

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), the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive ESRD Care (CEC) Initiative, and the Next Generation ACO Model (Next Generation Model, Next Generation, or the Model).

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 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 other 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 payment mechanisms to enable a graduation from FFS reimbursements to population-based payments. Also central to the Model are several tools to help ACOs improve engagement with beneficiaries, such as: (1) enhanced access to post-discharge home visits, telehealth services, and skilled nursing facility services; (2) a reward payment to beneficiaries 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 and 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 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). Consistent with this standard, the Secretary issued certain waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act for this Model. No fraud or abuse waivers are being issued in this document; the fraud and abuse waivers issued for the Next Generation ACO Model can be found at <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html>. 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 such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Next Generation Model.

## **III. Scope and General Approach**

There are 20 ACOs participating in the Next Generation Model for the first performance year of the Model, which began on January 1, 2016, with representation from a variety of provider organization types and geographic regions. CMS expects additional ACOs to participate in the Next Generation Model, starting in the second performance year of the Model (calendar year (CY) 2017), and the number of awards will be based on the level of interest in the Model and available resources. The Next Generation Model has two application rounds for ACOs starting in the second performance year of the Model —the narrative portion of the application will be due May 25, 2016, and the applicant's provider lists and geographic service areas list will be due June 3, 2016. The first round of selected ACOs have an initial agreement term that consists of three one-year performance periods with the potential of two additional one-year extensions. 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 will 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 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 provides for two application rounds in consecutive years. Each application round has its own respective Letter of Intent and Application processes. Organizations that completed the round one process and were 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 that completed the round one process and was not selected for participation must submit a unique Letter of Intent and Application for consideration in round two. Organizations selected for the Model in 2016 who elected to defer participation or whom CMS deferred until 2017 must submit a Letter of Intent and the application specific to deferred ACOs.

##### **A. Letter of Intent**

For round two consideration, interested organizations must submit an LOI no later than 11:59 p.m. EDT April 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 two applications will be made available in March 2016. The narrative portion of the application must be submitted electronically no later than 11:59 p.m. EDT May 25, 2016, and the applicant's provider lists and geographic service areas list must be submitted electronically no later than 11:59 p.m. EDT June 3, 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](mailto:NextGenerationACOModel@cms.hhs.gov) with the subject “Application Question”.

### **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](mailto: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 Next Generation Participants and Preferred Providers in order to allow for screening by CMS and its law enforcement partners and final approval by CMS. Prior to signing the Participation Agreement, applicants must have a written agreement that meets the criteria set forth in the Participation Agreement with each Next Generation Participant and Preferred Provider on its list.*

## **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 Next Generation Participants (defined in the Glossary at Appendix B) 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 Next Generation Participants or Preferred Providers may participate in an ACO formed by one or more of the entities listed above, provided that they satisfy the requirements of the Model and are not Prohibited Participants (defined in the Glossary at Appendix B). See Program Overlap at Section V.H below for an explanation of how ACOs, Next Generation Participants, and Preferred Providers 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 Next Generation Participants, Preferred Providers, or any relevant individuals or entities. CMS may also deny individual Next Generation Participants or Preferred Providers 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 identified by a Federal taxpayer identification number (TIN) 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 Next Generation Participant compliance with health care quality criteria, including quality performance standards; and
- Fulfilling other ACO functions identified in the Next Generation ACO Model Participation Agreement.

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

If the ACO is formed by a single Next Generation Participant, the ACO's legal entity and governing body may be the same as that of the Next Generation Participant.



ACO legal entities that in the year prior to entry into the Next Generation Model have participated (without termination for cause) in either MSSP as a MSSP ACO pursuant to a participation agreement (as defined at 42 C.F.R. § 425.20) or the Pioneer Model as a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement 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 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 (unless the ACO is formed by a single Next Generation Participant, in which case the ACO's governing body may be the same as that of the Next Generation Participant).

