AMERICAN ACADEMY OF FAMILY PHYSICIANS

Next Generation Accountable Care Organization (NGACO)

To be successful, participants considering a NGACO need a broad understanding of the model. The table below provides an overview of its key features and outlines the associated risks and rewards.

Topic/Subject	
Performance Year	• NGACO is a five-year initiative that began January 1, 2016, and will end December 31, 2020. • Two application cycles were offered in 2016, with an initial three-year agreement period. • In 2017, an application cycle for participation had a start date of January 2017 with an initial two-year agreement period. There was also an additional application cycle in 2017 for a participation start date of January 2018 with an initial one-year agreement period. • Following the initial performance years, ACOs have the potential for two additional one-year extensions.
Agreement Period	• ACOs that entered in 2016 have an initial agreement period of three one-year performance periods, with the potential for two additional one-year extensions. • For ACOs entering in 2017, the initial agreement period is two one-year performance periods, with the potential for two additional one-year extensions. • ACOs entering in 2018 will have an initial agreement period of a one-year performance period, with the potential for two additional one-year extensions.
Participation Criteria	• CMS will evaluate applications to participate according to specific criteria in five key domains: (1) Organizational structure (2) Leadership and management (3) Financial plan and experience with risk sharing (4) Patient centeredness (5) Clinical care model • Applicants also need to demonstrate that their organizational structure promotes the goals of the NGACO Model by including a diverse set of providers who demonstrate a commitment to high-quality care. • Applicants with prior participation in a CMS program or demonstration need to demonstrate good performance and conduct in the previous initiative. • NGACOs must maintain a population of at least 10,000 Medicare beneficiaries. • NGACOs that are rural ACOs will be permitted to have a minimum population of 7,500 Medicare beneficiaries. An NGACO is considered rural if at least 40% of the zip codes in its service area are determined to be rural according to the definition used by the HRSA Office of Rural Health Policy.
Beneficiary Assignment	Beneficiaries are prospectively aligned via claims. In 2016, claims-based alignment is augmented with voluntary beneficiary alignment for PY 2017. In general, a beneficiary will be aligned to an NGACO if he or she received the plurality of Qualified Evaluation and Management services from NGACO participants during the two-year alignment window.
Reporting Beneficiary Assignment	Alignment is performed prior to the beginning of each PY. Alignment eligibility is determined on a quarterly basis throughout the PY.
Benchmarking	The trend used to project the NGACO's baseline expenditure is set prior to the PY. This prospective benchmark is initially set using expenditure, risk score, and quality data available at the time the PY-trended baseline is calculated. The benchmark is updated at the time of financial reconciliation utilizing the average PY risk scores of beneficiaries aligned to the NGACO for the PY, as well as the quality score for the PY.

AAPM = Advanced Alternative Payment Model; ACO = accountable care organization; CMS = Centers for Medicare & Medicaid Services; CY = calendar year; EHR = electronic health record; E/M = evaluation and management; HRSA = Health Resources and Services Administration; MACRA = Medicare Access and CHIP Reauthorization Act of 2015; MSSP = Medicare Shared Savings Program; PY = performance year

