Alternative Payment Mechanisms in the Next Generation ACO Model
INTRODUCTION

This document provides a discussion of Next Generation ACOs and their ability to execute negotiated financial arrangements directly with providers. Included are an overview of the Next Generation ACO model, a case example of how NGACO’s may pay using a non-fee-for-service payment model in which the NGACO pays providers directly rather than CMS, and a series of FAQs.

Next Generation ACO Overview

The Next Generation Accountable Care Organization (NGACO) model is the latest ACO model being tested by the Center for Medicare and Medicaid Innovation (CMMI). In January, 21 organizations were announced as the first Next Generation ACO cohort; the map below shows where they are located. Click here to see the full list of participant organizations.

Figure 1: Location of Next Generation ACOs, Cohort 1 (January 2016)¹

The Next Generation ACO model builds upon experience from the Pioneer ACO model and the Medicare Shared Savings Program. NGACOs will be able to take advantage of various program waivers and policy options intended to give them the tools necessary to manage their patient populations within a fee-for-service environment. Among these policies is the option for Next Generation ACOs to execute flexible, non-fee-for-service payment mechanisms with other providers, including skilled nursing facilities. For each year of their performance agreement with CMS, Next Generation ACOs may choose to operate under one of four payment mechanisms.

Mechanisms #1 and #2 are standard fee-for-service (FFS) arrangements whereby providers will continue to be paid normal FFS rates, while Mechanisms #3 and #4 will allow preferred providers to engage in non-fee-for-service arrangements with Next Generation ACOs. Each mechanism is discussed in more detail in the next section.

ALTERNATIVE PAYMENT MECHANISMS

Fee-for-Service Payment Mechanisms

Mechanism #1: Normal fee-for-service (FFS) payment
ACO participants and preferred providers would be paid by CMS for services performed through the normal FFS channels at standard payment levels. This option represents no change from Original Medicare.

Mechanism #2: Normal FFS payment + monthly infrastructure payment
ACO participants and preferred providers receive normal FFS reimbursement, and the ACO receives an additional per-beneficiary per-month (PBPM) payment unrelated to claims. The ACO may use the additional revenue to invest in the infrastructure needed to support ACO activities. Preferred providers, such as skilled nursing facilities, will continue to be reimbursed at normal FFS rates with no additional monthly payments.

Figure 2: Flow of Payments in Mechanism #2
Non-Fee-For-Service Payment Mechanisms

Mechanism #3: Population-based payments (PBP)

PBP, also known as "partial capitation," provides Next Generation ACOs with a monthly payment to support ongoing ACO activities and allows flexibility in the types of arrangements the ACO enters into with its Next Generation Participants and Preferred Providers. The PBP is an estimate of the total amount by which FFS payments will be reduced for Medicare Part A and B services rendered by PBP participating Next Generation Participants and Preferred Providers who agree to accept Reduced FFS Payments when providing care to aligned beneficiaries during the upcoming Performance Year. This estimate will be based on available data on payments to Next Generation Participants and Preferred Providers participating in PBP for the applicable performance year for services that were provided to aligned beneficiaries during the 12-month period immediately prior to the performance year.

Not all Next Generation Participants and Preferred Providers must agree to receive Reduced FFS Payments for the ACO to participate in PBP and not all Next Generation Participants and Preferred Providers billing under a TIN must agree to receive Reduced FFS Payments for the TIN to participate in PBP. Next Generation Participants and Preferred Providers participating in PBP must agree to permit CMS to reduce their Medicare reimbursement for aligned beneficiaries by the specified percentage.

A Next Generation ACO will determine a percentage reduction to the FFS payments of its Next Generation Participants and Preferred Providers participating in PBP. An ACO may opt to apply a different percentage reduction to different subsets of its Next Generation Participants and Preferred Providers. CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments. When PBP-participating Next Generation Participants and Preferred Providers submit claims to CMS for services rendered to aligned beneficiaries, the payment will be reduced by the agreed upon amount.

The reductions to FFS payments do not affect the calculation of Shared Savings/Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the fee reduction. The reconciliation of PBP payments and reductions in FFS payments determines the net amount owed by either CMS or the Next Generation ACO as the difference between the total PBP payment amount paid during the Performance Year and the actual amount of the FFS reductions for PBP-participating Next Generation Participants and Preferred Providers.

