CMS Perspective:

Next Generation Accountable Care Organization (NGACO) Model

Evaluation Report 3 and Next Steps on Innovating in Medicare Accountable Care

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For information on the model and to download the independent evaluation report discussed in this document, please visit https://innovation.cms.gov/innovation-models/next-generation-aco-model

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The Next Generation Accountable Care Organization (NGACO) Model tests whether greater financial risk, with optional payment mechanisms and benefit enhancements designed to provide more flexibility in care, reduces Medicare expenditures and improves the quality of care for Medicare beneficiaries. The model seeks to further the evolution of Medicare ACO initiatives by testing advanced features that could inform permanent Medicare ACO programs. A detailed description of the model's features is provided here. The NGACO Model operates under the traditional Medicare fee-for-service (FFS) program and beneficiaries aligned to participating ACOs see no reduction in their Medicare benefits and retain freedom to see any Medicare health care provider. This CMS Perspective of the Third NGACO Evaluation Report summarizes the report's results and discusses future considerations for the NGACO and Direct Contracting Models.

Evaluation Findings

Across its first three years, the NGACO Model successfully reduced Medicare Parts A and B spending and was associated with $349 million in lower gross spending, but net Medicare Parts A and B spending did not decrease. The $349 million decline in Part A and B spending (-1.23%, p<0.01) was determined using a comparison group of similar non-NGACO beneficiaries residing in the same markets. Spending declines in professional services spending and post-acute care spending contributed to model-wide declines. The model was not associated with discernible reductions in quality in terms of preventable inpatient admissions, 30-day all-cause hospital readmissions, or hospital readmissions following a SNF stay.

There were substantive differences in the spending impact among the three NGACO cohorts which contributed to the overall gross and net impact of the model. The model's spending impact was unevenly distributed among the three NGACO cohorts owing to differences in number of beneficiaries, average spending impact, and duration of participation in the model. The 2017 cohort accounted for over half of the total model-wide decline in part A and B spending during its two years of participation in the model. The 2016 cohort contributed more modestly to lower model-wide part A and B spending. The smallest of the cohorts, the 2018 cohort, had statistically significant reductions in part A and B spending in its first year.

Although the model was associated with reductions in part A and B spending relative to a comparison group, after including CMS payments for shared savings and coordinated care rewards (CCRs), net spending across the three years did not decline. Shared savings and CCR payments from CMS across the first three years totaled $466 million with shared savings making up roughly 95 percent of this total. When these payments are included, the net spending impact of the model was a non-statistically significant $118 million increase in spending (+0.28%). Net spending impacts among the three NGACO cohorts showed notable differences. Higher model-wide net spending in the first three years was mostly due to the 2016 cohort, which had a statistically significant +$178 million increase in net spending. The 2017 cohort was associated with a non-statistically significant decrease in net spending and the 2018 cohort contributed a $22 million increase to net spending (not statistically significant).

ACO participation during the first three performance years (2016-2018) of the NGACO Model grew as a new cohort of ACOs joined the model each year. Participation in the model peaked in 2018, growing from 18 ACOs in 2016 to 50 in 2018. Larger proportions of ACOs joining the model after 2016 tended to elect 100% financial risk and population-based-payment (PBP) mechanisms that pay ACOs prospectively. As a result, the proportion of ACOs in the model bearing 100% risk grew from 17% in 2016 to 56% in 2018. The proportion of ACOs in the model participating in PBP mechanisms also grew from 11% in 2016 to over a quarter (26%) of ACOs in 2018. ACOs electing 100% risk exhibited statistically significant reductions in Medicare spending relative to their comparison groups. In contrast, ACOs that elected 80% risk did not have statistically significant reductions in spending relative to their comparison groups.

ACOs engaged in a variety of activities to enhance capabilities for population health management. These activities included enhancement of interoperability and data analytics to translate data into actionable information for clinicians and management. Many ACOs that joined the model built upon their existing care management services and engaged beneficiaries to help them improve self-management of clinical conditions, often equally for beneficiaries in and outside the model. ACOs also engaged physicians using comparative quality and utilization reports, and incentives related to shared savings distributions. Lastly, ACOs developed closer partnerships with skilled nursing facilities (SNFs), to improve communication and coordination of care, in some cases developing sub-networks of more closely aligned SNF partners.

Next Steps for Innovation Center ACO Models

The NGACO Model changed several methodology elements beginning in the fourth performance year (2019). These updates were intended to test new methods for the long-term sustainability of the model by shifting from an emphasis that rewards ACOs for improvement to one that rewards ACOs for having attained efficiency in their expenditures, thereby offering a strategy that sustains a long-term business case for both the ACOs and CMS. These updates included an attained performance adjustment, which rewarded ACOs who were more efficient than their regions and required additional savings from ACOs who were less efficient than their region. It also included a revised quality withhold, which increased the financial impact of the quality results on potential shared savings. CMS is looking forward to the evaluation of these updated methodology elements to determine the impact on model savings.

Additionally, the Direct Contracting Model, which was developed as a successor model to the NGACO Model, incorporates lessons learned from the NGACO experience and its evaluation in its new financial methodology and operational elements. Featured elements in the Direct Contracting Model which were designed to drive savings, include requirements that participants utilize either capitation or PBP-like arrangements with their providers. CMS is optimistic about future evaluation results as ACOs and other participating individuals and entities gain experience with new financial arrangements.