Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Next Generation ACO Model

Request for Applications

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I. Background and Introduction

The Centers for Medicare & Medicaid Services (CMS) is committed to achieving better care for individuals, better health for populations, and reduced expenditures for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). One mechanism for achieving this goal is for CMS to partner with groups of health care providers and suppliers who agree to accept joint responsibility for the cost and quality of care outcomes for a specified group of beneficiaries. CMS is currently pursuing such partnerships through several initiatives, including the Medicare Shared Savings Program (MSSP), Pioneer Accountable Care Organization (ACO) Model, and the Comprehensive ESRD Care (CEC) Initiative.

Several objectives underlie the overall CMS approach to testing accountable care models, including:

- Promoting changes in the delivery of care from fragmented to coordinated care systems as part of broader efforts to improve care integration, such as initiatives on advanced primary care and bundled payments;
- Improving effective beneficiary engagement and protections against harm;
- Protecting the Medicare Trust Funds while finding new ways of delivering care that will decrease expenditures over time;
- Learning and sharing best practices with providers to assist their pursuits of better care for individuals, better health for populations, and lower growth in expenditures for the Medicare fee-for-service population; and
- Developing close working partnerships with providers.

The purpose of the Next Generation Accountable Care Organization (ACO) Model ("Next Generation Model", "Next Generation", or the "Model") is to test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries. The Model offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using refined benchmarking methods that: (1) reward quality performance; (2) reward both attainment of and improvement in cost containment; and (3) ultimately transition away from reference to ACO historical expenditures. The Model additionally offers a selection of alternative payment mechanisms to enable a graduation from FFS reimbursements to capitation. Also central to the Next Generation Model are several tools to help ACOs improve engagement with beneficiaries, such as: (1) enhanced access to home visits, telehealth services, and skilled nursing facilities; (2) a reward payment for receiving care from the ACO; (3) a process that gives beneficiaries a decision in their alignment with ACOs; and (4) collaboration between CMS and ACOs to clearly communicate to beneficiaries the characteristics and potential benefits of ACOs in relation to their care.

II. Statutory Authority

A. General Authority to Test Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Center for Medicare & Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care.

B. Financial and Payment Model Authorities

Section 1115A(b)(2) of the Act requires the Secretary to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute provides a non-exhaustive list of examples of models that the Secretary may select, which includes the following: (1) a model under which the Center for Medicare & Medicaid Innovation (CMMI) contracts directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment (see section 1115A(b)(2)(B)(ii) of the Act); and (2) a model under which CMMI promotes care coordination between providers of services and suppliers that transition health providers away from fee-for-service based reimbursement and toward salary-based payment (see section 1115A(b)(2)(B)(iv) of the Act).

C. Waiver Authority

The authority for the Next Generation Model is section 1115A of the Act. Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Request for Applications, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Next Generation Model. Any such waiver would apply solely to the Next Generation Model and could differ in scope or design from waivers granted for other programs or models.

III. Scope and General Approach

CMS expects between 15 and 20 ACOs to participate in the Next Generation Model, with representation from a variety of provider organization types and geographic regions. CMS may make more than 20 awards if resources are available and a compelling reason exists to do so. The Next Generation Model will have two application rounds—the first application due date will be June 1, 2015, and the second will be June 1, 2016. The first round of selected ACOs will have an initial agreement term that consists of three one-year performance periods with the potential of

two additional one-year extensions. The first performance period is anticipated to begin January 1, 2016. The second round of selected ACOs will have an initial agreement term of *two* one-year performance periods, with the potential of two additional one-year extensions. The first performance period for round two is anticipated to begin January 1, 2017.

The goal of the Next Generation Model is to test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries. Core principles of the Model are:

- Protecting Medicare FFS beneficiaries' freedom to seek the services and providers of their choice;
- Creating a financial model with long-term sustainability;
- Utilizing a prospectively-set benchmark that: (1) rewards quality; (2) rewards both attainment of and improvement in efficiency; and (3) ultimately transitions away from updating benchmarks based on ACO's recent expenditures;
- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs;
- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process;
- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

While CMS is committed to improving care for beneficiaries, the Agency reserves the right to decide at any time not to move forward with the Next Generation Model for any reason, as is true for all models tested under section 1115A of the Act. Similarly, CMS reserves the right to modify or terminate the Model if it is determined that it is not achieving the goals and aims established for the Model.

IV. Application Process

As described in Section III above, the Next Generation ACO Model Agreement will allow two application rounds in consecutive years. Each application round will have its own respective Letter of Intent and Application processes. Organizations that complete the round one process and are not selected for participation may apply for participation in round two, but round one application materials will not be held for reevaluation in round two. Therefore, an organization must submit a unique Letter of Intent and Application for each round in which it wants to be considered for participation.

A. Letter of Intent

For round one consideration, interested organizations must submit a Letter of Intent (LOI) no later than 11:59 p.m. EDT May 1, 2015. For round two consideration, interested organizations must submit an LOI no later than 11:59 p.m. EDT May 1, 2016. Letters of Intent will be used only for planning purposes, and submitting an LOI will not bind an interested organization to moving forward under the Model. An LOI template is provided in Appendix A. To file an LOI, interested organizations may access an electronic portal at: http://innovationgov.force.com/vloi

CMS will not consider applications from organizations that do not submit a timely LOI.

B. Application

Round one applications will be made available in March, 2015 and must be submitted electronically no later than 11:59 p.m. EDT June 1, 2015. Round two applications will be made available in March, 2016 and must be submitted electronically no later than 11:59 p.m. EDT June 1, 2016. An application template is provided in Appendix G so that applicants can begin preparing their responses. CMS reserves the right to request interviews, site visits, or additional information related to application responses from applicants in order to assess their applications. Applicants may access the application portal at:

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

To submit an application, applicants must first visit the above URL to receive a username and password using the number code provided upon LOI submission. Applicants that do not submit an LOI successfully will be unable to access the application page. Any questions that arise during the application process may be directed to the Next Generation Model mailbox: NextGenerationACOModel@cms.hhs.gov.

C. Withdrawal of Application

Applicants seeking to withdraw completed applications must submit an electronic withdrawal request to CMS via the Next Generation Model mailbox: NextGenerationACOModel@cms.hhs.gov. The request must be submitted as a PDF on the organization's letterhead and signed by an authorized corporate official. It should include: the applicant organization's legal name; the organization's primary point of contact; the full and correct address of the organization; and a description of the nature of the withdrawal. Applicants seeking to withdraw only specific CMS Certification Numbers (CCNs) and/or National Provider Identifier (NPI) numbers from a pending application must follow the same process outlined above. Note that withdrawal of CCNs and/or NPIs from an application will require CMS to reassess the applicant's eligibility, including, for instance, the number of beneficiaries eligible for alignment.

Of important note, and as described in the Legal Entity and State Licensure sections below, applicants to the Next Generation Model will not be expected to have their legal entity formed or requisite state licensure verified until after selection. However, these requirements must be satisfied prior to the finalization of the Next Generation ACO Model Participation Agreement. Before signing the Participation Agreement, selected applicants must submit a list identifying 100% of their Providers/Suppliers and Preferred Providers in order to allow for screening by CMS and its law enforcement partners and final approval by CMS.

V. Applicant Eligibility and Participation Requirements

The following sections describe the structural requirements an entity must meet to be eligible to participate in the Next Generation Model.

A. 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, provided that they satisfy the requirements of the Model. See Program Overlap at Section V.H below for an explanation of how ACOs and providers/suppliers may or may not participate in multiple Medicare initiatives.

B. Screening

Applications will be screened to determine eligibility for further review using criteria detailed in this solicitation and in applicable law and regulations, including 2 CFR Parts 180 and 376. In addition, CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review of the applicant, its providers/suppliers, its affiliates or any relevant individuals or entities. CMS may also deny individual Providers/Suppliers, Preferred Providers, Affiliates, or any other relevant entity participation in the Next Generation Model based on the results of a program integrity review. Applicants will be required to disclose any investigations of, or sanctions that have been imposed on the applicant or individuals in leadership positions in the last three years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, a CEO, CFO, COO, CIO, medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data.

C. Legal Entity, Governance Structure, and Leadership

1. Legal Entity

A Next Generation ACO must be a legal entity, formed under applicable State, Federal, or Tribal law, and authorized to conduct business in each State in which it operates for purposes of the following:

- Receiving and distributing shared savings;
- Repaying shared losses or other monies determined to be owed to CMS;
- Establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards;
- Fulfilling other ACO functions identified in the Next Generation ACO Model Participation Agreement.

An ACO formed by two or more entities, each of which is identified by a unique TIN, must be a legal entity separate from any of its Next Generation Providers/Suppliers (defined in the Glossary at Appendix B.

ACO legal entities that have participated (without termination for cause) in either the Medicare Shared Savings Program (MSSP) or the Pioneer Model in the year prior to entry into the Next

Generation Model will be deemed to have met the Next Generation legal entity requirement. The applicant must comply with all applicable laws and regulations, as well as all Next Generation Model participation requirements.

2. Structure of the Governing Body

Next Generation ACOs must have an identifiable governing body with sole and exclusive authority to execute the functions and make final decisions on behalf of the ACO. The following requirements apply to all Next Generation ACOs:

- The ACO governing body must be separate and unique to the ACO and must not be the same as the governing body of any other entity participating in the ACO;
- The governing body must be the same as the governing body of the legal entity that is the ACO.
- Notwithstanding the foregoing, if a Next Generation ACO is an existing legal entity (e.g., Alpha Health System is Alpha ACO), the ACO governing body may be the same as that of the existing legal entity, provided all other requirements are met.

3. Responsibilities of the Governing Body

- The governing body must have responsibility for oversight and strategic direction of the ACO and will be responsible for holding ACO management accountable for the ACO's activities;
- The governing body must have a transparent governing process;
- The governing body members must have a fiduciary duty to the ACO and must act consistent with that fiduciary duty. A fiduciary duty to the ACO includes a duty of loyalty.
- The governing body must receive regular reports from the compliance officer, who is not legal counsel to the ACO, and who must report directly to the governing body.

4. Composition and Control of the Governing Body

- The ACO must provide for meaningful participation in the composition and control of the ACO's governing body for Next Generation Providers/Suppliers or their designated representatives. At least 75 percent control of the ACO's governing body must be held by Next Generation Providers/Suppliers or their designated representatives.
- The ACO governing body must include at least one Medicare beneficiary served by the ACO: (1) who does not have a conflict of interest with the ACO; (2) who has no immediate family member with a conflict of interest with the ACO; and (3) who is not a Next Generation Provider/Supplier.
- The ACO governing body must include at least one consumer advocate, who may be the same person as the beneficiary. A consumer advocate is a person with training or professional experience in advocating for the right of consumers.
- In cases where beneficiary and/or consumer advocate representation on the ACO governing body is prohibited by state law, the Next Generation ACO, with CMS approval, shall provide for an alternative mechanism to ensure that its policies and procedures reflective consumer and patient perspectives.
- The governing body members may serve in similar or complementary roles or positions for Next Generation Providers/Suppliers to the roles of positions in which they serve for the ACO.

5. Conflict of Interest

The ACO governing body must have a conflict of interest policy approved by CMS that applies to members of the governing body. The conflict of interest policy must:

- Require each member of the governing body to disclose relevant financial interests;
- Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise;
- Address remedial actions for members of the governing body that fail to comply with the policy.

6. ACO Leadership and Management

Next Generation ACOs must have a leadership and management structure that meets the following criteria:

- The ACO's operations must be managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.
- Clinical management and oversight must be managed by a senior-level medical director who is: (1) a physician and a Next Generation Provider/Supplier; (2) physically present on a regular basis at any clinic, office, or other location participating in the ACO; and (3) a board-certified physician and licensed in a state in which the ACO operates.
- Each Next Generation Provider/Supplier must demonstrate a meaningful commitment to the mission of the ACO to ensure the ACO's likely success. Meaningful commitment may include, for example, a sufficient financial or human investment (e.g., time and effort) in the ongoing operations of the ACO such that the potential loss or recoupment of the investment is likely to motivate the Next Generation Provider/Supplier to achieve the ACO's mission under the Next Generation Model.

D. Preferred Providers

The Next Generation Model clearly defines categories of providers/suppliers and their respective relationships to the ACO entity. Some of the Next Generation Model benefit enhancement descriptions refer to “Preferred Providers” (benefit enhancements are described in Section VI.C; Preferred Providers are defined in the Glossary in Appendix B). These providers are not Next Generation Providers/Suppliers but nevertheless contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO.

ACOs may allow certain benefit enhancements that are available to aligned beneficiaries when receiving care from Next Generation Providers/Suppliers to also be available through Preferred Providers, provided that the ACO has a written agreement to that effect with the Preferred Provider and has supplied CMS with the Preferred Provider list according to CMS instructions. ACOs may contract with Preferred Providers to offer any combination of the applicable benefit enhancements to aligned beneficiaries. At a maximum, ACOs could allow Preferred Providers to provide expanded telehealth services, post-discharge home visits, and Skilled Nursing Facility (SNF) admissions without a mandatory three-day inpatient stay. The Preferred Provider role is based solely upon benefit enhancements; therefore, Preferred Providers will not be associated with alignment or quality reporting through the ACO.

E. Next Generation Affiliates

Next Generation ACOs may contract with other individuals and organizations to advance ACO cost and quality goals ("Next Generation Affiliates" are defined in the Glossary in Appendix B). There are two types of these Next Generation Affiliates—Capitation Affiliates and SNF Affiliates—each associated with a specific optional Model design element. In themselves, Affiliates have no other formal relationships with ACOs. However, Preferred Providers may also be Affiliates, subject to ACO and CMS approval, in order to participate in the respective design elements.

The capitation payment mechanism (described in Section VI.A.1.iv) allows ACOs to enlist non-ACO providers/suppliers to collaborate in cost control efforts. Capitation Affiliates are Medicare providers/suppliers with whom the ACO contracts to participate in capitation with regards to Next Generation Beneficiaries. Additional information will be provided to Next Generation ACOs that decide to pursue the capitation payment mechanism in PY2 or later.

SNF Affiliates are SNFs to which Next Generation Providers/Suppliers or Preferred Providers may admit Next Generation Beneficiaries according to the SNF 3-Day Rule benefit enhancement. Section VI.C.2 describes the criteria for selection and approval of SNF Affiliates.

