Session 89 PD, Next Generation ACO

Moderator:
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Presenters:
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Scott Heiser
Lilith Ciccarelli McGhee, ASA, MAAA
Heather Orth
Next Generation ACO Model

Tuesday, October 25, 2016
Introductions

• Heather Orth, Market President, One Care Collaborative

• Lilith McGhee, Associate Director, Evolent Health

• Scott Heiser, Social Science Research Analyst, CMS/CMMI

• Patrick Colbert, Director, Evolent Health
Agenda

• Next Generation ACO Model Overview
• Operational Considerations
• Actuarial Role
• Question & Answer
Next Generation ACO Model Overview
January 2015: Secretary Burwell announces goal of moving 50% of Medicare payments to value-based payment arrangements (like Next Generation ACO) by the end of 2018

Quality Payment Program: creates financial and operational incentives for “qualified providers” participating in Advanced Alternative Payment Models bearing greater than nominal financial risk

- Beginning in 2019, QPs earn a 5.0% lump sum payment on Medicare Part B payments
- Beginning in 2026, eligible for higher fee updates compared to those providers not in A-APMs
- QPs participating in A-APMs will report quality through the model, and excluded from MIPS
Why did CMMI establish NGACO?

- Desire among early ACO entrants for *fully prospective benchmark*

- Test new methodological features (e.g. 1-year baseline, longitudinal risk adjustment)

- Desire to offer additional incentives for efficient providers to enter model (ACO to region efficiency credit via discount)

- New payment waiver flexibility
## Model Mechanics: Attribution

### Prospective
- Based on E&M spend
- Timing

### Exclusions
- Medicare Advantage
- MSP
- Service Area
- Loss of Part A/B

### Providers
- Selected by the ACO
- Need signed agreement
- Approved by CMMI

### Cross Sectional
- Performance year population is not identical to baseline

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<td>PY 1 - aligned</td>
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<td>Alignment period</td>
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<td>PY 1 Expenditures</td>
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<td>PY 2 - aligned</td>
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<td>Alignment period</td>
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<td>Alignment period</td>
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<td>PY 2 Expenditures</td>
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Panel

- Baseline Expenditures
- PY 1 Expenditures
- PY 2 Expenditures
## Model Mechanics: Benchmark

<table>
<thead>
<tr>
<th>Factor</th>
<th>Impact to Discount:</th>
<th>Best Case</th>
<th>Worst Case</th>
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<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td>2014 Experience</td>
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<tr>
<td><strong>Regional Growth Trend</strong></td>
<td>+Based on ACO’s region</td>
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<tr>
<td><strong>National Growth Trend</strong></td>
<td>For the period 2014 – 2016, the annual trends were 2.03% for Aged &amp; Disabled and 1.80% for ESRD populations</td>
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<tr>
<td><strong>Flat Discount</strong></td>
<td>−2.25%</td>
<td></td>
<td>−2.25%</td>
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<tr>
<td><strong>Quality Score Impact</strong></td>
<td>+1% ((100% \text{ quality score}))</td>
<td>+0% ((0% \text{ quality score}))</td>
<td></td>
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<tr>
<td><strong>Regional Efficiency</strong></td>
<td>+1.0% ((\text{ACO is much less costly than region}))</td>
<td>−1.0% ((\text{ACO is much more costly than region}))</td>
<td></td>
</tr>
<tr>
<td><strong>National Efficiency</strong></td>
<td>+0.5% ((\text{ACO’s region is much less costly than nation}))</td>
<td>−0.5% ((\text{ACO’s region is much more costly than nation}))</td>
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<tr>
<td><strong>Total</strong></td>
<td>Best Case Adjusted Discount: (\text{Adjusted Base} – 0%)</td>
<td>Worst Case Adjusted Discount: (\text{Adjusted Base} – 3.75%)</td>
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</table>
Model Mechanics: RAF

- Prospective – based on claims for twelve month period prior to performance period
- Normalized to national reference population
- 3% cap/floor
Model Mechanics: Settlement

Budget less Expense = Gross savings (loss)

TIMES: Shared Savings Rate
- Ranges from 80% - 100%
- Chosen by the ACO in December prior to each performance year

LESS: Capped savings/loss
- Ranges from 5% - 15% of the benchmark
- Chosen by the ACO in December prior to each performance year

LESS: Sequestration
- 2% federally mandated reduction
- Applies only to savings

EQUALS: Shared savings (loss)

BUDGET
- EQUALS risk standardized benchmark PMPM
- TIMES performance period risk score*
- TIMES eligible person-months

EXPENSE
- EQUALS incurred claims
- PLUS sequestration, PBP reduction, stop-loss charge
- MINUS uncompensated care payments, stop-loss payout