## **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.
- When acting as a member of the governing body of the ACO, each governing body member has a fiduciary duty to the ACO, including the duty of loyalty, and shall act consistent with that fiduciary duty.
- The governing body must receive regular reports from the designated compliance official of the ACO, 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**

- At least 75 percent control of the ACO's governing body shall be held by Next Generation Participants or their designated representatives. The required Medicare beneficiary and consumer advocate representation in the governing body shall not be included in either the numerator or the denominator when calculating the percent control.
- 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; (3) who is not a Next Generation Participant or Preferred Provider; and (4) who does not have a direct or indirect financial relationship with the ACO, a Next Generation Participant, or a Preferred Provider, except that such person may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO.
- 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 and who: (1) does not have a conflict of interest with the ACO; (2) has no immediate family member with a conflict of interest with the ACO; (3) is not a Next Generation Participant or Preferred Provider; and (4) does not have a direct or indirect financial relationship with the ACO, a Next Generation Participant, or a Preferred Provider, except that such person may be

reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO.

- The ACO Governing body shall not include a Prohibited Participant (defined in the Glossary at Appendix B), or an owner, employee or agent of a Prohibited Participant.
- 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 Participants or Preferred Providers 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 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; and
- 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 Next Generation Participant; (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.

### **D. Next Generation Participants and Preferred Providers**

The Next Generation Model clearly defines categories of Medicare providers/suppliers and their respective relationships to the ACO entity. The two primary categories are Next Generation Participants and Preferred Providers. Next Generation Participants are the core providers/suppliers in the Model. Beneficiaries are aligned to the ACO through the Next Generation Participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, Preferred Providers may participate in certain benefit enhancements. Services furnished by Preferred Providers will not be considered in alignment and Preferred Providers are not responsible for reporting quality through the ACO.

**Table 5.1 Types of Providers/Suppliers and Associated Functions<sup>1</sup>**

Provider Type	Alignment	Quality Reporting Through ACO	Eligible for ACO Shared Savings	PBP	All-Inclusive PBP	Coordinated Care Reward	Telehealth	3-Day SNF Rule	Post-Discharge Home Visit
Next Generation Participant	X	X	X	X	X	X	X	X	X
Preferred Provider			X	X	X	X	X	X	X

<sup>1</sup> This table is a simplified depiction of key design elements with respect to Next Generation Participant and Preferred Provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

<sup>2</sup> More information on the benefit enhancement may be found in Section VI.C.

### **E. State Licensure**

To participate in the Next Generation ACO Model, an ACO must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities unless it provides a written attestation to CMS that it is exempt from such state laws. 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 certain Next Generation payment mechanisms, 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.

### **F. Outcomes-Based Contracts with Other Purchasers**

CMS may require Next Generation ACOs to report to CMS, in a manner and by a date determined by CMS, information regarding the scope of outcomes-based contracts held by the ACO and/or its Next Generation Participants with non-Medicare Purchasers. For purposes of this Model, outcomes-based contracts mean contracts that evaluate patient experiences of care, include financial accountability (e.g., shared savings or financial risk) and/or quality performance standards.

### **G. Use of Certified EHR Technology**

Beginning in 2017, the ACO and its Next Generation Participants shall use certified EHR technology (as defined in section 1848(o)(4) of the Act) in a manner sufficient to meet the

requirements for an “eligible alternative payment entity” under section 1833(z)(3)(D)(i)(I) of the Act (added by section 101(e)(2) of the Medicare Access and CHIP Reauthorization Act of 2015) as prescribed through future regulation.

## **H. Program Overlap**

Next Generation ACOs may not simultaneously participate in MSSP, the Independence At Home medical practice pilot program under section 1866E of the Act, another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings. If the ACO is otherwise eligible, the ACO may participate in other Medicare demonstrations or models. CMS may issue guidance or work directly with the ACO in determining how participation in certain demonstrations or models can be combined with participation in the Next Generation ACO Model. CMS will undertake program overlap reviews during the application process.

A Next Generation Participant may not also be an ACO participant, ACO provider/supplier and/or ACO professional in an accountable care organization in the MSSP. This determination is made at the TIN level. A group of providers or suppliers identified by a single Tax Identification Number (TIN) will not be allowed to concurrently participate as Next Generation Participants in the Next Generation ACO Model and as ACO participants, ACO providers/suppliers, or ACO professionals in MSSP. Any individual provider or supplier, identified by a unique TIN / National Provider Identifier (NPI) combination, identified as a Next Generation Participant in the Next Generation Model precludes the entire TIN under which it bills from participation in the MSSP.