Table 5.1 Types of Next Generation Entities and Associated Functions[1]

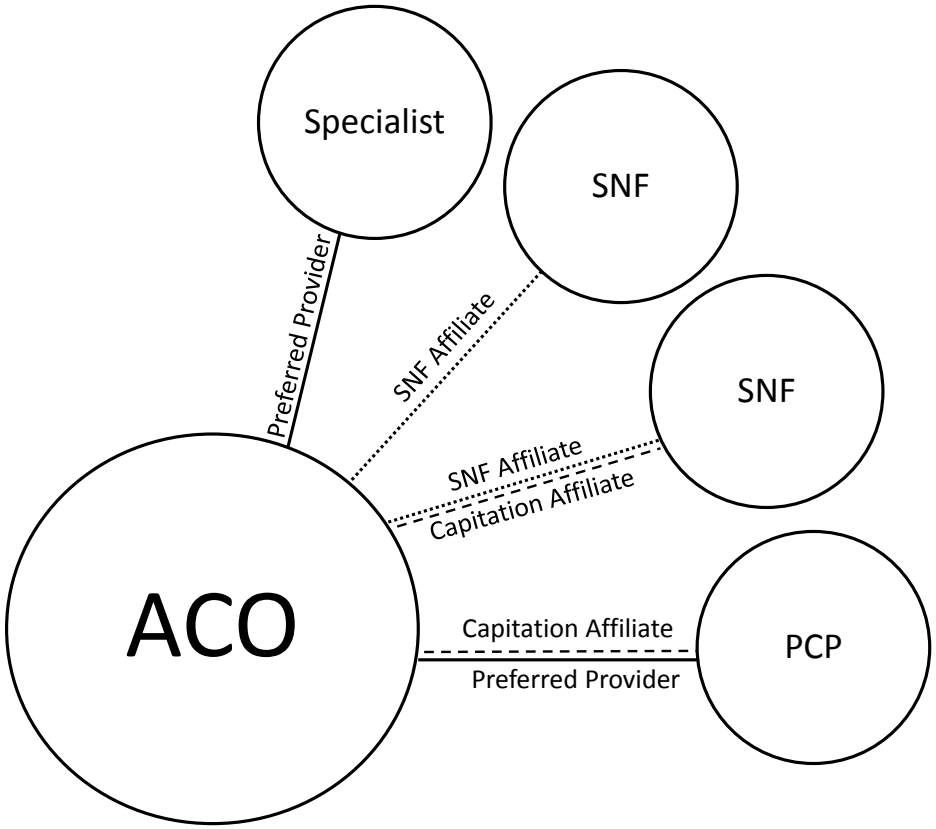
	Alignment	Quality Reporting Through ACO	Population-Based Payments	Capitation	Coordinated Care Reward	3-Day SNF Rule[3]	Telehealth	Post-Discharge Home Visit
Provider/ Supplier[2]	●	●	●	●	●	●	●	●
Preferred Provider					●	●	●	●
SNF Affiliate					●	●		
Capitation Affiliate				●	●			

[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.

[3] There are two distinct roles involved in the 3-Day SNF Rule benefit enhancement: (1) admitting practitioners; and (2) SNFs. Admitting practitioners must either be Next Generation Providers/Suppliers or Preferred Providers. SNFs may be Next Generation Providers/Suppliers or SNF Affiliates. More information on the benefit enhancement may be found in Section VI.C.2.

Figure 5.1 Examples of ACO Relationships with Non-Provider/Supplier Entities



This is a sample of some of the many possible relationships an ACO may have with non-Provider/Supplier entities according to Table 5.1. Each type of line depicts a possible form of relationship described by the text adjacent to each line.

F. State Licensure

To participate in the Next Generation ACO Model, ACOs must demonstrate compliance with all relevant state laws and regulations with respect to risk-bearing entities. ACOs must produce applicable documentation upon request, and CMS may also request attestations of compliance from state insurance commissioners. Each state has unique regulatory systems for health care delivery, the practice of medicine, fraud and abuse, and insurance, but CMS understands that most states do not have laws that specifically address provider organizations bearing substantial financial risk, distributing savings, or, in the case of capitated payments, paying claims. Therefore, depending on the particular state laws and the discretion of state authorities, Next Generation ACOs may be subject to insurer or third-party administrator (TPA) licensure requirements. It is a Next Generation ACO's responsibility to determine and meet all applicable licensure requirements. The Next Generation Model does not alter state law requirements, but it intends to engage relevant state agencies to promote understanding of the Model's features and requirements.

G. Outcomes-Based Contracts with Other Purchasers

Next Generation ACOs must operate under outcomes-based contracts with other purchasers (private health plans, state Medicaid agencies, and self-insured employers) such that the majority

(over 50 percent) of an ACO's total patients (including those in Medicare) are covered under such arrangements by the end of the first performance period (December 2016 for round one applicants; December 2017 for round two applicants).

For purposes of this Model, outcomes-based contracts are defined as those that include financial accountability (shared savings and/or financial risk), patient experience evaluations, and substantial quality performance incentives. For example, CMS would consider the following to have sufficient quality incentives: (1) contracts in which shared savings are contingent upon meeting all quality thresholds; or (2) contracts in which at least 10% of ACO revenues from that purchaser are linked to quality performance scores. Failure to enter such arrangements by the end of the first performance period may result in CMS terminating its agreement with the ACO or taking other corrective action.

H. Program Overlap

Next Generation ACOs will not be allowed to simultaneously participate in other Medicare shared savings initiatives—such as the Medicare Shared Savings Program (MSSP), Pioneer ACO Model, Comprehensive ESRD Care (CEC) Initiative, or Comprehensive Primary Care (CPC) Initiative. Participation in other demonstrations or models—such as Health Care Innovation Awards (HCIA) or Bundled Payments for Care Improvement (BPCI)—does not preclude participation in the Next Generation Model, though coordination across demonstrations will be considered. CMS will undertake such program overlap reviews during the application process.

A group of providers or suppliers identified by a single Tax Identification Number (TIN) will not be allowed to concurrently participate as Next Generation Providers/Suppliers in the Next Generation ACO Model and as participants, providers/suppliers, or ACO professionals in the Medicare Shared Savings Program (MSSP). Any individual provider or supplier, identified by a unique TIN / National Provider Identifier (NPI) combination, identified as a Next Generation Provider/Supplier in the Next Generation Model precludes the entire TIN under which it bills from participation in the MSSP. This rule does not apply to either Next Generation Preferred Providers or Affiliates, both of which may also participate in the MSSP.

Within the Next Generation Model, an individual provider designated as a primary care provider will not be allowed to concurrently participate as a Next Generation Provider/Supplier in multiple Next Generation ACOs. However, an individual provider identified as a specialist will be allowed to concurrently participate as a Provider/Supplier in multiple Next Generation ACOs. Next Generation Preferred Providers and Affiliates will not be exclusive to any one Next Generation ACO.

VI. Model Design Elements

A. Financial Benchmark, Payment Mechanisms, and Shared Savings

The Next Generation Model seeks to test ACO capacity to take on near-complete financial risk in combination with a stable, predictable benchmark and payment mechanisms that encourage ACO investments in care improvement infrastructure. Below are the explanations of the Next Generation Model benchmark methodology, risk adjustment, risk arrangement options, payment mechanism options, and shared savings calculation methodology. A detailed financial methodology paper will be made available to potential participants prior to the signing of the Participation Agreement.

1. Benchmark

The prospectively-set benchmark is a core feature of the Next Generation financial model. The same methodology will be used to set the benchmark for all Next Generation ACOs regardless of the chosen payment mechanism or risk arrangement.

Unlike the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model, in which a final updated benchmark is determined at the end of each performance year, CMS will establish the Next Generation Model benchmark prior to the start of each performance year. The benchmark will be set using the most accurate expenditure, quality, and risk score data available at the time of benchmark setting.[1]

In the first three years of the Model (calendar years 2016-2018), for each Next Generation ACO, this prospective benchmark will be established through the following steps: (1) determine the ACO's historic baseline expenditures; (2) apply the regional projected trend; (3) risk adjust using the CMS Hierarchical Condition Category (HCC) model; and (4) apply the discount, which is derived from one quality adjustment and two efficiency adjustments.

i. Baseline (Benchmark Step 1)

CMS will employ a hybrid approach to developing the benchmark that incorporates both historical and regional costs. First, baseline ACO expenditures will be determined by using an ACO's historic spending in a single baseline year. The same baseline year will be used for PY1 through PY3. However, the baseline will be updated each year to reflect the ACO's Provider/Supplier list for the given performance year. Second, CMS will calculate a regional FFS expenditure baseline for alignment-eligible beneficiaries in order to determine an ACO's relative efficiency in relation to its region. The ratio of an ACO's historic expenditures to regional FFS expenditures (regional efficiency) will be used in calculating the discount, described in Benchmark Step 4 below. Under this approach, ACOs achieve savings through year-to-year improvement over historic expenditures (improvement), but the magnitude by which they must improve will vary based on relative efficiency (attainment).

CMS recognizes that price volatility for services at critical access hospitals (CAHs) between the baseline and performance years has been a concern for ACOs. CMS is exploring options for using substitute prices in both the baseline and performance years for those claims. CMS will develop a policy that will be incorporated into the PY1 methodology paper and the Participation Agreement.

ii. Trend (Benchmark Step 2)

The expenditure benchmark will incorporate a regional projected trend, which will be determined using similar assumptions as those used in the national projected trend in Medicare Advantage (MA)[2] with the additional application of regional price adjustments.

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[1] Next Generation ACOs will be responsible for all Parts A and B expenditures for aligned beneficiaries. The final specifications will be described in the financial methodology paper and the Next Generation Model Participation Agreement.

[2] Additional information on the Medicare Advantage actuarial methodology can be found in the Medicare Trustee's report: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf and the Medicare Advantage Ratebook: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf.

Because the trend is projected prior to the performance year, there is the potential for legislative or regulatory changes enacted during the performance year to have a meaningful impact on expenditures (e.g., legislation regarding the Sustainable Growth Rate (SGR)). Under limited circumstances, CMS would adjust the trend in response to price changes with substantial expected impact on ACO expenditures. The terms and conditions for trend adjustments will be detailed in the Participation Agreement so that ACOs are not unfairly penalized or rewarded for major payment changes beyond their control.

iii. Risk Adjustment (Benchmark Step 3)

Risk adjustment accounts for the differing acuity of an ACO's aligned population over time to ensure an ACO's benchmark reflects the risk profile of the aligned population each performance year. CMS will use a cross-sectional approach to benchmarking. In a cross-sectional approach, the alignment algorithm (described in Section VI.B) is applied separately to the baseline year and the performance year. Therefore, the attributed population in the baseline year may be different than that in the performance year.

CMS will apply prospective CMS Hierarchical Condition Category (HCC) risk scores to both the baseline and performance year populations. The full HCC risk score (both demographic and diagnostic components of the score) will be used for all aligned beneficiaries. The ACO's full HCC risk score will be allowed to grow with a 3% annual maximum cap (performance year compared to the baseline). For example, if an ACO experiences a 4% risk score growth, the adjustment will be reduced to 3%. If the ACO has 1% risk score growth, the adjustment will remain at 1% because it is below the cap. If the risk scores for continuously aligned beneficiaries decrease, CMS will adjust downward correspondingly with a 3% downside cap. A Next Generation ACO's risk score will be determined prior to the performance year and incorporated into the prospective benchmark.

iv. Discount (Benchmark Step 4)

Unlike MSSP and the Pioneer Model, the Next Generation Model will *not* utilize a minimum savings rate (MSR). Instead, CMS will apply a discount to the benchmark once the baseline has been calculated, trended, and risk adjusted. The discount will vary across ACOs and reflects three factors: (1) ACO quality score; (2) ACO baseline expenditures compared to regional FFS expenditures (regional efficiency); and (3) regional FFS expenditures (in the baseline year) compared to national FFS expenditures (national efficiency).

Below is a description of each factor of the discount.

- **Quality**: The quality component of the discount will range from 2.0% to 3.0%. Therefore, an ACO with a 100% quality score would have a quality discount of 2.0%, and an ACO with a 0% quality score would have a quality discount of 3.0%. CMS will determine the quality component of the discount using the following formula: [2.0 + (1-quality score)] %. In PY1, a quality score of 100% will be used for all Next Generation ACOs. More information on the use of quality scores in calculating the benchmark can be found in Section VII.C.
- **Regional Efficiency**: The regional efficiency component of the discount will range from -1% to 1%. This compares the ACO's risk-adjusted historical per capita baseline (described in Benchmark Step 1) to a risk-adjusted regional FFS per capita baseline (determined by ACO beneficiaries' counties of residence). This ratio will determine the

regional efficiency component of the discount.

- **National Efficiency**: The national efficiency component of the discount will range from -0.5% to 0.5%. This compares the risk-adjusted county FFS baseline to risk-adjusted national FFS per capita spending to determine the national efficiency component of the discount.
- When these three components are added together, the discount range is 0.5% to 4.5%. For an example discount calculation, see Appendix C.

In the last two performance years of the Model (calendar years 2019-2020), which will be governed by a new Participation Agreement, CMS may employ an alternative benchmarking methodology with the following principles:

- Eliminate or further de-emphasize the role of recent ACO cost experience when updating the baseline;
- Take into account public comments received in response to the MSSP Notice of Public Rulemaking (NPRM) on alternative benchmark approaches;
- Shift to valuing attainment more heavily than improvement;
- Consider the use of a normative trend;
- Continue to refine risk adjustment for beneficiary characteristics that balances changes in disease burden against diagnostic upcoding;
- Consider adjustments reflecting geographic differences in utilization or price changes.

CMS intends to provide details on this alternative methodology no later than the end of 2017 to allow Next Generation ACOs time for review before making decisions on continued participation for the final two performance years.

2. Risk Arrangements

The Next Generation Model will offer a choice of two risk arrangements that determine the portion of the savings or losses that accrue to the Next Generation ACO. The risk arrangement applies to the difference between actual expenditures and the discounted benchmark. In both arrangements: (1) the sharing rate will be higher than those in MSSP or the Pioneer Model; (2) individual beneficiary expenditures will be capped at the 99th percentile of expenditures to prevent substantial impacts by outliers (the Next Generation ACO is not accountable for expenditures beyond the 99th percentile); and (3) aggregate savings or losses will be capped at 15% of the benchmark.