*capped at +/- 3% change from baseline period

SOCIETY OF ACTUARIES
**Key Differences between NGACO and MSSP**

**Beneficiary Alignment**

<table>
<thead>
<tr>
<th>MSSP Track 1</th>
<th>Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation</th>
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</thead>
<tbody>
<tr>
<td>MSSP Track 2</td>
<td>Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation</td>
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<tr>
<td>MSSP Track 3</td>
<td>Prospective assignment for reports, quality reporting, and financial reconciliation</td>
</tr>
<tr>
<td>NGACO</td>
<td>Prospective alignment for reports, quality reporting, and financial reconciliation; ability to elect to participate in voluntary alignment</td>
</tr>
</tbody>
</table>
### Key Differences between NGACO and MSSP

<table>
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<tr>
<th></th>
<th>MSSP</th>
<th>NGACO</th>
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</thead>
</table>
| **Benchmark**             | • Baseline: 3-year historic  
                          • Trend: national flat dollar | • Baseline: 1-year historic  
                          • Trend: projected regional trend  
                          (national utilization, regional prices)  
                          • Quality and efficiency adjusted discount |
| **Payment Mechanisms**    | • Traditional FFS                                                   | • Choice of 4 options:  
                          • Traditional FFS  
                          • Infrastructure Payments  
                          • PBP  
                          • All-inclusive PBP (PY2) |
| **Quality**               | • 34 measures, most recently updated in CY2015 PFS                 | • Same as MSSP except removing EHR measure |
# Key Differences between NGACO and MSSP

## Risk Arrangements

| MSSP Track 1 | One-sided risk; up to 50% shared savings based on quality performance (MSR: 2.0% - 3.9%, dependent upon # of beneficiaries)  
Savings capped at 10% |
|--------------|--------------------------------------------------|
| MSSP Track 2 | Two-sided risk; up to 60% shared savings based on quality performance, Choice of symmetrical MSR/MLR:  
(i) no MSR/MLR  
(ii) 0.5% increment between 0.5% - 2.0%  
(iii) MSR/MLR to vary based upon number of assigned beneficiaries  
Savings capped at 15%; losses capped phased over 3 years (5% Y1, 7.5% Y2, 10% Y3) |
| MSSP Track 3 | Two-sided risk; up to 75% shared savings based on quality performance (Same MSR/MLR choices as Track 2)  
Savings capped at 20%; losses capped at 15% |
| NGACO        | Two-sided risk; First-Dollar Savings (no MSR) Options:  
A. 80% Shared Risk (up to 85% Shared Risk for 2019-2020)  
B. 100% Full Risk  
Savings/Losses capped at 15% of benchmark expenditures |
### Key Differences between NGACO and MSSP

#### Benefit Enhancement Elections

<table>
<thead>
<tr>
<th></th>
<th>Telehealth Expansion Waiver</th>
<th>Post-Discharge Home Visit Waiver</th>
<th>SNF 3-Day Rule Waiver</th>
<th>Coordinated Care Reward</th>
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<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td><strong>Track 3</strong></td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td><strong>NGACO</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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Changes to NGACO Methodology Since Launch

- **Change #1:** Adjusted projected trend derived from CMS Office of the Actuary United States Per Capita Cost (USPCC) to account for reduction in Uncompensated Care (UCC) payments.

- **Change #2:** The base discount was changed from 3.0% to 2.25%, with a floor of 0.0%. The updated range of the discount is thus 0.0% to 3.75% (from old range of 0.5% to 4.5%).

- **Change #3:** NGACOs will now have the option to select a symmetric cap between +/- 5.0% and 15.0% of the total NGACO benchmark.
Variation in Original Discount in NGACO

Variation in Original PY1 Aged/Disabled Discount

Discount Amount

ACO ID

A  B  C  D  E  F  G  H  I  J  K  L  M  N  O  P  Q  R

0%  0.5%  1.0%  1.5%  2.0%  2.5%  3.0%
Variation in Reduced Discount in NGACO

Variation in Reduced PY1 Aged/Disabled Discount

Discount Amount

ACO ID

A B C D E F G H I J K L M N O P Q R
Operational Considerations
Next Generation ACO Operations: Focused Team Dedicated to Program Success

The team supports the network, clinical and operational plan, and the resulting financial business case.

