

Next Generation ACO Model



*Open Door Forum:
Beneficiary Engagement*

April 7, 2015

Agenda

- Preliminary Beneficiary Engagement Timeline
- Beneficiary Engagement Topics
 - Next Generation ACO Entities
 - Providers/Suppliers
 - Preferred Providers
 - Affiliates
 - Coordinated Care Reward
 - Benefit Enhancements
 - Telehealth
 - Post-Discharge Home Visits
 - 3-Day SNF Rule Waiver
 - Implementation Plans
 - Voluntary Alignment

Preliminary Beneficiary Engagement Timeline

Milestone	Date
LOI Due Date	May 1, 2015
Application Due Date	June 1, 2015
Providers/Suppliers List Submitted	June 1, 2015
Preferred Provider List Submitted	Early Fall 2015
Agreements Signed	Fall 2015
Implementation Plans and SNF Affiliate List Submitted (if applicable)	Mid-Late Fall 2015
Start of 1 st Performance Year	January 1, 2016

ACO Entities

- Preliminary Beneficiary Engagement Timeline
- Beneficiary Engagement Topics
 - **Next Generation ACO Entities**
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 - **Preferred Providers**
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Eligible Providers/Suppliers

- Next Generation ACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
 - Physicians or other practitioners in group practice arrangements
 - Networks of individual practices of physicians or other practitioners
 - Hospitals employing physicians or other practitioners
 - Partnerships or joint venture arrangements between hospitals and physicians or other practitioners
 - Federally Qualified Health Centers (FQHCs)
 - Rural Health Clinics (RHCs)
 - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers/suppliers may participate in an ACO formed by one or more of the entities listed above.
- ACOs will be required to identify all providers/suppliers participating in the Model.

Next Generation Preferred Providers

- Goal: Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO:
 - ACO-selected set of partners to contribute to ACO goals;
 - May offer an ACO's benefit enhancements to aligned beneficiaries;
 - Services delivered to Next Generation Beneficiaries count toward the coordinated care reward calculation (direct payments made to beneficiaries by CMS);
 - Preferred Providers will NOT be associated with alignment or used for quality reporting by the ACO;
 - Preferred Providers may also be Affiliates in order to participate in the capitation payment mechanism or the SNF 3-Day Rule waiver.
- ACOs will be required to identify all providers participating as Preferred Providers.

Next Generation Affiliates

- Goal: extend and advance ACO cost and quality goals.
- Two types of ACO partner entities associated with specific Next Generation design elements:
 - Capitation Affiliates
 - SNF Affiliates
- Affiliate care counts toward the coordinated care reward calculation.
- Preferred Providers may also be Affiliates.
- ACOs will be required to identify all providers participating as Affiliates.

Types of Next Generation Entities and Associated Functions¹

	Alignment	Quality Reporting Through ACO	Population-Based Payments	Capitation	Coordinated Care Reward	3-Day SNF Rule ³	Telehealth	Post-Discharge Home Visit
Provider/Supplier ²	●	●	●	●	●	●	●	●
Preferred Provider					●	●	●	●
SNF Affiliate					●	●		
Capitation Affiliate				●	●			

¹ This table is a simplified depiction of key design elements with respect to provider and supplier roles. It does not necessarily imply that this list of capabilities is exhaustive with regards to possible ACO relationships and activities.

² Providers/Suppliers may NOT also be any of the other three entity types. However, Preferred Providers, Capitation Affiliates, and SNF Affiliates are not mutually exclusive with respect to each other. For instance, a Preferred Provider may also be a Capitation Affiliate but not a Provider/Supplier.

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Types of Next Generation Entities and Associated Functions¹