Table 6.1 Risk Arrangements in the Next Generation Model

Arrangement A: Increased Shared Risk	**Arrangement B: Full Performance Risk**
Parts A and B Shared Risk • 80% sharing rate (PY1-3) • 85% sharing rate (PY4-5) • 15% savings/losses cap • Discount	100% Risk for Part A and B • 15% savings/losses cap • Discount

3. Payment Mechanisms

In addition to normal FFS payments, the Next Generation Model will test the effectiveness of alternative payment mechanisms in facilitating investments in infrastructure and care coordination to improve health outcomes. The Next Generation Model intends to offer full capitation as a fourth payment option starting in 2017. None of the alternative payment mechanisms offered in the Next Generation Model will affect beneficiary out-of-pocket expenses. The payment mechanism options are summarized below, and example calculations of each alternative mechanism are included in Appendix D.

i. Payment Mechanism 1: Normal FFS Payment

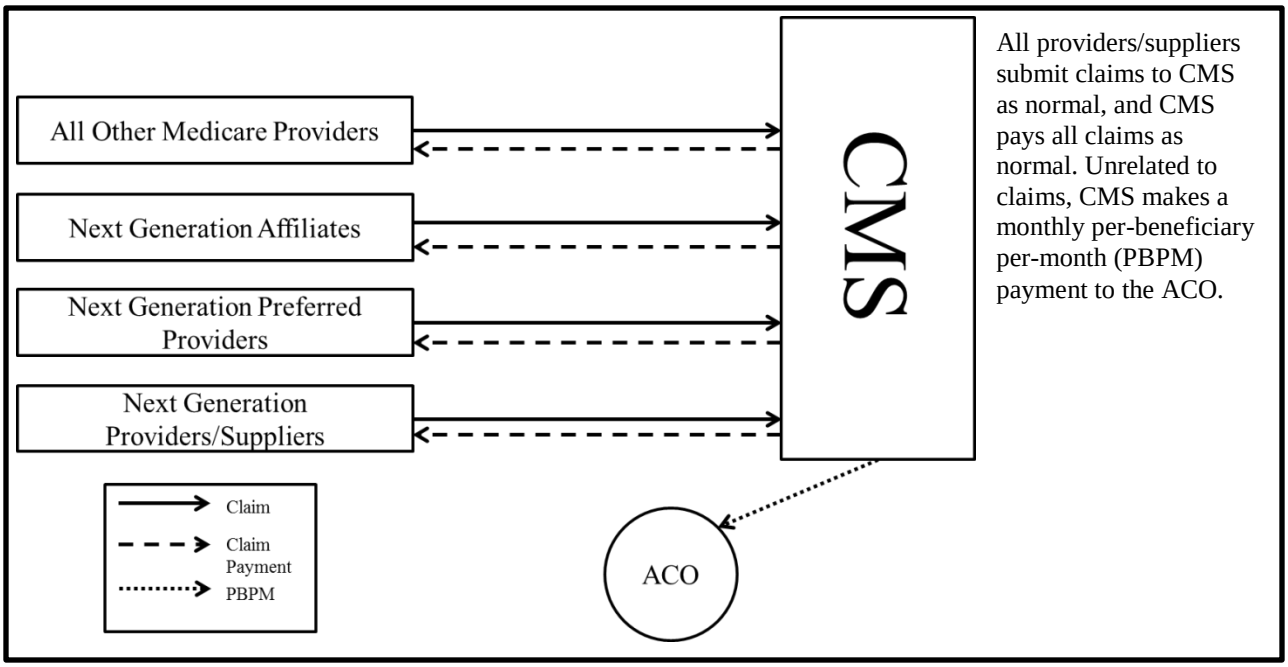
Next Generation Providers/Suppliers and non-ACO Providers/Suppliers would be paid by CMS for services performed through the normal FFS channels at standard payment levels. This represents no change from Original Medicare.

ii. Payment Mechanism 2: Normal FFS Payment + Monthly Infrastructure Payment

Next Generation Providers/Suppliers receive normal FFS reimbursement, and the ACO receives an additional per-beneficiary per-month (PBPM) payment unrelated to claims. These payments offer a stable and predictable payment option throughout the year without requiring ACOs to take on a claims-paying function. This allows the ACO to invest in infrastructure required to support ACO activities.

CMS will make this infrastructure payment at a rate of no more than $6 PBPM, and infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses. As described in Section VI.A.4 below, ACOs that elect to receive infrastructure payments will be required to have in place a sufficiently large financial guarantee to assure repayments to CMS of a potentially greater magnitude than would be likely through other payment mechanisms. The aggregate monthly payment amount may be updated periodically to adjust for beneficiaries that have been dropped from ACO alignment to mitigate overpayments.

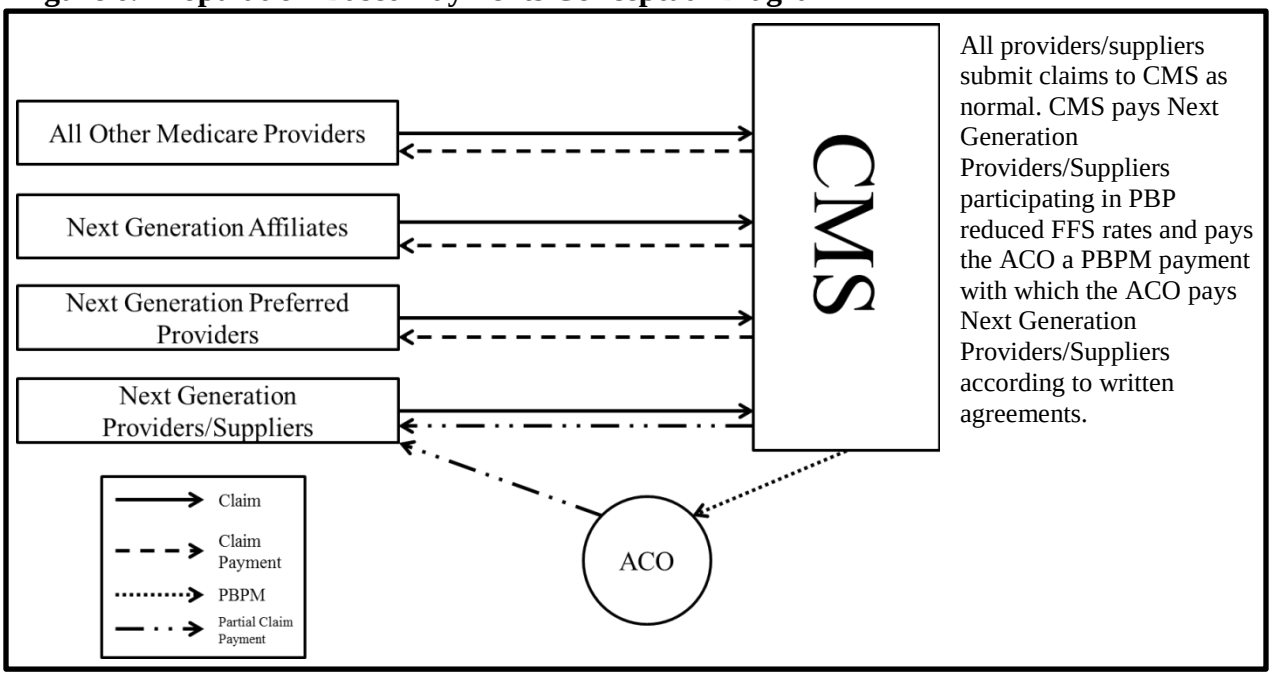
Figure 6.1 Infrastructure Payments Conceptual Diagram



iii. Payment Mechanism 3: Population-Based Payments (PBP)

PBP provides Next Generation ACOs with a monthly payment to support ongoing ACO activities and allows flexibility in the types of arrangements the ACO enters into with its Providers/Suppliers. First, a Next Generation ACO will determine a percentage reduction to the base FFS payments of its Next Generation Providers/Suppliers. An ACO may opt to apply a different percentage reduction to different subsets of its Providers/Suppliers. Providers/Suppliers participating in PBP must agree to permit CMS to reduce their Medicare reimbursement for aligned beneficiaries by the specified percentage. Only Next Generation Providers/Suppliers may participate in PBP with a Next Generation ACO. Second, CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments. The aggregate monthly payments may be updated periodically throughout the performance year to account for changes in beneficiary and provider populations.

Figure 6.1 Population-Based Payments Conceptual Diagram



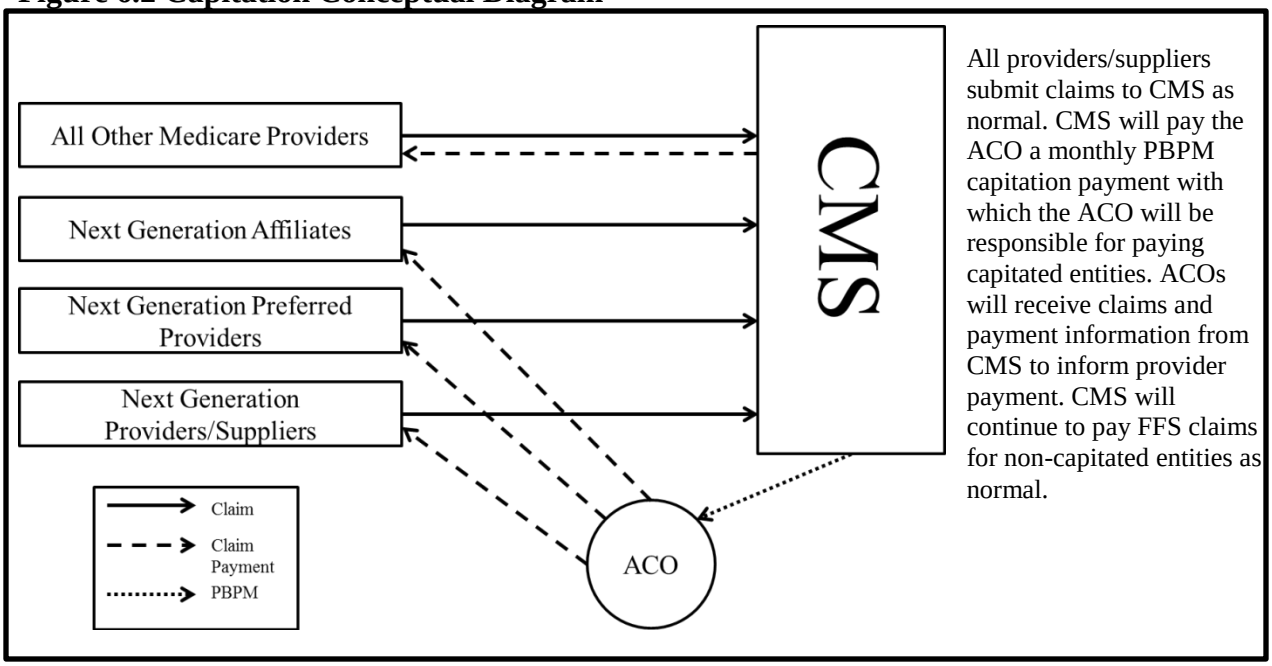
iv. Payment Mechanism 4: Capitation

Capitation functions by estimating total annual expenditures for Next Generation Beneficiaries and paying that projected amount to the ACO in a PBPM payment with some money withheld to cover anticipated care by non-ACO Providers/Suppliers. A Next Generation ACO participating in capitation will be responsible for paying claims for its Providers/Suppliers and Capitation Affiliates with whom the ACO has written agreements regarding capitation. ACOs will not be required to pay capitated providers 100 percent of FFS rates; ACOs may have alternative compensation arrangements with these providers consistent with all applicable laws. Providers paid under capitation will continue to submit claims to CMS for processing, and CMS will continue to be responsible for confirming beneficiary eligibility. ACOs must establish a process for payment disputes from capitated providers, the requirements for which will be detailed in the Model Participation Agreement.

On an ongoing basis, CMS will send Next Generation ACOs claims for those services for which the Next Generation ACO is responsible for making payment. These claims reports will be in addition those described in Section IX below. Additional financial requirements for ACOs participating in capitation will be described in the Participation Agreement.

CMS will continue to pay normal FFS claims for care provided to Next Generation Beneficiaries by providers and suppliers not covered by a Next Generation capitation agreement. CMS may periodically update capitation amounts to account for the actual percentage of aligned beneficiaries' care furnished by Next Generation Providers/Suppliers and Capitation Affiliates, as well as to account for changes in the aligned beneficiary population.

Figure 6.2 Capitation Conceptual Diagram



4. Savings/Losses Calculations

An ACO's savings or losses will be determined by comparing total Parts A and B spending for Next Generation Beneficiaries to the benchmark (with individual expenditures capped at the 99th percentile). The risk arrangement is then applied to determine the ACO's share of savings or losses. Savings payment or loss recoupment will occur annually following a year-end financial reconciliation. CMS will also account for monthly payments that occurred during the performance year through PBP, infrastructure payments, or capitation. This reconciliation may result in monies owed from CMS to the ACO, or vice versa, that are separate from shared savings or losses. Illustrative examples of reconciliation involving the risk arrangements and payment mechanisms may be found in Appendix D. Additional information regarding the reconciliation process, including ACO appeal rights, will be in the Participation Agreement.

Next Generation ACOs will be required to comply with all applicable state regulations regarding provider-based risk-bearing entities and have in place a financial guarantee sufficient to cover potential losses. Providers receiving infrastructure payments will be required to have in place a larger financial guarantee to cover these additional monies. The specific amount of the financial guarantee will be set in the Participation Agreement.

B. Beneficiary Eligibility and Alignment to Next Generation ACOs

Like participants in other Medicare ACO initiatives, Next Generation ACOs will earn savings or accrue losses and receive quality scores with regards to an aligned population of Medicare beneficiaries. The following sections describe how beneficiaries may be aligned to Next Generation ACOs and the requirements and duties of Next Generation ACOs with regards to alignment.

1. Minimum Aligned Population

To be eligible for participation in the Next Generation Model, ACOs must maintain an aligned

population of at least 10,000 Medicare beneficiaries. Next Generation ACOs that are deemed to be Rural ACOs (according to the Glossary in Appendix B) will be permitted to have a minimum population of 7,500 Medicare beneficiaries.

2. Beneficiary Eligibility

During the base- or performance-year, the beneficiary must:

- Be enrolled in both Medicare parts A and B;
- Not be enrolled in a Medicare Advantage plan, cost plan, or other non-Medicare Advantage Medicare managed care plan;
- Not have Medicare as a secondary payer;
- Be a resident of the United States;
- Not have relocated from a county that was included in the Next Generation ACO's service area to a county that was not included in the Next Generation ACO's service area; and
- Not have received more than 50% of their evaluation and management (E&M) services from providers practicing in counties outside the Next Generation ACO's service area during the base- or performance-years.

Where a beneficiary may meet eligibility criteria and be aligned/assigned/attributed to more than one Medicare shared savings initiative, the Agency applies a hierarchical set of rules to determine which initiative will include that beneficiary. CMS currently employs a formal (cross-agency) governance structure to execute hierarchical decision-making and determine how best to integrate new initiatives.