**Strengthening the Network**
- Contracting
- Communication & Population Health Team support
- Incentives
- Reporting & Focused Initiatives
- In System Utilization/Care Coordination

**Clinical and Operational Platform**
- Program implementation & evaluation
- Develop operational plan to close any gaps
- PAC
- Specialist Council
- EMR Optimization & IT Infrastructure
- Benefit Enhancements

**Financial Platform**
- P&L Management
- Business Case Execution
- Actuarial Support
- TME/Med Econ
- Program Modifications
Physician Leadership & Governance: Critical Component of Success

Physician Advisory Council (PAC)

Subcommittees: Specialist Council, RAF/Physician Incentives, Initiatives

Pod Team Lead

Practice A
Practice B
Practice C
Practice D
Practice E
Practice F

Practice Physicians

Commercial ACO / Medicare ACO

VBSO: People, Processes, & Tools
Driving Engagement Across the ACO: Network Communication & Coordination of Care

Epic OneCare Patient Identification Banner

June 5, 2015
Dear Colleague:

We are excited to announce a new feature now live in EPIC, the OneCare Banner. For patients enrolled in care advising services, the banner will display the care program, the patient’s current status and the assigned Care Advisor’s name and phone number.

OneCare Collaborative Provider Newsletter

OneCare Collaborative and Anthem Partner to Provide Care Advising to Anthem MA and Commercial Patients

OneCare Collaborative Website
Overview: Clinical Operations

Optimize existing programs & deploy best-of-breed population health management capabilities to drive improved quality and outcomes.

<table>
<thead>
<tr>
<th>Clinical Programs</th>
<th>Physician Engagement</th>
<th>Key NG ACO Optimizations</th>
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</table>
| • Complex Care    | • Physician Advisory Council  
| • Condition Care  | • Incentive Alignment  
| • Transition Care | • RAF Education  
| • Emergent Care   | • Communication  
| • Proactive Care  | • PHMs – Practice Assessments  
| • Roster Reviews  | • Clinical Integration Programs  
| • PATH Visits     | • LEAP  
| • Benefit Enhancements | • Specialist Involvement |

“My nurse worked with me between my doctor’s visits so I now understand how to take my insulin. She also connected me with resources so I can now afford the medications I need. I am enjoying my life again thanks to the help I’ve received.”

- Network Patient

“I wish all of my visits were like this. I had the information I needed for the visit and my patient stated he has a much better understanding of his condition and he loved the extra attention!”

- DC PAC Physician
Actuarial Role
Actuarial Role: Operations

**Communications**
- Audience appropriate presentations
- Risk conceptualization

**CMMI Reports**
- Raw claims files (CCLF)
- Attribution
- Data Sharing Preferences
- Expenditure & Lag

**Reporting & Projections**
- Medical Economics
- RAF
- ASOP #23
- Shared savings calculations
- Forecast future months
Actuaries in Business Development

New ACO models provide a platform to drive new business

Assisting ACOs with managing shared savings arrangements is an expanding area with which actuaries are getting involved

Working with Accountable Care Organizations, firms like Evolent Health can help achieve success by addressing various needs

Actuarial Support – Monitoring Progress, Identifying and Evaluating Opportunities

Clinical Capabilities – Implementing clinical transformation to achieve shared savings

Downside Protection – Providing a shared incentive to improve while dampening the fear of first dollar losses

For the partnership to work, the ACO must be a good fit

Evaluating an ACOs likelihood for success involves financial analyses as well as more qualitative evaluations
# How does NextGen measure up?

<table>
<thead>
<tr>
<th>Provider Value Drivers</th>
<th>MSSP Track 1 and 2</th>
<th>MSSP Track 3</th>
<th>Typical Commercial Payer Partnership</th>
<th>Next Generation ACO</th>
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<td>Membership</td>
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<td>Infrastructure Cost</td>
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<td>Risk Exposure</td>
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<td>Defined Population and Benchmark</td>
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The Financial Questions...

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<th>Question</th>
<th>Answer</th>
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<td>How many providers do I need to include in my ACO?</td>
<td>How many beneficiaries will be aligned to my population?</td>
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<td>How have my costs been trending since 2014?</td>
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<td>How has my population risk score been changing?</td>
</tr>
<tr>
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<td>How do I compare to other ACOs in my region and the country?</td>
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<tr>
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<td>How do operating costs compare to potential shared savings?</td>
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<tr>
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<td>How big of a risk am I taking?</td>
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<tr>
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<td>What’s the expected ROI under various scenarios?</td>
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<tr>
<td>What’s the expected ROI under various scenarios?</td>
<td>How does that compare to other alternatives?</td>
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Before signing on for NextGen, an ACO must consider...
What Else Should You Be Asking Yourself?

What is your timeframe for expanding the at-risk population you manage?

Do you have a plan for how to generate savings?

Do you have infrastructure and operational workflows in place?

Are you comfortable with assuming full risk for a population?

How quickly are you able to make a strategic decision about Medicare ACO?

How does NextGen fit into your organization's broader strategy?