A Next Generation Participant who is a non-primary care specialist may be a Next Generation Participant in another accountable care organization in this Model or serve in an equivalent role in or any other model or program in which such non-primary care specialists are not required to be exclusive to one participating entity, subject to the limitation specified in the preceding paragraph.

A Next Generation Professional (defined in the Glossary at Appendix B) who is a primary care specialist may not: (a) be identified as a Next Generation Participant by a different ACO in the Model; (b) be an ACO participant, ACO provider/supplier or ACO professional in the MSSP; or (c) participate in another Medicare ACO model, except as expressly permitted by CMS.

A Preferred Provider may serve in the following roles provided all other applicable requirements are met: (1) Preferred Provider for one or more other ACOs participating in the Next Generation ACO Model; (2) Next Generation Participant in one or more other accountable care organizations participating in the Next Generation ACO Model; (3) ACO participant, ACO provider/supplier and/or ACO professional in an accountable care organization in the MSSP (note: CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and 42 C.F.R. § 425.114(a) as they apply to Preferred Providers); and/or (4) a role similar in function to the Next Generation Participant in another shared savings initiative.

## **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 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 prospective Benchmark prior to the start of each performance year. The prospective Benchmark will be set using the most accurate expenditure, quality, and risk score data available at the time of benchmark setting, with minimal updates to arrive at the final Benchmark after the performance year ends.<sup>1</sup>

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: calendar year (CY) 2014. The same baseline year, CY 2014, will be used for PY1 (CY 2016) through PY3 (CY 2018). However, the baseline will be updated each year to reflect the ACO's Next Generation Participant 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).

#### **ii. Trend (Benchmark Step 2)**

The Benchmark will incorporate a regional projected trend, which will be determined using

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<sup>1</sup> 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 ACO Model Participation Agreement.

similar assumptions as those used in the national projected trend in Medicare Advantage (MA)<sup>2</sup> with the additional application of regional price adjustments.

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. 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 for the performance year will not be available until after the completion of the performance year, and thus cannot be incorporated into the prospective Benchmark. The prospective Benchmark will use the most recent available final HCC risk score as a placeholder. For example, the PY1/CY2016 final risk scores are expected to be released in April 2017. The PY1/CY2016 final Benchmark will be updated to reflect the final PY1/CY2016 risk scores.

### 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 standard discount is 3.0% and then ranges from 0.5% to 4.5% based on ACO-specific adjustments reflecting three factors: (1) ACO quality score; (2) ACO baseline expenditures compared to regional FFS expenditures (regional efficiency); and (3) ACO baseline expenditures compared to national FFS expenditures (national efficiency).

Below is a description of each factor of the discount.

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<sup>2</sup> 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/MedicareAdvgtgSpecRateStats/Downloads/Announcement2015.pdf>.

- **Quality:** The standard discount will be reduced by up to 1% depending on the quality score attained by the ACO in the Performance-Year. Therefore, an ACO with a 100% quality score would have the discount reduced to 2.0%, and an ACO with a 0% quality score would receive no reduction to the 3.0% standard discount. In PY1 (CY 2016), a quality score of 100% will be used for all Next Generation ACOs so long as the ACO successfully reports quality measures (pay-for-reporting). ACOs with agreements commencing with an effective January 1, 2017 will have a quality score of 100% so long as the ACO successfully reports quality measures for 2017. 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% (i.e., the standard discount will be decreased or increased +/- 1.0%). 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% (i.e., the standard discount will be decreased or increased +/- 0.5%). This compares the ACO's risk-adjusted historical per capita 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 99<sup>th</sup> percentile of expenditures to prevent substantial impacts by outliers (the Next Generation ACO is not accountable for expenditures beyond the 99<sup>th</sup> 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**

<b>Arrangement A: Increased Shared Risk</b>	<b>Arrangement B: Full Performance Risk</b>
Parts A and B Shared Risk <ul style="list-style-type: none"> <li>• 80% sharing rate (PY1-3)</li> <li>• 85% sharing rate (PY4-5)</li> <li>• 15% savings/losses cap</li> </ul>	100% Risk for Part A and B <ul style="list-style-type: none"> <li>• 15% savings/losses cap</li> </ul>

### 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 “all-inclusive population-based payments” as a fourth payment option starting in 2017. None of the 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 payment mechanism are included in Appendix D.