3. Claims-Based Alignment

The Next Generation Model will use the same methodology as the Pioneer Model to prospectively align beneficiaries to Next Generation ACOs. This methodology uses a two-stage alignment algorithm. First, CMS will analyze the claims for all beneficiaries who received care from Next Generation Providers/Suppliers to determine the percentage of each beneficiary's outpatient evaluation and management (E&M) services delivered by Next Generation Providers/Suppliers in select primary care specialties. Those beneficiaries with such ACO services comprising a plurality of their total care will be aligned to the ACO for the subsequent year.

In the second stage, the analysis focuses on beneficiaries with less than 10 percent of their E&M services delivered by Next Generation ACO primary care providers. A determination that Next Generation Providers/Suppliers in select subspecialties (listed at page 39 in the methodology paper linked below) was central to such a beneficiary's care may result in alignment for the subsequent year.

Details of the Pioneer Model alignment methodology are described in the Pioneer ACO Alignment and Financial Reconciliation Methods paper, available at: http://innovation.cms.gov/Files/x/PioneerACOBmarkMeghodology4to5.pdf

4. Voluntary Alignment

In addition to claims-based alignment, CMS will offer beneficiaries an opportunity to become aligned to Next Generation ACOs voluntarily. During PY1, and repeated annually in PY2-PY4, Next Generation ACOs may offer currently and previously aligned beneficiaries the option to

confirm or deny their care relationships with specific Next Generation Providers/Suppliers. These decisions will take effect in alignment for the subsequent year. A beneficiary who completes the voluntary alignment process will have the option to reverse that decision or change the identified provider prior to development of the ACO's alignment list.

Confirmation of care relationships through voluntary alignment supersedes claims-based attribution. For example, beneficiaries who indicate Next Generation Providers/Suppliers as their main sources of care will be aligned with the ACO, even if claims-based alignment would not result in alignment.

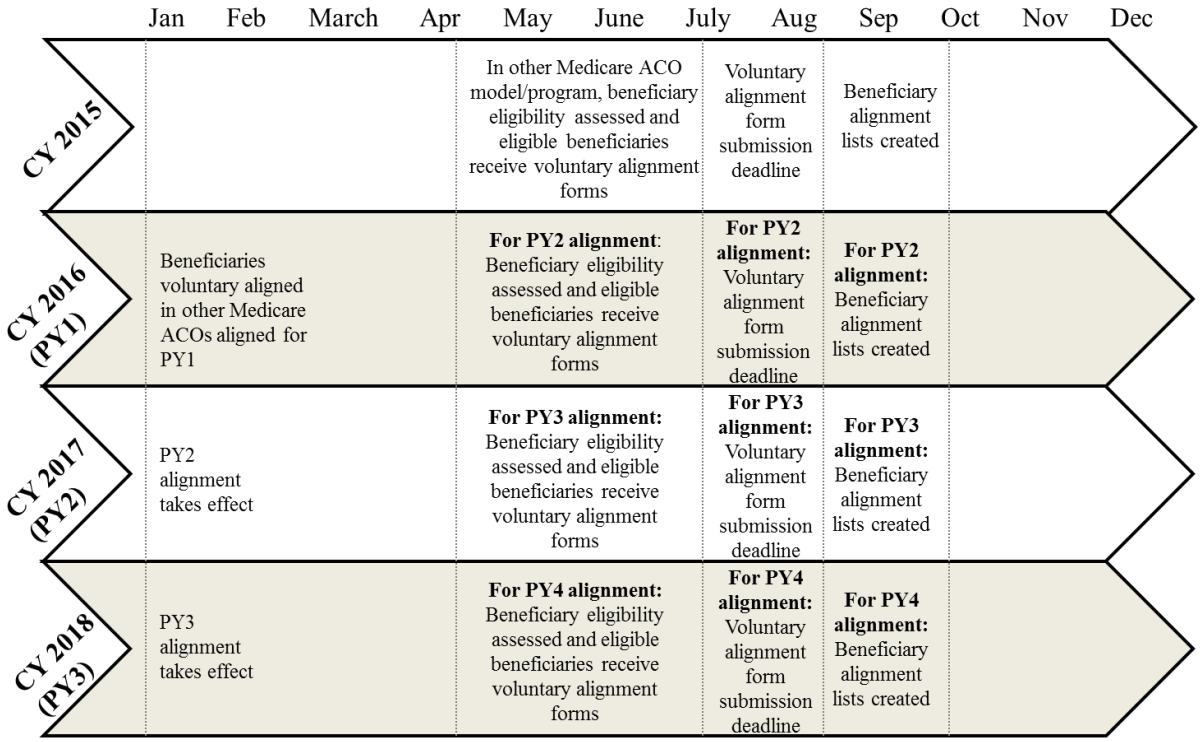
ACOs joining the Next Generation Model from other Medicare ACO initiatives with voluntary alignment may be allowed to retain beneficiaries who voluntarily aligned through the other ACO initiatives when transitioning into the Next Generation Model. For example, a Pioneer ACO participating in voluntary alignment in calendar year 2015 could retain those voluntarily-aligned beneficiaries for Next Generation PY1 if the ACO enters the Next Generation Model in 2016.

In advance of the voluntary alignment confirmation process, ACOs will be required to send a CMS-approved letter directly to beneficiaries with information regarding voluntary alignment and the potential benefit enhancements associated with alignment to Next Generation ACOs (described in Section VI.C below). In addition, ACOs will communicate to beneficiaries the principles of an ACO and specific services the ACO may offer to aligned beneficiaries. The specific guidelines and approval processes of such communications will be described in the Participation Agreement. CMS also intends to allow ACOs and their providers to directly discuss the policy with beneficiaries, provided that such discussions comply with requirements that will be specified by CMS in the Participation Agreement.

Given the unique characteristics of each ACO, CMS will consider allowing ACOs to select their preferred mode(s) of confirmation (e.g., phone, mailed forms, online forms) to best meet the needs of their respective beneficiary populations. CMS regional offices, State Health Insurance Assistance Programs (SHIPs), and consumer coalitions may also be resources to educate beneficiaries about voluntary alignment. ACOs and their providers will be instructed to refer beneficiaries to 1-800-MEDICARE and SHIP counselors for additional information. CMS will implement certain program integrity safeguards and monitoring measures and may require Next Generation ACOs and/or Next Generation Providers/Suppliers to implement protections to ensure that voluntary alignment does not result in coercion of beneficiaries or violations of Model terms.

In later years of the Model, CMS may refine voluntary alignment policies to: (1) make alignment accessible to a broader group of Medicare beneficiaries, regardless of current or previous alignment with an ACO; (2) include affirmation of a general care relationship between beneficiaries and ACOs, instead of between beneficiaries and specific providers; and/or (3) allow beneficiaries to *opt out* of alignment to a particular ACO in addition to *opting into* ACO alignment. Allowing voluntary *de-alignment* will require additional provisions to monitor ACO communications on this design element and to protect beneficiaries.

Figure 6.3 Voluntary Alignment Conceptual Timeline



C. Benefit Enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS plans to design policies as well as use the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the Next Generation Model. An ACO may choose not to implement all or any of these benefit enhancements. Applicants will be asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

Following acceptance into the Next Generation Model, each ACO will be required to provide additional information to CMS, which, upon approval, will enable the ACO's use of the optional benefit enhancements. Each optional benefit enhancement will have such an "implementation plan" requiring, for example: (1) descriptions of the ACO's planned strategic use of the benefit enhancement; (2) self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and (3) documented authorization by the governing body to participate in the benefit enhancement.

As part of the Next Generation Model monitoring and oversight strategy, CMS will incorporate a variety of program integrity safeguards (described in Section VIII) to ensure that these benefit enhancements do not result in program or patient abuse.

In pursuit of policy goals based upon accountable care and driving beneficiary value, CMS may continue to explore the operational feasibility and potential effectiveness of additional benefit enhancements in future performance years. For instance, for similar policy reasons as those

stated in the beneficiary coordinated care reward below, CMS may consider reducing or waiving the Next Generation Beneficiary requirements to pay the Part B deductible and/or coinsurance when receiving care from Next Generation ACO Providers/Suppliers or Preferred Providers.

1. Beneficiary Coordinated Care Reward

In order to support alternative payment and delivery models and to reward beneficiary engagement with providers and suppliers accountable for the cost and quality of their care, CMS will make direct payments to each Next Generation Beneficiary who receives at least a certain percentage of his or her Medicare services from Next Generation Providers/Suppliers, Preferred Providers, and Affiliates. All Next Generation Beneficiaries will automatically participate in this benefit enhancement and be eligible for this reward payment beginning in 2016. These payments are independent of cost-sharing requirements and will be paid according to the specified criteria, regardless of beneficiary supplemental coverage.

The exact amounts of the payments and the threshold percentage of care necessary to receive the reward will be finalized in the Participation Agreement. CMS expects that the reward amount will be approximately $50 per-beneficiary per-year, paid semiannually, and expects to set the threshold at least at 50% of all Parts A and B care from Next Generation Providers/Suppliers, Preferred Providers, and Affiliates. The methodology for calculating the percentage of ACO care will be described in guidance documentation and communicated to Next Generation Beneficiaries prior to the beginning of PY1. Beneficiaries will be responsible for paying all applicable state and federal taxes associated with the reward payment.

Sample Reward Payment Calculation

- Illustrative Reward Amount: $50/year ($25 available semiannually)
- Illustrative ACO Care Threshold: 50%
- Beneficiary A is aligned to Next Generation ACO Alpha. During the first half of the year, she receives 65% of her care from ACO Alpha entities. She receives a $25 payment from CMS.
- During the second half of the year, Beneficiary A receives 40% of her care from ACO Alpha entities. She does not receive a payment from CMS for that period.

2. 3-Day SNF Rule Waiver

CMS will make available to qualified Next Generation ACOs a waiver of the three-day inpatient stay requirement prior to admission to a skilled nursing facility (SNF) or acute-care hospital or CAH with swing-bed approval for SNF services ("swing-bed hospital"). This benefit enhancement will allow beneficiaries to be admitted to qualified Next Generation SNF Affiliates (or Providers/Suppliers if a SNF or swing-bed hospital is on the Next Generation Provider/Supplier list) either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to Next Generation SNF Affiliates by Next Generation Providers/Suppliers or Preferred Providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if: (1) the beneficiary does not reside in a nursing home or SNF for long-term custodial care at the time of the decision to admit to a SNF; and (2) the beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:

- be medically stable;
- have confirmed diagnoses (e.g., does not have conditions that require further testing for proper diagnosis);
- not require inpatient hospital evaluation or treatment; and
- have an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

Next Generation ACOs will identify the SNF Affiliates with which they will partner in this waiver. Through the application and implementation plan, Next Generation ACOs will be asked to describe how SNF Affiliates have the appropriate staff capacity and necessary infrastructure to carry out proposed coordination activities. In addition to the information the ACO includes in its implementation plan, SNF Affiliates must also have, at the time of application submission, 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 star standard is subject to change in response to changes in the scoring methodology that will take effect in 2015.

3. Telehealth Expansion

CMS will make available to qualified Next Generation ACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by Next Generation Providers/Suppliers or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation with the exception that 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 visit 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.

4. Post-Discharge Home Visits

CMS will make available to qualified Next Generation ACOs waivers to allow "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the *general* supervision—instead of *direct* supervision—of Next Generation Providers/Suppliers or Preferred Providers. Licensed clinicians may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, e.g., inpatient prospective payment system (IPPS) hospitals, CAHs, SNFs, Inpatient

Rehabilitation Facilities (IRFs)) and will be limited to no more than one visit in the first 10 days following discharge and no more than one visit in the subsequent 20 days. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 C.F.R. § 410.26.

D. Part D Interaction

Due to complex interactions between the Part D bidding process, timing of Part D enrollment versus ACO alignment, regulatory and statutory constraints on defining Part D service areas, and the highly fragmented nature of the Part D market, CMS has concluded that it is not possible to explicitly combine Part D spending with Parts A and B spending in the Next Generation expenditure benchmark.

CMS believes it is important to find strategies for including Part D accountability into ACO initiatives and is exploring options for facilitating partnerships between Part D Plans and ACOs in this Model. The earliest CMS would be able to implement such Part D interaction would be Performance Year 2 (2017). Any Part D interaction would be subject to appropriate safeguards and conditions to protect against fraud and abuse.

VII. Quality and Performance

Quality measures and performance standards in the Next Generation Model will be aligned with those in MSSP and other CMS quality measurement efforts. For each performance year, the Model will follow quality domains, measures, benchmarking methodology, sampling, and scoring as reflected in the most recent final regulations for MSSP and the Physician Fee Schedule, with limited exceptions detailed below.

A. Quality Measures

The Next Generation Model will adopt the MSSP quality measure set, except for the electronic health record (EHR) measure (ACO-11: Percent of PCPs Who Successfully Meet Meaningful Use Requirements), for a total of 32 measures. Similar to MSSP, the Model will follow a transition of individual measures from pay-for-reporting in the first performance year to pay-for-performance in subsequent years. The Next Generation Model Quality Measures can be found in Appendix E.

B. Quality Monitoring

To ensure quality measures are reported accurately and completely, CMS will conduct data validation audits on ACO quality data. These may involve ad hoc or scheduled desk reviews, focused audits, or full audits. These efforts will be in addition to the overall program monitoring and oversight strategy described in Section VIII.

C. Quality in Calculating the Benchmark

Quality performance scores will partly determine the magnitude of the financial opportunity for Next Generation ACOs through the benchmark calculation. A better quality score results in a smaller, more favorable discount for the ACO; conversely, a poorer quality score leads to a larger discount (see Section VI.A for the benchmark description).

To implement pay-for-reporting in PY1, CMS will assume a 100% quality score for all Next Generation ACOs when calculating the discount and setting the prospective benchmark. In the event an ACO fails to successfully report for PY1, CMS will retroactively adjust the discount and reconcile the ACO's financial performance accordingly.

In PY2, CMS will initially apply a flat performance quality score that would approximate most ACOs' expected quality scores based on the most recently available average quality scores. Once PY1 quality scores are calculated at mid-year PY2, CMS will adjust the discount and financial benchmark accordingly.

For PY3 and beyond, the initial quality score component of the discount will be based on the quality score from two years prior to the performance year. ACOs will have the opportunity to elect a mid-year update to reflect their most recent quality results (from the immediately preceding year) if they are higher than the older quality score.

Table 7.1 Quality Scores Used for Calculating the Benchmark

Performance Year	Initial Benchmark	Quality Score Used in Initial Benchmark	Benchmark Update	Quality Score Used in Update
PY1 (2016)	Late Fall 2015	100%	N/A	N/A
PY2 (2017)	Late Fall 2016	Approximated mean quality score.	Summer 2017	Actual quality score for 2016 service dates.
PY3 (2018)	Late Fall 2017	Actual quality score for 2016 service dates.	Summer 2018	ACO to elect either: 1) Keep actual quality score for 2016 service dates; OR 2) Actual quality score for 2017 service dates (if higher).