Topic/Subject	
Shared Savings	Shared savings or losses are determined by subtracting PY expenditures for beneficiaries aligned with the NGACO for that PY from the NGACO's benchmark expenditure.
Risk Associated With Quality and Cost (Performance Risk)	Two risk arrangements are offered: (1) Arrangement A is increased shared risk. • PY 1-3 (2016-2018): 80% sharing rate • PY 4-5 (2019-2020): 85% sharing rate • 5-15% savings/losses cap (Elected annually by the ACO) (2) Arrangement B, which is available in PY 2017, is full performance risk. • 100% risk • 5-15% savings/losses cap (Elected annually by the ACO) In both arrangements, benchmarks are calculated in the same way, with individual beneficiary expenditures capped at the 99th percentile to moderate for outlier effects. In 2017, NGACOs can elect to participate in a capitation payment mechanism known as All-Inclusive Population-Based Payment (AIPBP). This is one of four available payment mechanisms that are distinct from the risk arrangements. NGACOs will not be required to select AIPBP.
Quality Measures	Uses the same quality measures as the MSSP, minus the EHR measure. In the application process, NGACOs are expected to demonstrate that they meet EHR criteria.
Quality Performance Standards	NGACOs follow MSSP quality domains, measures (minus the EHR measure), benchmarking methodology, sampling, scoring, and other CMS quality measurement efforts.
Sharing Rate	The risk arrangement selected (i.e., A or B) determines the portion of the aggregate gross savings paid to the NGACO, or the portion of the gross loss recovered from it. • Arrangement A: 80% (PY 1-3) to 85% (PY 4-5) shared savings/losses with a 15% savings/losses cap • Arrangement B: 100% shared savings/losses with a 5-15% savings/losses cap (elected annually by each ACO)
Advantages	• Relies on data to make decisions at the practicing-physician level • Qualifies as an AAPM under MACRA • Greater financial risk is offset by a greater portion of savings • Offers four payment options for stable, predictable cash flow Benefit enhancements include: • Makes waiver of the Skilled Nursing Facility 3-Day Rule available for aligned beneficiaries who have a confirmed diagnosis of skilled nursing/rehab need • Expands telehealth • Allows physicians to furnish services in a beneficiary's home and bill using E/M (These are not home health services.) • Offers beneficiaries a coordinated-care reward that is paid directly to the beneficiary from CMS
Disadvantages	• Beneficiaries retain the right to choose providers or suppliers inside or outside of the ACO. This may drive up costs since care is not coordinated within the ACO. • Many ACOs may not be ready to take on the greater financial risk required. • Up to three years of shared savings/losses are tied to a benchmark based on a single baseline year. Specifically, the NGACO's benchmark for PYs 2016, 2017, and 2018 is based on the experience of its aligned beneficiary population for CY 2014.

AAPM = Advanced Alternative Payment Model; ACO = accountable care organization; CMS = Centers for Medicare & Medicaid Services; CY = calendar year; EHR = electronic health record; E/M = evaluation and management; HRSA = Health Resources and Services Administration; MACRA = Medicare Access and CHIP Reauthorization Act of 2015; MSSP = Medicare Shared Savings Program; PY = performance year

RESOURCES

The following resources are available from the Centers for Medicare & Medicaid Services:

Next Generation ACO Model.
https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/. Accessed February 23, 2017.

Next Generation ACO Model benchmarking methods.
https://innovation.cms.gov/Files/x/nextgenaco-methodology.pdf. Accessed February 23, 2017.

Next Generation ACO Model – financial & alignment: frequently asked questions.
https://innovation.cms.gov/initiatives/next-generation-aco-model/nextgenaco-fnclalgnfaqs.html. Accessed February 23, 2017.

Next Generation ACO Model: frequently asked questions.
https://innovation.cms.gov/Files/x/nextgenacofaq.pdf. Accessed February 23, 2017.

Next Generation ACO Model: model overview presentation.
https://innovation.cms.gov/Files/slides/nextgenaco-odf1slides.pdf. Accessed February 23, 2017.

Next Generation ACO Model request for applications.
https://innovation.cms.gov/Files/x/nextgenacorfa.pdf. Accessed February 23, 2017.

Next Generation ACO Model voluntary alignment: frequently asked questions.
https://innovation.cms.gov/files/x/nextgenaco-voluntaryalignmentfaqbeneficiary.pdf. Accessed February 23, 2017.

Pioneer ACO Model and Next Generation ACO Model: comparison across key design elements.
https://innovation.cms.gov/Files/fact-sheet/nextgenaco-comparefactsheet.pdf. Accessed February 23, 2017.

Next Generation ACO Model Request for Applications.
https://innovation.cms.gov/Files/x/nextgenacorfa.pdf. Accessed March 7, 2018.