A
countable care organizations have been promoted by the Centers for Medicare & Medicaid as a key al-
ternative practice model to the current value-based model that all physicians will soon face. ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctors’ offices, hos-
opitals, and long-term care facilities. The ACO is a financial and medical entity, providing efficient care and meeting performance standards while controlling costs. There are two basic types of ACOs – the Pioneer and the Medicare Shared Savings Program (MSSP). The success of the Pioneer model has been equivocal, with only a minority of original programs still functioning or being fiscally sound. The jury is still out on the MSSP model, but the interest is certainly there. There are currently about 14 million lives covered in 47 different states in all ACO models.

There are many issues with the MSSP that have slowed its uptake or success. First, the program is tiered. Simply put, the higher the tier, the more risk the organization takes if spending exceeds target goals. To compensate for this risk, the higher tiers have more potential reward through shared savings, in which savings beyond a benchmark, usually historical spending, are split between Medicare and the ACO. These ACO savings are then shared among the hospital and various providers. As important as the fiscal reward, higher tiers offer more liberal CMS consideration of binding historical hindrances to efficient medical care, such as the 3-day qualifying stay rule for skilled care in a skilled nursing facility under Medicare Part A.

A second obstacle to ACO uptake is the fact that shared savings are based on historical spending of the organization, rather than whether they are already efficient. An ACO that starts out his-
torically saving 20% of usual Medicare spending per patient will have a harder time being more efficient and providing more savings than an ACO that was at the historical benchmark. The net effect of this is that ACOs that started as effi-
cient organizations do not have as much ability to be rewarded for better cost-
eff ective care, whereas ACOs whose past performance has been poor are essen-
tially rewarded because their incremen-
tal improvement will be greater.

Current MSSP ACOs are still ham-
pered by traditional Medicare rules that may limit efficient care, such as restrictions on telehealth, extent of post-
discharge home services, and the 3-day rule for SNF services. Even higher tier ACOs have some of these restrictions, which CMS is considering waiving fur-
ther. In the interim, such restrictions do not encourage participation in higher risk sharing ACO models.

Another difficulty in current ACO structure is the fact that they may not know for certain what patients the ACO is responsible for, given difficulties with attribution. Attribution is the process by which patients are ultimately assigned to an ACO. The basic rule is that the pro-
vider (and the ACO they belong to) who makes the most visits at the end of the year “owns” the patient, his or her care quality, and expense, regardless of what provider or ACO the patient started with. With all these considerations, the current fiscal reward – given the current struc-
tural issues noted – has not been great enough to encourage most MSSP ACOs to move to higher tiers of risk sharing.

Next Generation, Next Answer

Due to the aforementioned structural problems, CMS announced in March the formation of a new ACO model called the Next Generation ACO. This model has been viewed favorably by ACO experts, who believe it improves the basic ACO model, allows for better care of the patient, and offers greater success for the physician. Patrick Conway, MD, MSc, chief medical officer at CMS, said the Next Generation ACO is a response to physicians’ feedback and requests. This new and improved ACO is more evidence that CMS is committed to shifting at least half of all Medicare physician payments away from fee-for-service payments toward alternative payment models by the end of 2018.

The Next Generation ACO model gives providers greater opportunities to coordinate care, and ensures more appropriate and consistent fiscal targets. This new ACO will also make it easier to attain the highest standards of patient care. There will be greater financial risks for doctors and hospitals in exchange for greater shared savings when high perfor-
mance is achieved. The increased risk sharing will be offset by a more stable, predictable benchmark and flexible pay-
ment options that support investments in care improvement infrastructure that provide high-quality care to patients.

Cost Efficiency Rewarded

The fiscal issues surrounding shared sav-
ings of Pioneer and MSSP ACOs have been mitigated to a good extent in this new model. The Next Generation ACO model will use historical expenditures to develop baseline and benchmark data for performance years 1 through 3, which will be risk-adjusted and trending before a discount is applied, just as for previous ACOs. However, the discount incorpo-
rates regional and national efficiency. The net result is that ACOs that have already attained cost efficiency com-
pared with their regions will have a more favorable discount and a greater reward. With this approach, ACOs achieve sav-
ings through year-to-year improvement over historic expenditures (improve-
ment), but the magnitude by which they must improve will vary based on rela-
tive efficiency (attainment). In years 4 and 5, attainment becomes the primary payment consideration, de-emphasizing improvement goals. This method recog-
nizes past achievements of efficient Next Generation ACOs, unlike past models, and encourages currently efficient orga-
nizations to become ACOs.

Issues of alignment and attribution are better addressed with this new model, which supplements current claims-based alignment with voluntary alignment. Under voluntary alignment, beneficiaries are offered the option to confirm or deny their care relationships with specific Next Generation providers and suppliers. This beneficiary input will be reflected in align-
ment for the subsequent year, and con-
firrnations of care relationships through voluntary alignment supersede claims-
based attributions. This should take care of the current quandary for the PA/LTC 
physician who can become responsible for the patient’s entire cost and care simply because they saw the patient more often in the SNF in 1 year than did the primary care doctor. Such voluntary alignment continuity should allow the primary care 
physician and ACO to more accurately follow the care and cost of their patients across performance years. It is impossible to improve patient health while decreas-
ing cost of care without the primary care 
physician/ACO being able to con-
sistently follow the patient.

CMS will work with Next Generation 
ACOs to improve communication with 
beneficiaries about the characteristics and potential benefits of ACOs in relation to their care. Beneficiaries who seek high levels of coordinated care through their aligned ACO can receive waived or reduced copays and a $50 coordinated care reward per year from CMS. Expanded use of SNF 
services without a qualifying hospital stay, increased use of telehealth, and enhanced postdischarge home health care services should also encourage patients to use Next Generation ACO services.

Building on Past Models

Many have stated that this ACO model is a marriage of past ACO models and Medicare Advantage (MA) plans. There are distinct differences between the two, however. Patients who are aligned to Next Generation ACOs maintain origi-
nal Medicare benefits. Beneficiaries have freedom of choice of their provider in the ACO, as opposed to the defined provider network of an MA plan. Patients are not required to receive services from an ACO, and there is no additional premium paid by the beneficiary for being in an ACO, as there is for most MA plans. Patients may receive a reward for receiving most of their care from ACO providers but are not penalized in any way for seeing non-ACO providers. The Next Generation ACO model does not require beneficiary enroll-
ment. Beneficiaries are aligned to ACOs through claims, which voluntary align-
ment supplements by allowing beneficia-
tes to confirm a care relationship with an ACO provider. The Next Generation ACO may eventually be viewed as an improve-
ment on both past ACOs and MA plans.

This new ACO model, however, does require a large and well-established organization in order to control the inherent risks and manage populations. This Center for Medicare & Medicaid Innovation-sponsored ACO model will be limited to larger groups, with a total number of 15 to 20 organizations anti-
cipated to qualify. Applications are being accepted in two rounds with deadlines of June 1, 2015 and June 1, 2016. Quality metrics, including patient experience rat-
ings, will be posted on the CMS website.

There is little doubt that the princi-
ples – if not the exact model – embodied in the Next Generation ACO is the direc-
tion that CMS and value-based model will be headed. Efficient use of resources, coordination of care, communication among providers, and patient invest-
ment in their care are principles that AMDA has promoted for years. Newer models of value-based care, including ACOs, are beginning to acknowledge the value of the competent PA/LTC 
physician. It is equally important that competent PA/LTC physicians under-
stand how these newer models of care operate in order to maximize their value and optimize patient care.

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Public Policy

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April 2015