VIII. Monitoring and Oversight

As part of the Next Generation ACO Model, CMS will implement a monitoring plan designed to protect beneficiaries and address potential program integrity risks. Relative to the MSSP and the Pioneer Model, the Next Generation Model presents new risks—and hence requires additional, more rigorous safeguards—both because of the incentives inherent in the model design and the potential waiver of laws meant to constrain certain activities.

A. Compliance Plan

Among other requirements that will be described in the Participation Agreement, participating ACOs will be required to develop a compliance plan with at least the following attributes:

- Designation of a compliance officer who is not legal counsel to the ACO and who reports directly to the ACO's governing body;
- Mechanisms, such as internal audits and Corrective Action Plans (CAPs), to identify and address noncompliance with the Participation Agreement, Medicare regulations, and/or internal procedures and performance standards;
- Development of a quality assurance strategy that includes a peer review process to investigate cases of potentially suboptimal care;
- Compliance training programs;

- A method for employees or contractors of the ACO, Next Generation Providers/Suppliers, Preferred Providers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer.

B. CMS Monitoring

CMS will employ a range of methods to monitor and assess Next Generation ACO behavior, including, but not limited to:

- Claims analyses to identify fraudulent behavior or program integrity risks such as inappropriate reductions in care, efforts to manipulate risk scores or aligned populations, overutilization, and cost-shifting to other payers or populations;
- Analysis of beneficiary and provider complaints such as those received through 1-800-MEDICARE and emails to the Next Generation Model inbox;
- Periodic targeted audits focusing on claims data, medical chart reviews, beneficiary survey data, coding, and financial transactions.

C. Corrective Actions

Noncompliance with the terms of the participation agreement will trigger appropriate actions based on the type of issue, degree of severity, and the ACOs compliance record while in the program. Such actions will include but will not be limited to:

- ACO education on how to operate in compliance with relevant standards;
- Corrective Action Plan (CAP) detailing how an ACO will rectify noncompliance;
- Suspension of data sharing rights if data sharing is implicated in the violation;
- Suspension of termination of infrastructure payments or other payments due to the ACO;
- Termination of the ACO from the Next Generation Model;
- Referral to the Secretary for temporary or permanent revocation of Medicare billing privileges;
- Referral to law enforcement agencies for potential civil, administrative, and/or criminal violations.

IX. Data Sharing and Reports

A. Data Sharing

Under appropriate data use agreements (DUAs) and upon a Next Generation ACO's request, CMS will make available several types of Medicare data to support care coordination and quality improvement efforts, consistent with all relevant laws and regulations to protect beneficiary privacy. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations (45 C.F.R. § 164.514(b)), CMS may make available de-identified beneficiary data to Next Generation ACOs for the express purpose of submitting such data to approved local multi-purchaser databases in order to support comprehensive performance assessment by the ACO or its Providers/Suppliers.

The Next Generation Model will honor the data sharing opt-out decisions by beneficiaries who were previously given that choice while an aligned beneficiary in another Medicare ACO initiative. However, Next Generation ACOs will not be required to notify newly aligned beneficiaries at the beginning of the performance year regarding the ACO's intent to request their claims data from CMS or to provide information or forms regarding the opportunity to decline data sharing. Data sharing will be offered to Next Generation ACOs in accordance with HIPAA for all beneficiaries who were either: (1) not previously aligned to any ACO; or (2) previously aligned to an ACO but did not opt out of data sharing.

Next Generation ACOs may inform each newly-aligned beneficiary, in compliance with applicable laws, that he/she may elect to allow the Next Generation ACO to receive beneficiary-level data regarding the utilization of substance abuse services, the mechanism by which the beneficiary can make this election, and contact information to answer any questions about data sharing of substance abuse services. CMS will provide Next Generation ACOs with the Substance Abuse Opt-In Form.

In addition to the data mentioned above and the reports listed below, Next Generation ACOs that elect the capitation payment mechanism will receive claims and payment information from CMS for the services performed by Next Generation Providers/Suppliers and Capitation Affiliates. This information will be sent from CMS to the ACO on a frequent basis, at a minimum of once per month.

B. Reports

CMS will provide Next Generation ACOs with reports on a regular basis. Data reports will provide program performance and program payment data to Next Generation ACOs for performance management and for program cost and savings analyses. The reports may include, but are not limited to: Beneficiary Claims Data; Quarterly and Annual Utilization; Provider/Supplier List; Monthly Expenditures; Beneficiary Data Sharing Preferences; and Beneficiary Alignment.

1. Monthly

ACOs will receive standard monthly financial reports on the most recent and cumulative expenditures for aligned beneficiaries. This report summarizes claims based on the previous month's expenditures but includes no claims run-out. For ACOs that select the capitation payment mechanism in 2017 or later, the monthly financial reports will also show the allowed amount that CMS would have paid the billing Providers/Suppliers and Capitation Affiliates before the capitation reduction of 100% was applied. Finally, a monthly claims lag report will show the differences between claim and date of service.

2. Quarterly

ACOs will receive standard, aggregated reports on the utilization and non-utilization of select services and total per-capita expenditures. This is a summary claims report of beneficiary-level data aggregated on a rolling quarterly basis based on quarterly alignment updates. ACOs will also receive a report on previously aligned beneficiaries that have become de-aligned in the most recent quarter.

3. Other

Other reports may include:

- Financial Settlement reports including annual savings/losses in Medicare Parts A and B expenditures relative to the benchmark;
- Standard reports on per-capita expenditures and quality measures;
- Through its ACO Shared Learning System (described in Section XIV), other de-identified data and reports such as dashboards that show an ACO its performance in various dimensions relative to other Next Generation ACOs.

X. Evaluation

All Next Generation ACOs will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the model, which may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will assess the impact of the Next Generation Model on the goals of better health, better health care, and lower per beneficiary expenditures. The evaluation will be used to inform policy makers about the effect of Next Generation Model concepts relative to health care delivery under Original Medicare and other models of care. To do so, the evaluation will seek to understand the behaviors of providers and beneficiaries, the impacts of increased financial risk, the effects of various payment arrangements and benefit enhancements, the impact of the model on beneficiary engagement and experience, and other factors associated with patterns of results.

XI. Information Resources for Beneficiaries and Providers

The primary resource for beneficiaries with questions about the Next Generation Model will be 1-800-MEDICARE. CMS will develop scripts for customer service representatives (CSRs) that will answer anticipated questions related to the Model. Questions that CSRs cannot answer will be triaged to CMS Regional Offices. Next Generation ACOs will also be required to establish processes to answer beneficiary queries. Because of potentially substantial enhancements to certain Medicare benefits in the Next Generation Model, CMS will develop processes for Next Generation ACOs and CMS to notify and educate beneficiaries of these changes. Finally, CMS will maintain an email inbox for inquiries related to the Next Generation Model at NextGenerationACOModel@cms.hhs.gov.

XII. Application Scoring and Selection

CMS will evaluate applications in accordance with specific criteria in five key domains: (1) organizational structure; (2) leadership and management; (3) financial plan and experience with risk sharing; (4) patient centeredness; and (5) clinical care model. These domains and associated point scores are detailed in Appendix F. In addition, applicants should demonstrate that their organizational structure promotes the goals of the model by including diverse sets of providers who will demonstrate a commitment to high quality care. Lastly, applicants with prior participation in a CMS program or demonstration will be asked to demonstrate good performance and conduct.

As part of the Next Generation Model application process, applicants will be asked questions specific to their proposed implementation of benefit enhancements and per-beneficiary per-

month payments. Acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement, payment mechanism, or risk arrangement. Responses to questions regarding proposed implementation will assess interest in model design elements and assist with CMS planning and model implementation.

Complete and eligible applications will be reviewed by a panel of experts that may include individuals from the Department of Health and Human Service (DHHS) and other organizations, with an emphasis on expertise in provider payment policy, care improvement and coordination, and ACOs. Final selection for acceptance into the program will be based on the scoring criteria set forth in Appendix F as well as assessments of program integrity risks and potential market effects. CMS will normalize scores across review panels. CMS may choose to interview applicants and/or conduct pre-selection reviews of applicants during the application process in order to better understand applicant organizations and their Providers/Suppliers.

XIII. Duration of Agreement

The Next Generation ACO Model Agreement will have an initial term that consists of three performance periods for ACOs entering in 2016 and two performance periods for ACOs entering in 2017. Following the initial performance periods, there will be the potential for two additional one-year extensions regardless of entry year. The first performance period for 2016 entrants will extend from the start date of the initiative—anticipated to be January 1, 2016—until December 31, 2016. Subsequent performance periods will each last 12 months.

In choosing whether to offer the additional two performance periods, CMS may consider a variety of factors, including whether the Next Generation ACO generated savings and/or met performance standards or other program requirements during the first two performance periods. Any data available from the third performance period would also be considered. CMS also reserves the right to terminate the Model at any time if it is determined that it is not achieving the aims of the initiative.

XIV. Learning and Diffusion Resources

CMS will support Next Generation ACOs in accelerating their progress by providing them with opportunities to both learn about achieving performance improvements and share experiences with one another and with participants in other CMMI initiatives. This will be accomplished through a "learning system" for the Next Generation ACOs. The learning system will use various group learning approaches to help Next Generation ACOs effectively share experiences, track progress, and rapidly adopt new methods for improving quality, efficiency, and population health. CMS expects Next Generation ACOs to actively participate in the learning system by attending periodic conference calls and meetings and actively sharing tools and ideas through an online collaboration site.

XV. Public Reporting

The Next Generation Model emphasizes transparency and public accountability. At a minimum, Next Generation ACOs will be required to publicly report information regarding their organizational structure and Providers/Suppliers. CMS will publicly report the quality performance scores of Next Generation ACOs, among other data and information as appropriate. Specific public reporting requirements will be clearly described in the Participation Agreement.

XVI. Termination

CMS reserves the right to review the status of a Next Generation ACO and terminate the ACO's Participation Agreement or require the ACO, as a condition of continued participation, to terminate its agreement with a Provider/Supplier, Preferred Provider, or Affiliate, for reasons associated with poor performance, non-compliance with the terms and conditions of the Participation Agreement, program integrity issues, or if otherwise required under Section 1115A(b)(3)(B) of the Social Security Act. Specific reasons and procedures for termination will be clearly outlined in the Participation Agreement.

XVII. Amendment

CMS may modify the terms of the Next Generation Model in response to stakeholder comments and operational matters. The terms of the Next Generation Model as set forth in this Request for Applications may differ from the terms of the Next Generation Model as set forth in the Participation Agreement between CMS and the Next Generation ACO. Unless otherwise specified in the Participation Agreement, the terms of the Participation Agreement, as amended from time to time, shall constitute the terms of the Next Generation Model.

Appendices

Appendix A: Letter of Intent Template

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

The LOI can be found and completed at: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/. Questions about the Letter of Intent (LOI) for the Next Generation Model should be directed to NextGenerationACOModel@cms.hhs.gov.

1. Applicant Name
   Organization Name:
   Doing Business As (if applicable):
   Organization Type:
   Organization TIN/EIN:
   Street Address 1:
   Street Address 2:
   City:
   State:
   ZIP Code:
   Website (if applicable):
2. Applicant Primary Contact
   First Name:
   Last Name:
   Title/Position:
   Business Phone Number:
   Business Phone Number Extension:
   Alternative Phone Number (e.g., cell phone):
   E-mail Address:
   Street Address 1:
   Street Address 2:
   City:
   State:
   ZIP Code:
3. Secondary Contact
   First Name:
   Last Name:
   Title/Position:
   Business Phone Number:
   Business Phone Number Extension:
   Alternative Phone Number (e.g., cell phone):
   E-mail Address:
   Street Address 1:
   Street Address 2:
   City:
   State:

ZIP Code:

4. Indicate whether the Applicant ACO, or any of the proposed providers/suppliers, is currently participating in or has applied to any of the following initiatives listed below. Please check all that apply.

ACO	Bundled Payments for Care Improvement	Primary Care Transformation
☐ Advance Payment ACO Model ☐ Care Management for High-cost Beneficiaries Demonstration ☐ Comprehensive ESRD Care Initiative ☐ Medicare Health Care Quality Demonstration ☐ Medicare Shared Savings Program ☐ Nursing Home Value-Based Purchasing Demonstration ☐ Physician Group Practice Transition Demonstration ☐ Pioneer ACO Model ☐ Private, For-Profit Demo Project for the Program of All-Inclusive Care for the Elderly (PACE) ☐ Rural Community Hospital Demonstration	☐ Bundled Payments for Care Improvement 1 ☐ Bundled Payments for Care Improvement 2 ☐ Bundled Payments for Care Improvement 3 ☐ Bundled Payments for Care Improvement 4 ☐ Medicare Acute Care Episode Demonstration ☐ Medicare Hospital Gainsharing ☐ Physician Hospital Collaboration Demonstration	☐ Comprehensive Primary Care Initiative ☐ FQHC Advanced Primary Care ☐ Frontier Extended Stay ☐ Graduate Nurse Education Demonstration ☐ Independence at Home Demonstration ☐ Medicare Coordinated Care Demonstration ☐ Multi-payer Advanced Primary Care Practice
Initiatives Focused on the Medicaid and CHIP Population	**Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models**	**Initiatives to Speed the Adoption of Best Practices**
☐ Financial Alignment Initiative for Medicare-Medicaid ☐ Initiatives to Reduce Avoidable Hospitalizations Among Nursing Facility Residents ☐ Medicaid Emergency Psychiatric Demonstration ☐ Medicaid Incentives for the Prevention of Chronic Diseases Model ☐ Strong Start-Prenatal Care Models ☐ Strong Start-Reduce Elective Deliveries	☐ Health Care Innovation Awards Round One ☐ Health Care Innovation Awards Round Two ☐ Medicare Care Choices ☐ Medicare Intravenous Immune Globulin Demonstration ☐ State Innovation Models Initiative: Model Design Awards Round One ☐ State Innovation Models Initiative: Model Design Awards Round TwoState Innovation Models Initiative: Model Design Awards Round Two ☐ State Innovation Models Initiative: Model Pre-testing Awards ☐ State Innovation Models Initiative: Model Testing Awards Round One ☐ State Innovation Models Initiative: Model Testing Awards Round Two	☐ Community-based Care Transitions Program ☐ Innovation Advisors Program ☐ Million Hearts ☐ Medicare Imaging Demonstration ☐ Partnership for Patients

5. Medicare ACO Name (if participating in current Medicare ACO program or demonstration):
6. If a Medicare ACO, what is the ID number (e.g., P123 or A123)?