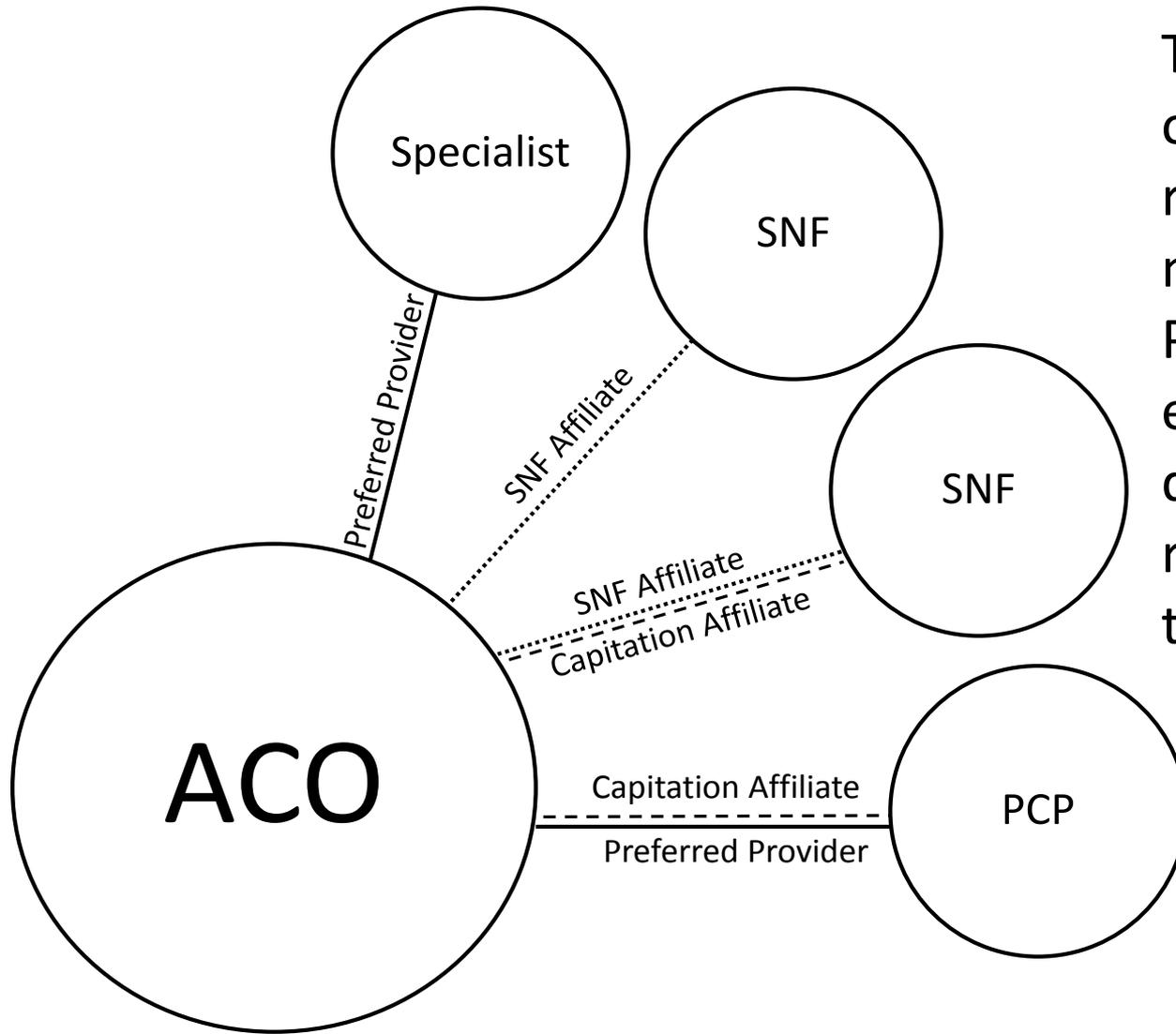
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Examples of ACO Relationships



This is a sample of some of the many possible relationships an ACO may have with non-Provider/Supplier entities. Each line depicts one type of relationship between the entity and the ACO.

Possible Combinations

- Provider/Supplier
- Preferred Provider
- SNF Affiliate
- Capitation Affiliate
- Preferred Provider – SNF Affiliate
- Preferred Provider – Capitation Affiliate
- SNF Affiliate – Capitation Affiliate
- Preferred Provider – SNF Affiliate – Capitation Affiliate

Program Overlap

- **With other Medicare models and programs:**
 - Participation in other demonstrations or models generally *allowed*;
 - Next Generation ACOs *NOT allowed* to simultaneously participate in other Medicare shared savings initiatives (e.g., Shared Savings Program, Pioneer ACO Model)
 - Next Generation Provider/Supplier TINs *may not* overlap with Shared Savings Program TINs.
 - Preferred Provider and Affiliate TINs *may* overlap with Shared Savings Program TINs.
- **Within the Model:**
 - Primary care providers may be Providers/Suppliers in only one Next Generation ACO.
 - Specialists may be Providers/Suppliers in more than one Next Generation ACO.
 - Preferred Providers and Affiliates are not required to be exclusive to any one Next Generation ACO.

