodology has been set for the first three Performance Years of the Next Generation ACO, CMS has specifically reserved the right to alter the Participation Agreement in Performance Years 4 and 5 to respond to experience acquired in the early stages of the Next Generation model's existence.

In addition to these new financial features, the Next Generation model includes several "benefit enhancements" intended to mitigate the higher risk inherent in the Next Generation system by encouraging beneficiaries to seek higher rates of care from the ACO with which they are aligned. These "benefit enhancements" include:

- **Co-Pay Waivers:** A Next Generation ACO will be permitted to reduce or even eliminate co-pays for "high-value" services, such as preventative care, in exchange for a beneficiary's voluntary alignment with a Next Generation ACO. The reduction of such co-pays is intended to encourage more preventative care visits, which, in turn, could contribute to the reduction of health care expenditures over time.
- **Beneficiary Coordinated Care Reward:** Under the Next Generation model, beneficiaries retain their freedom of provider choice, allowing them to seek care outside of the ACO network. However, beneficiaries who obtain a high rate of care from providers in the ACO with which they are aligned will become eligible for cash rewards from CMS, thereby incentivizing more active engagement by beneficiaries. These rewards are expected to equal around $50 and will be paid semi-annually.
- **Increased Coverage for Skilled Nursing Facility Care:** A qualified Next Generation ACO will be exempt from the three-day inpatient stay requirement for admissions to skilled nursing facilities.
- **Telehealth Expansion:** CMS will reimburse telehealth services for aligned Next Generation ACO beneficiaries regardless of where they live. This contrasts with standard payment rules, under which reimbursement for telehealth services generally is available only for beneficiaries who live in rural areas.
- **Post-Discharge Home Visits:** Next Generation ACOs will also be able to offer, with "incident to" reimbursement, in-home services to beneficiaries after their discharge from an inpatient facility. Such visits will be limited to no more than one in the first ten days after discharge and one more in the twenty days thereafter.

In addition to benefitting Next Generation-aligned patients, the expansion of telehealth, SNF, and post-discharge visit coverage also provides an incentive for providers to affiliate with a Next Generation ACO in order to take advantage of these new reimbursement opportunities.

In another important shift from the previous Pioneer and Shared Savings Program models, Next Generation ACOs will be required to operate under risk-based contracts with commercial payors, in addition to governmental payors. By instituting this requirement, CMS appears to be attempting to stimulate similar cost-reduction models in the private health care insurance sector as well. This requirement, however, may be an impediment to forming a Next Generation ACO in areas where such risk-based provider contracts are less prevalent.

Due to the specifics of the new model, particularly the heightened risk ACOs will be required to assume, the Next Generation ACO will likely be most attractive to large provider organizations that have experience in delivering advanced coordinated care to specific populations. Provider groups must have a beneficiary population of over 10,000 to be eligible to qualify as a Next Generation ACO. The Shared Savings and Pioneer models require only 5,000 beneficiaries to qualify.

CMS has stated that it expects 15 to 20 providers to participate in the Next Generation model. CMS will accept applications in two rounds, on June 1, 2015 and June 1, 2016. In order to be eligible to submit an application in the first round, interested organizations must submit a Letter of Intent by May 1, 2015. Applicant organizations that are accepted into the program are expected to commence operations on January 1, 2016.

If you have any questions, please do not hesitate to contact your usual Ropes & Gray contact.