7. Is the Applicant ACO or any of the proposed providers/suppliers currently participating in an ACO with a payer other than Medicare?
8. How many of the counties your proposed ACO serves are considered rural?
9. Please provide us with your expected number of aligned Medicare beneficiaries in 2016.

Appendix B: Glossary of Key Definitions

The following terms have the meaning set forth below. CMS may modify these definitions as it further refines the Next Generation Model.

BENEFIT ENHANCEMENTS: The Next Generation Model plans to use the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment rules in order to further emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries. This suite of payment rule waivers is referred to as benefit enhancements. Acceptance into the Next Generation Model is not contingent upon an ACO implementing any particular benefit enhancement.

CAPITATION: A payment mechanism wherein the Next Generation ACO receives a per-beneficiary per-month payment for projected total annual expenditures for services provided by Next Generation Providers/Suppliers or Capitation Affiliates to Next Generation Beneficiaries. The ACO is responsible for paying claims for services rendered to Next Generation Beneficiaries by Next Generation Providers/Suppliers and Next Generation Affiliates with whom the Next Generation ACO has written agreements regarding capitation. CMS will withhold some money to cover anticipated care delivered by other providers. Capitation only represents a payment mechanism; Next Generation ACOs separately select a risk arrangement.

DISCOUNT: The discount is a calculated reduction of the prospective benchmark. Each ACO will have a discount based on quality, regional efficiency, and national efficiency. Example: Baseline, trend, and risk adjustment calculations determine that an ACO is projected to spend $10,000 per beneficiary. If the ACO's discount is determined to be 2%, the final benchmark is $9,800 per beneficiary.

INFRASTRUCTURE PAYMENT: A payment mechanism wherein the Next Generation ACO receives a per-beneficiary per-month payment of no more than $6 to support ongoing ACO activities. This payment is not related to claims, and CMS will continue to pay Next Generation Provider/Supplier claims at normal FFS rates. Infrastructure payments will be reconciled and recouped in full against shared savings or in addition to shared losses. Infrastructure payments only represent a payment mechanism; Next Generation ACOs separately select a risk arrangement.

NPI: National provider identifier.

NEXT GENERATION AFFILIATE: An entity that is not a Next Generation Provider/Supplier and has a written agreement with a Next Generation ACO regarding a specific Model design element. An Affiliate: (1) is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202) other than a DMEPOS supplier; (2) is identified by a National Provider Identifier (NPI) or CMS Certification Number (CCN); and (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations. There are two types of Next Generation Affiliates. Capitation Affiliates are Medicare providers/suppliers that contract with the ACO in order to participate in the capitation payment mechanism (described in Section VI.A.1.iv). SNF Affiliates are skilled nursing facilities to which Next Generation Providers/Suppliers or Preferred Providers may admit Next Generation Beneficiaries according to the SNF 3-Day Rule benefit enhancement (described in Section VI.C.2).

NEXT GENERATION BENEFICIARY: A Medicare beneficiary who has been aligned to a Next Generation ACO using the methodology described in Section VI.B.

NEXT GENERATION PREFERRED PROVIDER: An ACO-selected Medicare provider with whom the Next Generation ACO has a relationship based upon high-quality care and care coordination for Next Generation Beneficiaries. A Preferred Provider: (1) is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202) other than a DMEPOS supplier; (2) is identified by a National Provider Identifier (NPI) or CMS Certification Number (CCN); and (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations. ACOs may allow certain benefit enhancements that are available to aligned beneficiaries when receiving care from Next Generation Providers/Suppliers to also be available through Preferred Providers, provided that the ACO has a written agreement to that effect with the Preferred Provider and has supplied CMS with the Preferred Provider list according to CMS instructions. Preferred Providers may also be Capitation Affiliates and/or SNF Affiliates by entering into written arrangements with Next Generation ACOs participating in the respective design elements.

NEXT GENERATION PROVIDER/SUPPLIER: An individual or entity that: (1) is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202) other than a DMEPOS supplier; (2) is identified by a National Provider Identifier (NPI) or CMS Certification Number (CCN); and (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations. A Next Generation Provider/Supplier is the primary component of a Next Generation ACO described throughout this RFA, particularly in Section V. Certain design elements associated with a Next Generation ACO will automatically apply to its Providers/Suppliers. These include, for example, beneficiary alignment, quality reporting through the ACO, payment mechanisms, and benefit enhancements. Next Generation ACOs will be required to submit and maintain a list of Providers/Suppliers to CMS in accordance with terms set forth in the participation agreement. When used in the plural, "Providers/Suppliers" indicates all applicable providers and suppliers.

OTHER MONIES OWED: Next Generation ACOs may elect a payment mechanism in which they receive monthly per-beneficiary payments that require repayment to CMS. These monies will be recouped from the ACO, but are not considered shared losses. There may also be cases where the ACO has been underpaid in monthly payments because of an estimation made by CMS. In these cases CMS may owe the ACO additional money, but that money is not considered shared savings. Savings or losses are determined by comparing an ACO's spending to the benchmark.

POPULATION-BASED PAYMENTS: A payment mechanism wherein the ACO Next Generation Providers/Suppliers receive FFS payment from CMS reduced by a percentage agreed upon with the ACO. The projected total annual amount taken out of the base FFS rates will be distributed to the ACO in monthly per-beneficiary per-month payments. PBP only represents a payment mechanism; Next Generation ACOs separately select a risk arrangement.

RURAL ACO: A Next Generation ACO is considered rural if any of its primary service areas are located in a rural county. All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural counties. Large parts of many "urban" counties may be rural in nature. Therefore, census tracts with Rural Urban

Commuting Area Codes (RUCA) 4 through 10 will be considered rural, and micropolitan areas will be considered rural for the purposes of the Next Generation Model. See: http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/

SHARED LOSSES: Any monetary amount owed to CMS by the ACO according to the risk arrangement due to spending in excess of the ACO's Medicare expenditure benchmark for the applicable performance year.

SHARED SAVINGS: Under a "shared savings" arrangement, CMS rewards an ACO with a specified percentage of total savings achieved. Savings owed to Next Generation ACOs will be determined through reconciling expenditures against the benchmark.

TIN: Federal taxpayer identification number.

VOLUNTARY ALIGNMENT: A process whereby beneficiaries elect to be aligned to a Next Generation ACO through confirming a relationship with a Next Generation Provider/Supplier. Beneficiaries who indicate that a Next Generation Provider/Supplier is their main provider will be aligned with the ACO, even if claims-based alignment would otherwise not align them. In later years of the Model, CMS may refine voluntary alignment policies to: (1) make alignment accessible to a broader set of Medicare beneficiaries, regardless of current or previous alignment with an ACO; (2) include affirmation of a general care relationship between beneficiaries and ACOs instead of between beneficiaries and specific providers; and/or (3) allow beneficiaries to opt out of alignment to a particular ACO in addition to opting into alignment.

Appendix C: Example Discount Calculation

The following is a sample discount calculation. The example uses the same ACO to illustrate each component. In PY1, a quality score of 100% will be used for all Next Generation ACOs.

- The sample ACO had a quality score of 90%. The quality score of 90% is inputted into the formula [2.0 + (1-quality score)]%.
    - Quality Score: 90%
    - Quality Discount Component: 2.0% + (1-.90) = 2.1%
- The regional efficiency component of the discount will range from -1% to 1%. This ACO is moderately efficient compared to its region, which results in a small reduction to the discount (a more favorable discount for the ACO).
    - ACO Risk-Adjusted Per Capita Expenditure: $8,000
    - Regional Risk-Adjusted Per Capita Expenditure: $8,500
    - ACO-to-Region Ratio: 0.94
    - Regional Discount Component: -0.6%
- The national efficiency component of the discount will range from -0.5% to 0.5%. This ACO is in an extremely efficient region—the region's FFS expenditures are significantly less than national risk-adjusted per capita expenditures. This ACO has its discount reduced to reflect that efficiency.
    - Regional Risk-Adjusted Per Capita Expenditure: $8,500
    - National Risk-Adjusted Per Capita Expenditure: $10,500
    - Region-to-Nation Ratio: 0.81
    - Regional Discount Component: -0.5%
- The final discount is calculated by adding the three components. Because of its strong quality performance and regional and national efficiency, this ACO has a highly favorable discount.
    - Quality (2.1%) + Regional (-0.6%) + National (-0.5%) = 1.0% Discount

Appendix D: Example Payment Mechanism Calculations

Normal FFS Payment + Monthly Infrastructure Payment

- An ACO has 25,000 beneficiaries and elects to receive infrastructure payments under the 100% risk arrangement. Each month the ACO receives $150,000 ($6 PBPM x 25,000 beneficiaries). Over the course of the performance year, the ACO receives $1,800,000.
- Using the benchmark methodology described in Section V.A, the ACO has a benchmark of $300,000,000.
- Scenario 1: Over the course of the performance year, $298,000,000 is paid out in FFS claims for the ACO's aligned beneficiaries. The ACO has achieved savings of $2,000,000. CMS has paid the ACO $1,800,000 in infrastructure payments that must be recouped. CMS must pay the ACO $200,000, representing the savings achieved by the ACO minus the infrastructure payments to be recouped.
- Scenario 2: Over the course of the performance year, $301,000,000 is paid out in FFS claims for the ACO's aligned beneficiaries. The ACO has losses of $1,000,000. CMS has already paid the ACO $1,800,000 in infrastructure payments that must be recouped. The ACO must pay CMS $2,800,000, of which $1,000,000 is shared losses and $1,800,000 is other monies owed to CMS.

Population-Based Payment (PBP)

- Calculating the PBP:
    - An ACO has 25,000 beneficiaries and elects to receive PBP under the 100% risk arrangement.
    - Using the benchmark methodology described in Section VI.A, the ACO has a benchmark of $300,000,000 or $12,000 per beneficiary. Dividing the per-beneficiary amount over 12 months would result in expected payments of $1,000 PBPM overall.
    - Using historic claims, CMS projects that the Next Generation Providers/Suppliers participating in PBP should account for 75% of ACO beneficiaries' spending; the remaining 25% will likely occur outside of the ACO. Thus the ACO's projected spending for use in calculating the PBP is 75% x $1,000 = $750.
- Next Generation Providers/Suppliers will take a 10% reduction in their FFS claims to support the PBP. The ACO will be paid $75 PBPM (10% of the ACO's 75% share of expected spending ($750)). Over the course of the year, the ACO is paid $22,500,000 in PBP ($75 PBPM x 25,000 beneficiaries x 12 months), and participating providers are paid FFS with claims reduced by 10%.
- Year-end reconciliation:
    - Determining savings or losses: CMS pays $295,000,000 in FFS claims for Next Generation Beneficiaries, including claims for both Next Generation Providers/Suppliers and non-ACO providers/suppliers. Reconciliation uses the pre-PBP amount for claims that were reduced. This ACO generated $5,000,000 in savings.
    - Reconciling PBP: CMS calculated the PBPM assuming 75% of care would be performed by providers/suppliers participating in PBP. After the performance year it is determined that 70% of care was performed by providers/suppliers

participating in PBP. CMS should have paid $21,000,000 in PBP instead of $22,500,000, so the ACO must pay CMS $1,500,000 in other monies owed.

Capitation (available beginning in PY2)

- An ACO has 25,000 beneficiaries and elects capitation under the 100% risk arrangement. Using historic claims, CMS projects that the ACO (both Next Generation Providers/Suppliers and Capitation Affiliates) should account for 75% of ACO beneficiaries' spending; the remaining 25% will likely occur outside of the ACO.
- Using the benchmark methodology above, the ACO has a benchmark of $300,000,000 ($12,000 per beneficiary). Dividing the per-beneficiary amount over 12 months results in payment of $1,000 PBPM. Because 25% of care is projected to occur outside of the ACO and the ACO is not responsible for paying claims for non-ACO providers/suppliers, the ACO will receive 75% of this amount: $750 PBPM.
- Over the course of the performance year, the ACO is paid $225,000,000 in capitation payments to pay claims for services delivered to Next Generation Beneficiaries by Next Generation Providers/Suppliers and Capitation Affiliates.
- Scenario 1: Upon reconciliation, it is determined that CMS paid $75,500,000 in FFS claims for Next Generation Beneficiaries by non-ACO providers/suppliers. CMS had projected 25% of care outside of the ACO: $62,500,000. The ACO must pay CMS $500,000 in other monies owed.
- Scenario 2: Upon reconciliation, it is determined that CMS paid $74,500,000 in FFS claims for Next Generation Beneficiaries by non-ACO providers/suppliers. CMS had projected 25% of care outside of the ACO: $75,000,000. CMS must pay the ACO an additional $500,000 in other monies owed.