Coordinated Care Reward and Benefit Enhancements

- Preliminary Beneficiary Engagement Timeline
- Beneficiary Engagement Topics
 - Next Generation ACO Entities
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 - **Coordinated Care Reward**
 - **Benefit Enhancements**
 - **Telehealth**
 - **Post-Discharge Home Visits**
 - **3-Day SNF Rule Waiver**
 - **Implementation Plans**
 - Voluntary Alignment

Beneficiary Coordinated Care Reward

- Each Next Generation Beneficiary automatically eligible.
- Reward earned if at least a specified percentage of patient encounters are with Next Generation Providers/Suppliers, Preferred Providers, and Affiliates.
- Payment made directly to beneficiaries from CMS.
- No contribution or recoupment from ACOs.
- Projected values:
 - Reward amount: \$50/year (\$25 available semi-annually).
 - Reward threshold: 50% of patient encounters with ACO entities.
 - Values may change due to actuarial analysis.

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Benefit Enhancements

- Conditional waivers of certain Medicare payment rules.
- Goals:
 - Emphasize high-value services;
 - Support care management and closer care relationships;
 - Allow ACO flexibility;
 - Promote communication to beneficiaries;
 - Evaluate ACO utilization and impact.

Payment Rule Waivers

- Section 1115A(d)(1) of the Act authorizes the Secretary to waive such requirements of Title XVIII of the Act as may be necessary solely for purposes of carrying out the testing by CMMI of certain innovative payment and service delivery models, including the Next Generation ACO Model.
- Any payment rule waivers will apply solely to the Next Generation Model and could differ in scope or design from waivers granted for other programs or models. Any such waivers granted would be contingent upon:
 - 1) The Next Generation ACO entering into a Participation Agreement with CMS;
 - 2) Continued compliance with the terms and conditions of the Participation Agreement, including the terms and conditions of the payment rule waivers as specified in the Agreement;
 - 3) Written agreements between the Next Generation ACO and its Next Generation Providers/Suppliers, Preferred Providers, and Affiliates outlining the financial relationships and duties of the parties as part of the Model; and
 - 4) CMS not making a determination that continued use of a payment rule waiver puts beneficiaries or program integrity at undue risk.

Telehealth: Current Originating Sites

- Geography:
 - A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
 - A county outside of a MSA.
- Facilities:
 - The offices of physicians or practitioners;
 - Hospitals;
 - Critical Access Hospitals (CAH);
 - Rural Health Clinics;
 - Federally Qualified Health Centers;
 - Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
 - Skilled Nursing Facilities (SNF); and
 - Community Mental Health Centers (CMHC).

Telehealth Expansion Overview

- Elimination of geographic (rural) component of originating site requirements.
- Beneficiaries may receive telehealth services from place of residence.
- Telehealth services (CPT and HCPCS codes) unchanged.

Telehealth Expansion

- Applicable to all telehealth services provided to ACO-aligned beneficiaries by ACO providers/suppliers or Preferred Providers, the geographic location of the originating site will not be a component of eligibility for payment. Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria.
- To be eligible for payment the beneficiary must be located at an originating site that is either:
 - One of the sites listed in Sec. 1834(m)(4)(C)(ii) of the Social Security Act.
 - The beneficiary's residence.
- The facility fee for originating sites would be waived if there is no facility used as an originating site.
- ACO Providers/Suppliers and/or Preferred Providers may not submit a claim to CMS when the originating site is a beneficiary's home or place of residence and the service was unable to be provided due to technical issues with telecommunications equipment required for that service.
- Claims will not be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:
 - Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. HCPCS codes G0406 - G0408.
 - Subsequent hospital care services, with the limitation of 1 telehealth visits every 3 days. CPT codes 99231 - 99233.
 - Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days. CPT codes 99307 - 99310.

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Post-Discharge Home Visits Overview

- A licensed clinician under the *general* – instead of direct – supervision of a Next Generation Provider/Supplier or Preferred Provider may bill for “incident to” services at an aligned beneficiary’s home.
- Such services may be furnished not more than one time in the first 10 days following discharge from an inpatient facility (hospital, CAH, SNF, IRF) and not more than one time in the subsequent 20 days.