Figure 3: Flow of Payments in Mechanism #3
Mechanism #4: All-inclusive population-based payments (AIPBP)

All-Inclusive Population-Based Payments (AIPBP), also known as “full capitation,” will be determined by estimating total annual expenditures for care furnished to aligned beneficiaries by Next Generation Participants and Preferred Providers who have agreed to participate in AIPBP and CMS will pay that projected amount to the ACO in a PBPM payment. A Next Generation ACO participating in AIPBP will be responsible for paying claims for its Next Generation Participants and Preferred Providers with which the ACO has written agreements regarding participation in AIPBP. ACOs will not be required to pay 100 percent of FFS rates to Next Generation Participants and Preferred Providers participating in AIPBP; ACOs may have alternative compensation arrangements with these providers consistent with all applicable laws. Next Generation Participants and Preferred Providers that have agreed to participate in AIPBP will continue to submit claims to CMS for processing, and CMS will continue to be responsible for confirming beneficiary eligibility. ACOs must establish a process for payment disputes from Next Generation Participants and Preferred Providers participating in AIPBP, the requirements for which will be detailed in the Model Participation Agreement.

On an ongoing basis, CMS will send Next Generation ACOs claims information for those services for which the Next Generation ACO is responsible for making payment.

CMS will continue to pay normal FFS claims for care provided to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers not covered by an AIPBP agreement, as well as care furnished to aligned beneficiaries by Medicare providers/suppliers that are not Next Generation Participants or Preferred Providers. AIPBP is a payment mechanism and does not affect the Next Generation ACO’s benchmark. As with all of the Next Generation payment mechanisms, Next Generation ACOs will also have a separately calculated benchmark, which determines the savings in which the ACO may share or the losses for which the ACO is accountable. While CMS will not be actually making payment on a subset of FFS claims for aligned beneficiaries, CMS will use the FFS amount that would have been paid in conducting financial reconciliation. CMS will separately reconcile the AIPBP. Monthly AIPBP amounts will be calculated prior to the start of the performance year by estimating the proportion of care to be delivered by Next Generation Participants and Preferred Providers that have agreed to participate in AIPBP and accept a 100% FFS reduction. At the end of year, CMS will reconcile the estimation versus claims that were actually reduced. This reconciliation may result in monies owed from the ACO to CMS, or vice versa. This accounting is separate from the savings and losses calculation (similar to the PBP payment mechanism).

Figure 4: Flow of Payments in Mechanism #4
POSSIBLE AIPBP PAYMENT APPROACH: EPISODIC MODEL

Overview of an AIPBP-episodic Approach

NGACOs could pay using a variety of different methods including sub-capitation to groups of providers or payments design for specific provider types. For post-acute care (PAC) providers, NGACO’s could examine PAC expenditures for attributed beneficiaries. Upon arriving at PAC costs, NGACO’s might arrive at the conclusion that paying using an episode-based payment system for all PAC providers would be the easiest to implement. Long-Term Acute Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRF), and home health agencies (HHA) already are paid using a stay or episode of care systems and have experience with such systems. NGACOs could replicate the existing PAC PPS for these provider types and simply discount the episode rates offering some gainsharing for providers who achieve quality measures when aiding the NGACO with staying achieving its Medicare saving targets and/or under a discounted episode rate.

For skilled nursing centers (SNFs), NGACOs would need to develop an episode-based payment system because SNFs still are paid using a per diem system. To arrive at such a system NGACOs might examine attributed beneficiaries’ SNF admission conditions. Upon studying the admission conditions, NGACOs would define a set of condition categories which make up the majority of SNF admissions. The specific condition related episodes of care might be defined as a broad range of clinically similar SNF stays that are very common across the spectrum of SNFs. Nationally, the top four conditions which drive SNF admission are lower extremity orthopedic surgery, major organ failure, respiratory conditions and sepsis and other infections. When determining the condition categories and related base rates, lengths of stay (LOS) by condition category also would need to be defined. LOS could be established by examining existing LOS within the SNF PPS.