Appendix E: Next Generation Model Quality Measures

Domain	ACO Measure #	Measure Title	New Measure	NQF #/Measure Steward	Method of Data Submission	Pay for Performance Phase In R – Reporting P – Performance PY1	PY2	PY3
Aim: Better Care for Individuals								
Patient/Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information		NQF #0005, AHRQ	Survey	R	P	P
	ACO - 2	CAHPS: How Well Your Doctors Communicate		NQF #0005 AHRQ	Survey	R	P	P
	ACO - 3	CAHPS: Patients' Rating of Doctor		NQF #0005 AHRQ	Survey	R	P	P
	ACO - 4	CAHPS: Access to Specialists		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO - 5	CAHPS: Health Promotion and Education		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO – 6	CAHPS: Shared Decision Making		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO – 7	CAHPS: Health Status/Functional Status		NQF #N/A CMS/AHRQ	Survey	R	R	R
	ACO - 34	CAHPS: Stewardship of Patient Resources	X	NQF #N/A CMS/AHRQ	Survey	R	P	P
Care Coordination/ Safety	ACO - 8	Risk-Standardized, All Condition Readmission		Adapted NQF #1789 CMS	Claims	R	R	P
	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	X	NQF #TBD CMS	Claims	R	R	P
	ACO - 36	All-Cause Unplanned Admissions for Patients with Diabetes	X	NQF#TBD CMS	Claims	R	R	P
	ACO -37	All-Cause Unplanned Admissions for Patients with Heart Failure	X	NQF#TBD CMS	Claims	R	R	P
	ACO -38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	X	NQF#TBD CMS	Claims	R	R	P
	ACO - 9	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or		NQF #0275 AHRQ	Claims	R	P	P

Domain	ACO Measure #	Measure Title	New Measure	NQF #/Measure Steward	Method of Data Submission	Pay for Performance Phase In R – Reporting P – Performance		
						PY1	PY2	PY3
		Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)						
	ACO - 10	Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)		NQF #0277 AHRQ	Claims	R	P	P
	ACO -39	Documentation of Current Medications in the Medical Record	X	NQF #0419 CMS	GPRO Web Interface	R	P	P
	ACO - 13	Falls: Screening for Future Fall Risk		NQF #0101 NCQA	GPRO Web Interface	R	P	P
Aim: Better Health for Populations								
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization		NQF #0041 AMA-PCPI	GPRO Web Interface	R	P	P
	ACO – 15	Pneumonia Vaccination Status for Older Adults		NQF #0043 NCQA	GPRO Web Interface	R	P	P
	ACO – 16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up		NQF #0421 CMS	GPRO Web Interface	R	P	P
	ACO – 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		NQF #0028 AMA-PCPI	GPRO Web Interface	R	P	P
	ACO – 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan		NQF #0418 CMS	GPRO Web Interface	R	P	P
	ACO – 19	Colorectal Cancer Screening		NQF #0034 NCQA	GPRO Web Interface	R	R	P
	ACO – 20	Breast Cancer Screening		NQF #NA NCQA	GPRO Web Interface	R	R	P
	ACO - 21	Preventive Care and Screening: Screening		CMS	GPRO Web	R	R	P

Domain	ACO Measure #	Measure Title	New Measure	NQF #/Measure Steward	Method of Data Submission	Pay for Performance Phase In R – Reporting P – Performance		
						PY1	PY2	PY3
		for High Blood Pressure and Follow-up Documented			Interface			
Clinical Care for At Risk Population - Depression	ACO – 40	Depression Remission at Twelve Months	X	NQF #0710 MNCM	GPRO Web Interface	R	R	R
Clinical Care for At Risk Population - Diabetes	ACO-27	Diabetes Composite (All or Nothing Scoring): ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control		NQF #0059 NCQA (individual component)	GPRO Web Interface	R	P	P
	ACO 41	ACO - 41: Diabetes: Eye Exam	X	NQF #0055 NCQA (individual component)	GPRO Web Interface	R	P	P
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure		NQF #0018 NCQA	GPRO Web Interface	R	P	P
Clinical Care for At Risk Population – Ischemic Vascular Disease	ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic		NQF #0068 NCQA	GPRO Web Interface	R	P	P
Clinical Care for At Risk Population - Heart Failure	ACO - 31	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)		NQF #0083 AMA-PCPI	GPRO Web Interface	R	R	P
Clinical Care for At Risk Population – Coronary Artery Disease	ACO - 33	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)		NQF # 0066 ACC	GPRO Web Interface	R	R	P

Appendix F: Applicant Selection Criteria and Scoring Template

Selection Domain	Applicant Selection Criteria To earn the full amount of points in each domain, the applicant must:	Points
Organizational Structure	• Demonstrate a history of collaboration between Providers/Suppliers and/or a credible plan for how the Providers/Suppliers will work together in the model; • Have an organizational structure that promotes patient-centered care and the goals of the model. The applicant ACO is made up of a diverse set of Providers/Suppliers that demonstrates a clear commitment to providing high quality, coordinated care to beneficiaries.	10
Leadership and Management	• Have a governance structure that is clearly defined and demonstrates commitment to providing high quality care to beneficiaries consistent with the three-part aim of better health, better care, and lower costs; • Have a multi-stakeholder board comprised of well-qualified individuals that adequately and collectively represent the interests of patients and providers; • Demonstrate an effective governance structure plan, including a governing body and/or organizational mechanisms to make decisions, distribute payments, and obtain resources necessary to achieve the three-part aim; • Have identified, or demonstrated plans to identify, executives and lead staff throughout the organization with responsibility for clinical, financial, management, HIT, and quality improvement functions; • If applicable, demonstrate good conduct in prior CMS programs and/or demonstrations.	10
Financial Plan and Risk-Sharing Experience	• Demonstrate at least 3 years of experience with outcomes-based arrangements (that meet stated outcomes-based contracting definition); • If applicable, demonstrate good performance in past CMS programs, demonstrations, or both; • Demonstrate past experience with outcomes-based contracts for a minimum of 10,000 lives; • Document significant degrees of financial risk and revenue derived from outcomes-based contracts; • Document reductions in medical expenditures achieved through previous outcomes-based contracts; • Demonstrate a credible plan for converting the preponderance of revenue to outcomes-based contracts; • Have an ACO funding approach (including any savings/losses distribution, if applicable) that demonstrates: (1) a strong commitment to the three-part aim of better health, better care, and lower costs; and (2) a credible plan for ensuring repayment to Medicare of its share of losses relative to the benchmark.	30
Patient Centeredness	• Demonstrate the ability to engage beneficiaries and their caregivers in shared decision making, taking into account patient preferences and choices; • Have a feasible plan to establish mechanisms to conduct patient outreach and education on the benefits of care coordination; • Demonstrate the ability to effectively involve beneficiaries in care transitions to improve the continuity and quality of care across settings; • Demonstrate the ability to engage and activate beneficiaries at home to	20

Selection Domain	Applicant Selection Criteria To earn the full amount of points in each domain, the applicant must:	Points
	improve self-management; • Have mechanisms to evaluate patient satisfaction with access and quality of care, including choice of providers and choice in care settings.	
Clinical Process Improvement, Care Coordination, and Data Capacity	Clinical Process Improvement (10 points) • Present a strong, credible, coordinated, and feasible plan to realize the three-part aims of better health, better care, and lower costs; • Provide credible plan for incorporating medication management into the care coordination approach; • Demonstrate past experience designing, implementing, and assessing the effectiveness of specific care improvement interventions. Care Coordination (10 points) • Demonstrate existing capacity or plans to expand capacity to coordinate care through an interdisciplinary team structure that includes practitioners with the necessary areas of expertise and appropriate staffing to meet the needs of complex patients; • Demonstrate a history of collaboration among major stakeholders in the community being served, including incorporation of relevant social services in care plans and management; • Demonstrate a compelling plan to succeed in the areas of quality improvement and care coordination. Data Capacity (10 points) • Provide a clear and detailed plan for a majority of eligible professionals in the organization to meet EHR meaningful use criteria and requirements; • Have population health management tools and functions or concrete plans to develop and invest in such tools and functions; • Have the ability, or credible plans to develop the ability, to electronically exchange patient records across Providers/Suppliers and other providers in the community to ensure continuity of care; • Have the ability to, or credible plan to gain the ability to, share performance feedback on a timely basis with participating providers.	30
Total		100

Appendix G: Application Template

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

The application can be found and completed at: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model. Questions about the application for the Next Generation ACO Model should be directed to NextGenerationACOModel@cms.hhs.gov.

Background Information

A. ACO Organization Information
    1. Organization Name
    2. Organization TIN/EIN
    3. Street Address
    4. City
    5. State
    6. Zip Code
    7. Website, if applicable

B. ACO Organization Profile
    1. Type of Applicant organization. Check only one:
        i. Medical group practice
        ii. Network of individual practices (e.g., IPA)
        iii. Hospital system(s)
        iv. Integrated delivery system
        v. Partnership of hospital system(s) and medical practices
        vi. Other, please describe
    2. Does the Applicant ACO include any of the following providers or facilities? Check all that apply:
        i. Cancer or specialty hospitals
        ii. Psychiatric hospital or other mental or behavioral health facility
        iii. Hospital(s) receiving disproportionate share (DSH) payments or uncompensated care payments from Medicare or Medicaid
        iv. Critical Access Hospital (CAH)
        v. Other rural hospital
        vi. Federally Qualified Health Center (FQHC)
        vii. Other community health centers
        viii. Skilled nursing facility (SNF)
        ix. Inpatient rehabilitation facility (IRF)
        x. Home Health Agency (HHA)
        xi. Other post-acute care facility
    3. Is the Applicant ACO or any of its proposed providers/suppliers currently participating in a Medicare shared savings initiative? Check all that apply:
        i. None
        ii. Care Management for High-Cost Beneficiaries Demonstration
        iii. Comprehensive ESRD Care Initiative (CEC)
        iv. Comprehensive Primary Care Initiative (CPC)

v. Independence at Home Medical Practice Demonstration (IAH)
vi. Medicare Health Care Quality Demonstration Programs (including Indiana Health Information Exchange and North Carolina Community Care Network)
vii. Multi-payer Advanced Primary Care Practice Demonstration with a shared savings arrangement (MAPCP)
viii. Physician Group Practice Transition Demonstration (PGP)
ix. Pioneer ACO Model
x. Medicare Shared Savings Program (MSSP)
xi. Other (please specify):

4. Is the Applicant ACO or any of the proposed providers/suppliers, currently participating in the Bundled Payment for Care Improvements (BPCI) Model? For more information: http://innovation.cms.gov/initiatives/Bundled-Payments/. If YES, please check all Model(s) that apply:
   i. Model 1
   ii. Model 2
   iii. Model 3
   iv. Model 4
5. Please attach a copy of certificate of incorporation or other documentation that the Applicant ACO is recognized as a legal entity by the state in which it is located.
6. Using the provided template, please upload an Excel spreadsheet identifying the proposed providers/suppliers **to be used for alignment.** Please include the name, address, and appropriate identifiers for individual providers (e.g., individual physicians, non-physician practitioners), group providers (e.g., physician group practices), and institutional providers (e.g., critical access hospital).
7. Using the provided template, please upload an Excel spreadsheet identifying all the proposed providers/suppliers **that will constitute the Applicant ACO.** Please include the name, address, and appropriate identifiers for individual providers (e.g., individual physicians, non-physician practitioners), group providers (e.g., physician group practices), and institutional providers (e.g., critical access hospital, IPPS hospital, skilled nursing facility).
8. As described in the Federal Trade Commission and the Department of Justice Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Programs ("Antitrust Policy Statement"), does the Applicant organization's share of any common service, where two or more of its participants are providing that service to patients from the same Primary Service Area, exceed 50%? (To calculate the Primary Service Area, please access: http://www.cms.gov/apps/files/aco/application-zipcodes.zip). Organizations that are fully integrated entities and/or were formed before March 23, 2010 may answer N/A.
   i. Yes
   ii. No
   iii. N/A, formed before March 23, 2010
   iv. N/A, fully integrated entity

Contact Information

A. Application Contact(s)
    1. First Name
    2. Last Name
    3. Title/Position
    4. Business Phone Number
    5. Business Phone Number Ext.
    6. Alternate Phone Number
    7. E-mail Address
    8. Street Address
    9. City
    10. State
    11. Zip Code
B. Secondary Contact
    1. First Name
    2. Last Name
    3. Title/Position
    4. Business Phone Number
    5. Business Phone Number Ext.
    6. Alternate Phone Number
    7. E-mail Address
    8. Street Address
    9. City
    10. State
    11. Zip Code
C. ACO Executive Contact
    1. First Name
    2. Last Name
    3. Title/Position
    4. Business Phone Number
    5. Business Phone Number Ext.
    6. Alternate Phone Number
    7. E-mail Address
    8. Street Address
    9. City
    10. State
    11. Zip Code
D. IT/Technical Contact
    1. First Name
    2. Last Name
    3. Title/Position
    4. Business Phone Number
    5. Business Phone Number Ext.
    6. Alternate Phone Number
    7. E-mail Address
    8. Street Address

9. City
10. State
11. Zip Code

Leadership and Management

A. Leadership Team

1. Please provide a proposed organizational chart for the Applicant ACO. The proposed organizational chart should depict the legal structure, the proposed composition of the ACO (e.g., all of the TINs and organizations composing the ACO), and any relevant committees.
2. Please describe the contractual and/or employment relationships between and among the Applicant ACO and proposed providers/suppliers, as well as any contractual and/or employment relationships with other partners or entities that will provide services to the ACO.
3. Please upload:
    i. A sample contract or an amendment or addendum to a current contract between the ACO and proposed providers/suppliers; and
    ii. A sample contract or an amendment or addendum to a current contract between the ACO and any other partners or entities that will provide services to the ACO (if applicable).
4. Among Next Generation Providers/Suppliers, please report the following (please approximate if necessary):
    i. Total number of physicians participating in your ACO:
    ii. Total number of participating physicians employed by one or more ACO institutional providers/suppliers:
    iii. Total number of participating physicians with individual contracts with one or more ACO institutional providers/suppliers:
    iv. Total number of participating physicians whose group practice(s) contract with one or more ACO institutional providers/suppliers:
5. Please describe the history of the Applicant organization and its major member organizations in terms of prior business relationships (if any) and collaboration between members on care improvement or cost containment efforts (if any).
6. Does the applicant organization have a leadership team exclusive to the Next Generation ACO?
    i. Yes
    ii. No
7. Please complete the table below with information specific to the Applicant ACO's proposed leadership team. The leadership team may include, but is not limited to: key executives; finance officers; clinical improvement officers; compliance officers; information systems leadership; and the individual responsible for maintenance and stewardship of clinical data. If specific individuals have not yet been identified, please note that in the Leadership Team Member column and provide the anticipated date by which the individual will be identified.

Leadership Team Member	Position/Role

B. Governing Body

1. For Next Generation ACOs that comprise two or more Next Generation Providers/Suppliers, each of which is identified by a unique TIN, the ACO governing body must be separate and unique to the ACO and not the same as any other entity's governing body. If a Next Generation ACO is an existing legal entity (e.g., Alpha Health System is Alpha ACO), the ACO governing body may be the same as that of the existing legal entity, provided all other requirements are met. Please select one:
    i. Applicant ACO is an existing entity and the governing body will be the same as the existing entity's governing board.
    ii. Applicant Next Generation ACO's governing body will be separate and unique to the ACO.
2. Please complete the table below for the Applicant ACO's proposed governing body:

Name	Title	Expertise	Beneficiary (Y/N)	Consumer Advocate (Y/N)	Percent of Board Control

3. Please describe how responsibilities and accountability will be shared across the leadership team and governing body structures in the Applicant ACO.
4. Please describe how the governing body will ensure that the interests of beneficiaries and providers will be represented adequately. Specifically, explain the following:
    i. The role of the independent Medicare beneficiary and the independent consumer advocate who will participate in the governing body;
    ii. The rationale of the proposed or existing composition of the governing body and voting power distribution.
5. Please provide a narrative explanation of why the Applicant ACO wishes to participate in the Next Generation Model and how participation in the Model will help CMS and the Applicant ACO's proposed providers/suppliers achieve the goals of better health and better care for Medicare beneficiaries.
6. Please upload the compliance plan intended for use by the Applicant ACO.
7. Please complete the table below with information regarding any investigations, sanctions, penalties, or corrective action plans against the Applicant ACO and/or Applicant ACO's proposed providers/suppliers, including any sanctions or corrective actions imposed while participating in prior CMS demonstrations and programs (if applicable). Please provide information from the previous three-year period (e.g., January 1, 2012 – December 31, 2014).