Post-Discharge Home Visits

- A licensed clinician under the general supervision of a physician may bill for home visits to beneficiaries under the following circumstances:
 - The services are furnished to an ACO-aligned beneficiary who does not qualify for home health services under 42 C.F.R. § 409.42. The services are furnished in the beneficiary's home or place of residence during the period after discharge from an inpatient facility.
 - The services are furnished by licensed clinical staff under the *general supervision* (as defined at 42 C.F.R. § 410.32(b)(3)(i)) of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner), or of the same entity that employs or contracts with the physician (or other practitioner).
 - The billing provider is an ACO Provider/Supplier or Preferred Provider.
 - The services are furnished by a clinician licensed to perform the supervising provider-ordered services under applicable state law and billed by the provider in accordance with CMS standards.
 - The services are furnished not more than 1 time in the first 10 days following discharge and not more than 1 time in the subsequent 20 days.
 - The services are furnished in accordance with all other Medicare coverage and payment criteria, including the provisions of 42 C.F.R. § 410.26(b).

Levels of Supervision

- **42 CFR § 410.32(b)(3)**
 - **(i) General supervision** means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.
 - **(ii) Direct supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
 - **(iii) Personal supervision** means a physician must be in attendance in the room during the performance of the procedure.
- This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of “general supervision” as outlined in this provision.

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SNF 3-Day Rule Waiver Overview

- Eliminate the requirement of a 3-day inpatient stay prior to SNF (or swing-bed CAH) admission.
- Similar to Pioneer Model
 - Available to aligned beneficiaries by order of Next Generation Providers/Suppliers or Preferred Providers to eligible and CMS-approved SNF Affiliates.
 - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing/rehab need.

Eligibility for SNF or Swing-Bed Hospital or CAH

- Approval by CMS:
 - Review of SNF, swing-bed hospital, or CAH qualifications to accept direct admissions or admissions after an inpatient stay of less than 3 days.
 - Review may include program integrity history of the SNF, swing-bed hospital, or CAH.
 - At the time of approval any SNF must have a quality rating of 3 or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website. This standard is subject to change in response to new scoring methodologies designed by CMS.
- Annual reassessment of SNF, swing-bed hospital, or CAH eligibility.
- CMS retains the right to remove a SNF or swing-bed hospital from the Model for program integrity reasons or for violation of Medicare regulations.

SNF Beneficiary Eligibility

- The beneficiary is aligned to a participating Next Generation ACO.
- The beneficiary is not residing (at the beginning of the episode) in a SNF or long-term care setting.
- Admission is ordered by a licensed physician or practitioner who is an ACO Provider/Supplier or Preferred Provider.
- The beneficiary is medically stable.
- Confirmed diagnoses by a licensed physician or practitioner
- The beneficiary has an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis.
- For direct admission, evaluation by a physician or non-physician practitioner within 3 days prior to SNF admission.
- For direct admission, the beneficiary does not require inpatient hospital evaluation or treatment.
- For admission following fewer than 3 days of inpatient hospitalization, the beneficiary does not require further inpatient hospital evaluation or treatment.

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Implementation Plans

- Goal: ensure ACO preparedness while minimizing administrative burden.
- Following acceptance into the Model, each ACO must submit an implementation plan for each benefit enhancement it wishes to utilize.
- CMS will provide the specifications for each benefit enhancement implementation plan.
- Example requirements:
 - Description of planned strategic use of the benefit enhancement;
 - Key performance indicators the ACO will measure for determining success;
 - Self-monitoring plan to prevent unintended effects.

Voluntary Alignment

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Voluntary Alignment

- Augments claims-based alignment by allowing beneficiaries a decision in their alignment to an ACO.
 - Available to currently- or previously-aligned beneficiaries.
 - During each PY, beneficiaries will have the opportunity to voluntarily align for the subsequent PY.
- ACOs may select the mode(s) of beneficiary confirmation.
- Direct provider-beneficiary communication about voluntary alignment allowed.
- Additional resources for beneficiaries:
 - 1-800-MEDICARE;
 - Regional offices;
 - State Health Insurance Assistance Program counselors.
- Voluntary alignment decisions from other ACO programs/models in 2015 will be grandfathered into the Next Generation Model for PY1.

Potential Refinements to Voluntary Alignment

- In later years of the Model, CMS may:
 - Make alignment accessible to a broader group of Medicare beneficiaries, regardless of current or previous alignment;
 - Include affirmation of a general care relationship between beneficiaries and ACOs, instead of between beneficiaries and specific providers; and/or
 - Allow beneficiaries to *opt out* of alignment to a particular ACO in addition to *opting into* ACO alignment.

Questions?

Next Generation ACO Model Webpage:

<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

E-mail: NextGenerationACOModel@cms.hhs.gov