In addition to the dominant condition categories, default condition categories and related episodes of care would need to be defined for stays that do not meet the criteria for the specific episodes of care. Stays within these episodes likely would be very diverse and generally lower volume clinical situations, but may have some defining characteristics such as surgical aftercare, as distinct from medical post-acute care.

Each patient could be assigned to a condition related episode of care category by physicians, or other clinicians, prior to SNF admission. Assignment should not be associated with MS-DRGs. Research has shown that MS-DRGs are a poor predictor for PAC services. Within a certain period of time, a resident assessment might be conducted to validate the physician condition category assignment, establish a plan of care, and provide data for risk adjustment (see below). At the time the resident is admitted to the SNF, the SNF admission team would obtain clinical information about the resident’s reasons for needing SNF care. This information would be coded and recorded on SNF claims with documentation and certification by a physician in the medical record.

Costs associated with all medical care vary by patient needs. However, PAC, because of the extended nature of such care, is exposed to great risk. To mitigate such risk, payment adjusters likely would be needed. Payment adjusters are based on factors that predict higher or lower cost SNF stays. The MDS could be used as the patient assessment for payment adjusters.

Companion Payment Policies

An array of companion policies to further protect providers as well as beneficiaries likely would be needed. Without such provisions, providers might be exposed to additional costs which would create reluctance to admit certain patients. At the same time, still other provisions would be needed to prevent stinting on care.
**High Cost Outlier (HCO) Payments**

An outlier payment policy is intended to dampen the economic impact of unusual high cost events. In the cases of SNFs, the most important sources of high costs that the core payment system cannot predict will be very long stays and high cost prescription drugs or complex medical equipment, as well as some special services such as respiratory therapy. NGACOs could determine in consultation with SNFS, a specific set of services that would be defined as “outlier services.” Such services would include what have historically been referred to as Non-therapy Ancillaries (NTAs), as well as the days in very long stays that exceed a certain threshold.

Dollars might be set aside from the total amount of funds available to SNFs in order to fund the pool. In current PPS with a HCO policies, five to eight percent is set aside for HCO pools by reducing the base rates. Costs covered by the HCO policy might be covered paid for by having the HCO pool cover some larger percentage of costs, such as 80-90 percent, with the balance paid for by the provider.

**Short and Interrupted Stays**

A short stay is defined as a discharge from the SNF or a stay interrupted by hospitalization or death, such that the total covered days in the stay are less than some percentage of the LOS for episodes of care categories.

A short stay payment policy is a protection against admitting residents and then transferring or discharging them before the care they need has been delivered, to capture higher levels of payment. A short stay policy also provides proportional payment to cover the costs of delivering care when a stay is interrupted by hospitalization, death, self-discharge, transfer, or other reasons. A short stay policy might be paid using a per-diem amount calculated based on the adjusted episode of care payment divided by the LOS for the episodes of care.

**Transitional Risk Corridor Payments**

A likely goal of any NGACO designed payment system will be to shorten LOS. Because the transition to a new payment system will challenge facilities that have historically had long LOS, a buffer payment might be temporarily needed to allow such facilities to adapt to the new shorter LOS requirements. A transitional risk corridor policy might provide a pool of funds which would pay for days beyond the episode specific LOS but do not trigger a HCO payment for an extended LOS. The transitional risk corridor might be funded in the same manner at the HCO, by reducing the base rates by some percentage.

In terms of payment structure, transitional risk corridor days might be paid for using the same per diem used for HCO pays but with a different split in payment responsibility. The goal of the transitional risk corridor payment should be to protect providers but also to incentivize them to adapt to the new shorter LOS. Therefore, the transitional risk payments would cover less of the costs than HCO payments, perhaps 50 percent.

**Maintaining the Payment System**

Because such a payment system would be new for SNFs, as well as for NGACOs, the system should be evaluated continually and rates renegotiated on a regular basis.
1. Is the Next Generation ACO model a capitated model?

