# Some Considerations Before New ACO Generation Arrives

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The May 1, 2015, deadline for filing a letter of intent is approaching for those health care organizations that wish to apply for the "Next Generation Accountable Care Organization Model" offered by the Innovation Center at the Centers for Medicare & Medicaid Services.

In this new model, CMS updates and expands the possible payment models for ACOs in the Medicare Shared Savings Program. This Next Generation ACO allows ACOs to assume a higher level of financial risk and reward than is currently available in current Medicare ACO initiatives. Under the initial ACO model, called Pioneer ACOs and the prior MSSP, ACOs could choose between an upside-risk-only contract (i.e., sharing in savings; no risk for losses) or an upside/downside-risk contract (i.e., sharing in savings while being at risk for losses). The Next Generation Model includes more options for payment mechanisms (as described below) but requires both upside/downside risk (a.k.a., two-sided risk). Based on the history of the MSSP ACO program, it remains unclear how many health care organizations will be interested in assuming downside risk — even with the proposed cap on the financial risk — which is required in the Next Generation Model.

According to CMS' website, there are currently 405 ACOs participating in the MSSP program. Historically, fewer than half of the ACOs participating in any given year achieved shared savings and a significant number of those ACOs did not achieve the necessary performance on quality metrics to receive any payment for such savings. Therefore, it is not surprising that a survey of executive members of the National Association of Accountable Care Organizations, as quoted in Health Affairs Blog, revealed that a sizable majority (67 percent) of MSSP members were unlikely to sign up for a second three-year contract in which they must accept two-sided risk.

According to CMS, the goal of the Next Generation ACO Model is to address these concerns about two-sided risk by revising the financial models that are available and tackling some of the historic issues with benchmark data to achieve the required performance targets and/or financial savings.

Some of the key features of the Next Generation ACO Model are:

- Beneficiaries who are attributed to the ACO maintain their original Medicare benefits, consistent with existing ACO models, including open access to all health care providers of their choice.

- The benchmark data will be set prior to the start of a performance year, rather than CMS establishing final updated benchmarks at the end of each performance year as is the case with prior ACO models.

- Four payment mechanisms are available: (1) normal fee-for-service; (2) normal fee-for-service plus monthly infrastructure payment; (3) population-based payments; and (4) capitation (beginning in 2017).

- Two options for risk-sharing arrangement: (1) increased Parts A and B shared risk of 80 percent in years one through three and 85 percent in years four through five, with 15 percent savings/loss cap; and (2) full-performance risk with 15 percent savings/loss cap.

- Consistent calculation of all ACO benchmarks, regardless of the payment mechanism and risk arrangement chosen by the ACO.

- CMS has the ability to adjust the experience trend in response to price changes that have a substantial impact on ACO expenditures to prevent an ACO from being unfairly penalized or rewarded for major payment changes beyond its control.

- Relative efficiency is incorporated into the discount calculation, as well as the ability to develop a long-term benchmarking methodology for the ACO's performance in years four and five to address concerns about the increasing difficulty of achieving savings each year.

- Unlike current MSSP and the Pioneer Model, CMS will not utilize a minimum savings rate and will apply an individualized discount for each ACO once its benchmark basis has been calculated, trended and risk adjusted.

- Voluntary attribution of beneficiaries is allowed in addition to attribution based on historic claim data.

- CMS will continue to apply prospective CMS Hierarchical Condition Category risk scores to both the baseline and performance year populations, but this HCC risk score will be capped at 3 percent annually (for both growth and decrease in the score).

CMS has stated that a detailed financial methodology paper will be made available to potential participants prior to the signing of the participation agreement. In the meantime, the general outline of the financial design elements can be found in CMS Next Generation ACO Model request for applications here.

To help improve beneficiary engagement with the ACO, the Next Generation ACO Model includes specific benefit enhancement tools, including:

- Greater access to home care visits, telehealth services and skilled nursing facilities.

- Opportunities for beneficiaries to receive reward payments for receiving care from the ACO, although each beneficiary maintains his or her freedom of choice in regard to providers.

- A process for beneficiaries to confirm their care relationships with ACO providers.

- Greater collaboration between CMS and ACOs to improve communication with beneficiaries about the nature of ACOs and the potential benefit to their care.

CMS understands that number of organizations interested in becoming a Next Generation Model ACO may be limited to those organizations that have demonstrated previous success in two-sided risk models.

Counsel to ACOs need to help their clients focus on the applicant eligibility and regulatory requirements including:

- An appropriately formed legal entity which is authorized to conduct business in each state in which it operates.

- Appropriate regulatory approvals and/or licenses in the ACO's respective state(s) that govern the assumption of insurance risk by providers including, in some cases, the need to demonstrate

adequate reserves to cover potential losses, or a licensure as a third-party administrator, utilization management reviewer or insurance company.

- A governing body with at least 75 percent control by ACO providers/suppliers or their representatives and at least one Medicare beneficiary served by the ACO. These requirements often require an ACO-specific legal entity and governing body which is distinct from the health care organization.

- A conflict of interest policy that meets certain defined criteria and approved by CMS.

- The absence of any regulatory or accreditation investigations that would raise concern during CMS' program integrity review.

Lastly, although not specifically addressed in CMS' application process, an ACO requires appropriate (and often separate) insurance policies to mitigate financial and legal risks. Such coverage includes: (a) stop loss to address the financial risk for medical costs, (b) professional liability or management errors and omissions that cover the broad spectrum of ACO activities, including potential bodily harm for allegations of denied or missed care, (c) cybersecurity to address the risks associated with data privacy and security and (d) director and officer insurance for the governing board.

Any organization that meets the applicant eligibility requirements, including existing MSSP ACOs or Pioneer ACOs, may apply to be a Next Generation ACO even if the organization is in midcycle of its current ACO status. For those organizations with interest in being approved as a Next Generation ACO, the application can be found here.

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