Provider/Supplier	Federal or State Agency or Accrediting Body (e.g., DOJ, OIG, The Joint Commission, State Survey Agencies)	Description of Infraction (including date)	Resolution Status (including date)

i. N/A, Applicant ACO and/or ACO's proposed providers/suppliers have no investigations, sanctions, penalties, or corrective action plans in the past three years.

Financial Experience and Information

A. Financial Experience and Information
    1. What percentage of the Applicant ACO's total clinical revenues in the last fiscal year was derived from the following sources? Applicants may approximate this through summation of the revenue received by all proposed providers/suppliers for clinical services (e.g., fee-for-service, per-member per-year, per-member per-month, per-episode).
        i. Medicare fee-for-service
        ii. Medicare Advantage
        iii. Other Medicare health plans (e.g., PACE plans, Medicare cost plans)
        iv. Commercial health plans
        v. Medicaid
        vi. Self-pay patients
        vii. Patients who are dually eligible for Medicare and Medicaid
        viii. Other (e.g., local uncompensated care funds)
        ix. Please describe any additional sources of funding

B. Risk Sharing Experience
    1. Please describe the Applicant ACO's performance under prior or current outcomes-based contracts, if any. Outcomes-based contracts must include: (1) financial accountability; (2) evaluation of patient experiences of care; and (3) substantial quality performance incentives. If applicable, please include performance under CMS programs and demonstrations that meet the definition of outcomes-based contracts. Check N/A if no prior or current risk sharing arrangements
    2. Please indicate the number of covered lives in outcomes-based contracts with any of the Applicant ACO's proposed providers/suppliers for each of the past three fiscal years.
        i. 2012
            a. Number of Lives
            b. Name of member organization(s) in arrangement (if not ACO)
            c. Please provide a brief description of the type and scope of outcomes-based contracts in 2012 and how the applicant organization calculated the number of lives covered by these arrangements in 2012.
            d. N/A
        ii. 2013
            a. Number of Lives
            b. Name of member organization(s) in arrangement (if not ACO)
            c. Please provide a brief description of the type and scope of outcomes-based contracts in 2013 and how the applicant organization calculated the number of lives covered by these arrangements in 2013.
            d. N/A

iii. 2014
    a. Number of Lives
    b. Name of member organization(s) in arrangement (if not ACO)
    c. Please provide a brief description of the type and scope of outcomes-based contracts in 2014 and how the applicant organization calculated the number of lives covered by these arrangements in 2014.
    d. N/A

3. Please indicate the percentage of the Applicant ACO's clinical revenues (or an approximation based on the summation of clinical revenue from the ACO's proposed providers/suppliers) in the last fiscal year derived from outcomes-based contracts. Note: ACO total revenues include: (1) basic payments received by all ACO providers/suppliers for clinical services (e.g., Fee-for-Service, per member per year, per member per month, and per episode); (2) supplemental payments all ACO providers/suppliers received or returned due to risk—a financial or cost reconciliation for shared savings; (3) supplemental payments received as quality or cost bonuses (pay-for-performance) for all ACO providers/suppliers. Total revenue excludes revenues not related to clinical services (e.g., rent, investments) and any revenues specified above that are received by the ACO.
    i. Please describe how the Applicant ACO calculated the percentage of revenue cited above (e.g., which providers/suppliers were included, which services were included).
4. Please describe the Applicant ACO's business plan for converting the majority of its clinical revenues to outcomes based contracts, if not attained already.
5. Please describe the Applicant ACO's relationship (e.g., geographic, age, relative dominance in major areas of service delivery) to other health care entities in its market. Include information on what other organizations are its main competitors and the Applicant ACO's market share in its primary service area for professional and hospital services.
6. Please describe the history of collaboration among major stakeholders in the community being served and commitment from relevant community stakeholders to achieve seamless care. Include specific examples, if any.

C. Financial Plan if Selected for the Next Generation ACO Model
    1. Please attest that that the Applicant ACO has been licensed by the state(s) in which it is located as a risk-bearing entity or that it is exempt from such licensure and/or other such requirements.
        i. Applicant ACO has been licensed as a risk-bearing entity in state(s) in which it will operate. Upload certification/documentation.
        ii. N/A (e.g., state does not have licensure requirement for ACOs or ACO not required to be licensed as risk-bearing entity).
        iii. Applicant is required to obtain licensure, but it is not yet licensed as a risk-bearing entity. Please describe plans and timeline to become licensed, including the state and date of application submission. Please include the date by which licensure is anticipated.
    2. Funding Ongoing ACO Activity

i. Please describe how Applicant ACO intends to fund ongoing ACO activity. Indicate how the funding plan supports the three-part aim of better health, better health care, and lower per-capita costs and how it ties individual providers into the overall outcomes-based revenue strategy. To the extent applicable, please describe how savings or losses will be distributed among providers/suppliers and eligible affiliates.
ii. Please describe how the Applicant ACO plans to ensure payment to Medicare of its share of losses relative to the benchmark.

3. Please explain any plans the Applicant ACO has to better manage Part D utilization and expenditures. Please include any plans the ACO has to partner with Part D Plans while preserving beneficiary choice. Please include information on the types of activities that would fall under a Part D partnership, such as data sharing or medication reconciliation.
4. Please indicate intended risk arrangement:
    i. Risk Arrangement A: Shared Performance Risk
    ii. Risk Arrangement B: Full Performance Risk
5. Please indicate intended payment mechanism. Payment mechanism is separate from risk arrangement. It dictates the method of payment for provider/supplier claims and affords the ACO the option of receiving monthly payments. Please select one.
    i. Normal FFS [No changes to FFS claims payment.]
    ii. Normal FFS with monthly infrastructure payments [ACO providers/suppliers and all other Medicare providers that care for ACO beneficiaries will have claims reimbursed by CMS through FFS. The ACO may elect to receive monthly payments at an amount no greater than $6 PBPM. Monthly payments are reconciled and recouped (against both savings and losses) in the final financial reconciliation calculation.]
    iii. Population-based payments (PBP) [If an ACO elects population-based payments (PBP), ACO providers/suppliers will have FFS claims payments reduced by an agreed upon percentage. The ACO will receive a monthly payment commensurate with percentage taken out of providers/suppliers' FFS payments.]
6. Please indicate if the Applicant organization would be interested in receiving capitated payments. [Capitation functions by estimating total annual expenditures for an ACO's aligned beneficiaries and paying that projected amount to the ACO in a per-beneficiary per-month payment with some money withheld to cover anticipated care by non-ACO providers/suppliers. Next Generation ACOs will be responsible for paying claims for its Next Generation Providers/Suppliers and Capitation Affiliates with whom the ACO has written agreements regarding capitation.]
    i. Yes
    ii. No
    iii. If **YES**, please describe which payment system the ACO would use to operationalize capitation and the types of arrangements the ACO would enter into with ACO providers/suppliers and Capitation Affiliates.

Patient Centeredness and Beneficiary Engagement

A. Goals and Objectives
    1. Please describe the Applicant ACO's ability to accomplish the items below. The narrative should include the ability to achieve the goals and objectives of the Next Generation Model as it relates to patient centeredness:
        i. Promotion of evidence-based medicine, such as through the establishment and implementation of evidence-based guidelines at the organizational or institutional level. A genuine evidence-based approach would also regularly assess and update such guidelines.
        ii. Process to ensure patient/caregiver engagement, and shared decision making processes employed by Next Generation Providers/Suppliers that takes into account the beneficiaries' unique needs, preferences, values, and priorities. Measures for promoting patient engagement include, but are not limited to, the use of decision support tools and shared decision making methods with which the patient can assess the merits of various treatment options in the context of his or her values and convictions. Patient engagement also includes methods for fostering what might be termed "health literacy" in patients and their families.
        iii. Coordination of care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote patient monitoring, other enabling technologies).
        iv. Providing beneficiaries access to their own medical records and to clinical knowledge so that they may make informed choices about their care.
        v. Ensuring individualized care, such as through personalized care plans.
        vi. Routine assessment of beneficiary and caregiver and/or family experience of care and seek to improve where possible.
        vii. Providing care that is integrated with community resources beneficiaries require.

B. Beneficiary Engagement
    1. Please describe the existing or planned approach that the Applicant ACO will use to conduct beneficiary outreach.
    2. Please describe the Applicant ACO’s existing or planned approach for evaluating beneficiary satisfaction in addition to CMS required beneficiary experience surveys and how the ACO intends to use such information to improve its care management and coordination processes.

Clinical Care Model

A. Care Coordination and Health IT Capability
    1. Please describe the Applicant ACO’s plan to achieve better health, better care, and lower costs through integrated and coordinated care interventions. Please address the following in your narrative:
        i. The Applicant organization’s use of interdisciplinary care teams to coordinate care for patients;
        ii. The Applicant organization’s methods and processes to coordinate care throughout an episode of care and during care transitions, such as discharge

from a hospital or transfer of care between providers (both inside and outside the ACO);
   iii. The Applicant organization's use of health information technology;
   iv. The Applicant organization's strategies for improving beneficiary access to care;
   v. The Applicant organization's development and use of population health management tools;
   vi. The Applicant organization's plan to incorporate medication management into its care coordination approach; and,
   vii. Additional specific care interventions and tools.
2. Please provide the anticipated percentage of eligible professionals in the Applicant ACO that will have attested to Electronic Health Record (EHR) Stage 2 Meaningful Use Criteria by December 31, 2014.
3. Is the ACO a physician-based organization (e.g., convening entity is either a physician independent practice association (IPA); a physician practice management association; an individual physician group or collection of physician groups)?
   i. Yes
   ii. No
   iii. Please select one of the following categories that best reflects the EMR/HIT system functionality of the majority of ambulatory practices' in the applicant ACO:
      a. Paper chart based.
      b. Desktop access to clinical information, unstructured data, multiple data sources, intra-office/informal messaging.
      c. Beginning of a clinical data repository (CDR) with orders and results, computers may be at point-of-care, access to results from outside facilities.
      d. Electronic messaging, computers have replaced the paper chart, clinical documentation and clinical decision support.
      e. Computerized physician order entry (CPOE), Use of structured data for accessibility in electronic medical record (EMR) and internal and external sharing of data.
      f. Health Information Exchange (HIE) capable, sharing of data between the EMR and community based EHR, business and clinical intelligence.
4. Is the ACO hospital-based (e.g., convening entity is a physician hospital organization (PHO) or management service organizations (MSO) that includes hospitals)?
   i. Yes
   ii. No
   iii. Please select one of the following categories that best reflects the functionality of the majority of providers' EMR/HIT systems in the applicant ACO:
      a. Some clinical automation exists; however, systems allowing laboratory, pharmacy, and/or radiology services to be automated are not installed.
      b. Systems allowing laboratory, pharmacy, and radiology to be automated are installed.

c. Computerized practitioner/physician order entry (CPOE) installed and available. If one patient service area has implemented CPOE and completed previous stages, this stage has been achieved.
d. The closed loop medication administration environment implemented in at least one patient care service area. Electronic medication administration record (eMAR) system is implemented and integrated with CPOE and pharmacy.
e. Full physician documentation/charting (structured templates) implemented for at least one patient care service area. Full radiology picture archive and communication system (PACS) implemented (i.e. all images available to physicians via intranet or other secure network.)
f. Hospital has paperless EMR environment. Clinical information can be readily shared via Continuity of Care (CCD) electronic transactions with all entities within health information exchange networks (i.e., other hospitals, ambulatory clinics, sub-acute environments, employers, payers and patients).

5. Please describe the Applicant ACO's and proposed providers/suppliers' ability to use EHR data and electronic tools to understand patient risk, risk stratify, and use this information for decision-making.
6. Please describe the Applicant ACO's and proposed providers/suppliers' ability to transfer patient data and care plans between health care settings both inside and outside the ACO for purposes of care management and care coordination.
7. Please describe the experience of the proposed providers/suppliers reporting on established clinical and patient satisfaction quality measures. Please be specific about the measure set and purpose for collection. If applicable, include a description of any formal, third-party assessments within the past two years (2012-2014) of the Applicant ACO's performance on quality of care metrics relative to peers.
8. Please provide a narrative description and quantitative documentation of at least one illustrative instance in which the Applicant ACO has designed, implemented, and assessed the effectiveness of specific care improvement interventions. Include information on how the problem(s) was identified, why and how the intervention(s) was selected and designed, how progress (or lack thereof) was measured, and any corrective action or adjustments made.

<u>Benefit Enhancements Implementation</u>

The following section asks the Applicant ACO questions specific to its proposed implementation of a variety of benefit enhancements. Acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement. ACOs accepted into the Model will be required to provide CMS with additional information in order to enable each benefit enhancement they wish to use.

A. 3-Day SNF Rule

1. Please indicate if the Applicant ACO would be interested in implementing a waiver of the policy requiring a three-day inpatient stay prior to SNF admission:
   i. Yes
   ii. No

iii. Maybe in PY2 or later

1. Please describe how waiving the 3-Day SNF Rule will help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
2. Please describe any Applicant ACO and/or provider/supplier experience with a waiver of the 3-day SNF Rule (e.g., Medicare Advantage, PACE) or with direct access to SNFs for Medicare beneficiaries.

B. Post-Discharge Home Visits
    1. Please indicate if the Applicant ACO would be interested in billing for post-discharge home visits:
        i. Yes
        ii. No
        iii. Maybe in PY2 or later
    2. Please describe how reimbursement for post-discharge home visits will help the Applicant organization reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
    3. Please describe any Applicant ACO or ACO Provider/Supplier experience with performing home visits—through clinical staff or partnering with other providers/suppliers—or any experience with innovations in home health care.
C. Telehealth
    1. Please indicate if the Applicant ACO would be interested in greater flexibility in performing telehealth services:
        i. Yes
        ii. No
        iii. Maybe in PY2 or later
    2. Please describe how increased flexibility to perform telehealth services will help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
    3. Please describe any experience with live interactive telehealth services (either with Medicare or commercial arrangements).
    4. Please describe any experience with other telehealth capabilities (e.g., remote monitoring, store-and-forward/asynchronous communication).
D. Beneficiary Coordinated Care Reward
    1. Please describe how the CMS-funded coordinated care reward to beneficiaries will help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
E. Please describe how the Applicant ACO will identify a network of Preferred Providers for using the benefit enhancements above. Specifically, what data and information will the Applicant ACO utilize for determining with which community providers/suppliers to affiliate for these purposes? What criteria will the Applicant ACO use for assessing the suitability of providers/suppliers to be selected as Preferred Providers?