In Performance Year 2 (2017), Next Generation ACOs will have the option to participate in the capitation payment mechanism. Capitation, now referred to as All-Inclusive Population-Based Payment (AIPBP), will be one of four available payment mechanisms from which the ACO will select. AIPBP in the Next Generation ACO Model is a payment mechanism, which is distinct from the risk arrangement that the ACO selects. All ACO benchmarks will be calculated the same way, independent of the respective payment mechanism and risk arrangement an ACO selects. Next Generation ACOs will not be required to elect AIPBP and may continue to participate in any of the other three payment mechanisms once AIPBP becomes available.

AIPBP will function by estimating total annual expenditures for aligned beneficiaries and paying that projected amount to the ACO in a per-beneficiary per-month (PBPM) payment with some money withheld to cover anticipated care by providers not participating in capitation. A Next Generation ACO participating in AIPBP will be responsible for paying claims for its Next Generation Participants and Next Generation Preferred Providers with whom the ACO has written agreements regarding capitation.

2. AIPBP, is available in 2017. If an ACO starts in 2017, may that ACO immediately enter into AIPBP? Do ACOs have to participate in the lower risk arrangement before entering into AIPBP?

Risk arrangement and payment mechanism are independent in the Next Generation Model. ACOs in either risk arrangement may select any of the available payment mechanisms, including AIPBP in 2017, and vice versa. Beginning in 2017, all Next Generation ACOs (regardless of start date) will have the option to elect AIPBP. ACOs are not required to elect AIPBP and could remain in any of the other three available payment mechanisms in 2017.

3. Will ACOs participating in AIPBP be allowed to determine payment rates for providers under capitation agreements, or is it mandated that current CMS Medicare payment rates be applied? How will the beneficiary liability be calculated?

Yes, ACOs will be allowed to determine payment rates for providers under capitation arrangements and will not be required to pay capitated providers 100 percent of FFS rates as long as payment arrangements are consistent with all applicable laws. Additional financial requirements for ACOs participating in AIPBP will be described in the Model’s participation agreement prior to the start of AIPBP. Beneficiary liabilities are not affected by AIPBP and will continue to be calculated based on what Medicare would have paid in the absence of the ACO participating in capitation.
4. **Under Population Based Payments (PBP), will ACOs have the ability to elect FFS reduction percentages at the TIN/NPI level?**

Yes, Next Generation ACOs have the ability to differentiate FFS reductions at the TIN/NPI level. The percentage reduction is elected at the TIN level, but it is not required that each individual NPI under the TIN have the FFS reduction.

5. **Can an ACO change their selected payment mechanism during the three year Model agreement period — e.g. start with FFS and then move to PBP? Will CMS allow an ACO to opt into multiple payment mechanisms simultaneously?**

Yes, each year the ACO will have the ability to elect its payment mechanism for the upcoming performance year. ACOs are not required to move from normal FFS to any of the other payment mechanisms. No, each Next Generation ACO will elect one payment mechanism for a given performance year.

6. **Under PBP and AIPBP, CMS will project the amount of spending that will occur from participating providers to pay the monthly amount to the ACO. How will CMS make this determination?**

Each year, Next Generation ACOs will select a payment mechanism for the upcoming performance year. If an ACO selects PBP, the ACO must have in place written agreements with all its PBP-participating Participants to accept FFS fee reductions. Likewise, if an ACO selects AIPBP, the ACO will have written agreements regarding capitation with AIPBP-participating Participants and Preferred Providers. CMS will look at past spending for aligned beneficiaries by providers participating in the given payment mechanism to project the percentage of care that those providers will account for in the upcoming performance year and adjust the monthly payment. For example, if, in past years, providers who have agreed to participate in capitation accounted for 75% of aligned beneficiary spending, the monthly payment will reflect an assumption that 75% of care will be from capitated ACO providers and 25% will be from other providers and suppliers.

7. **Under AIPBP, can ACOs execute innovative payment methodologies that are not based on existing fee-for-service payment systems?**

Yes, ACOs and preferred providers, including skilled nursing facilities, may negotiate payment methodologies whereby the preferred provider is paid under a non-fee-for-service payment model. An example would be a DRG- or episode-based system where the provider is paid a flat rate regardless of length of stay. Any negotiated payment arrangement between providers will be allowable so long as it complies with all relevant laws and regulations.