#### i. Payment Mechanism 1: Normal FFS Payment

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

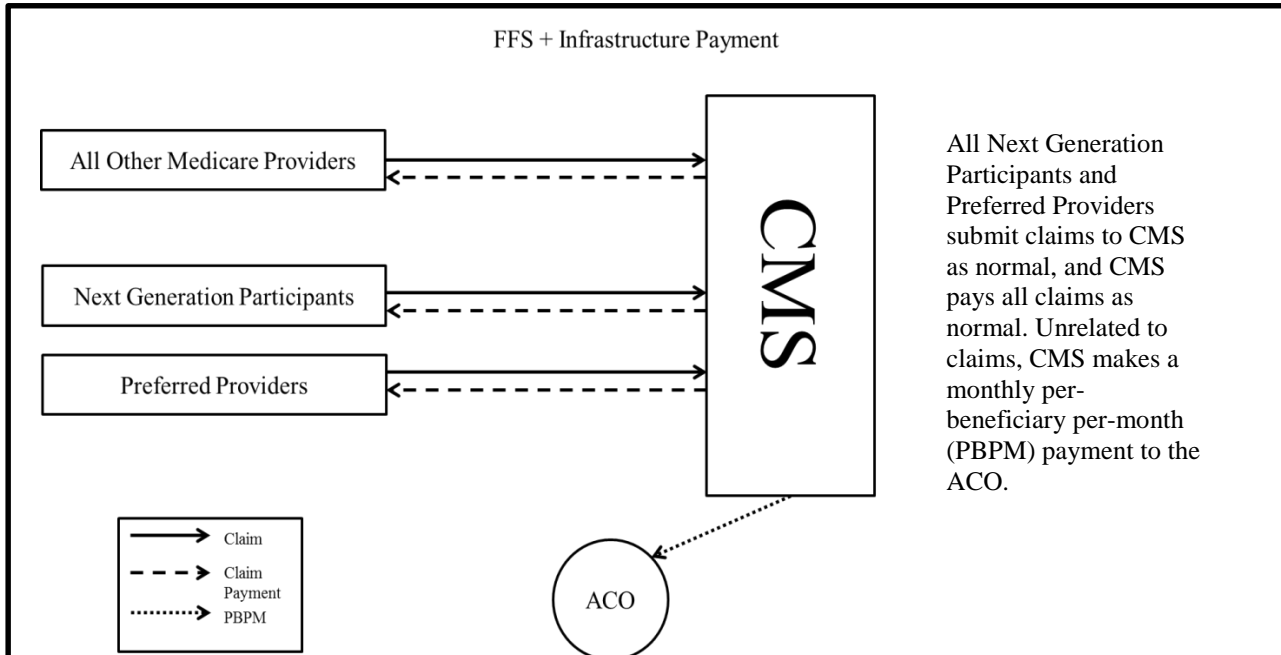
#### ii. Payment Mechanism 2: Normal FFS Payment + Monthly Infrastructure Payment

Next Generation Participants and Preferred Providers 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. The amount of the monthly infrastructure payment will be the product of the number of beneficiaries aligned to the ACO for a performance year and the PBPM amount selected by the ACO. The aggregate monthly payment will be calculated prior to the start of each performance year in which the ACO has elected to receive infrastructure payments and will not be updated during a performance year.



**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 Next Generation Participants and Preferred Providers. The PBP is an estimate of the total amount by which FFS payments will be reduced for Medicare Part A and B services rendered by PBP-participating Next Generation Participants and Preferred Providers who agree to accept Reduced FFS Payments when providing care to aligned beneficiaries during the upcoming Performance Year. This estimate will be based on available data on payments to Next Generation Participants and Preferred Providers participating in PBP for the applicable performance year for services that were provided to aligned beneficiaries during the 12-month period immediately prior to the performance year.

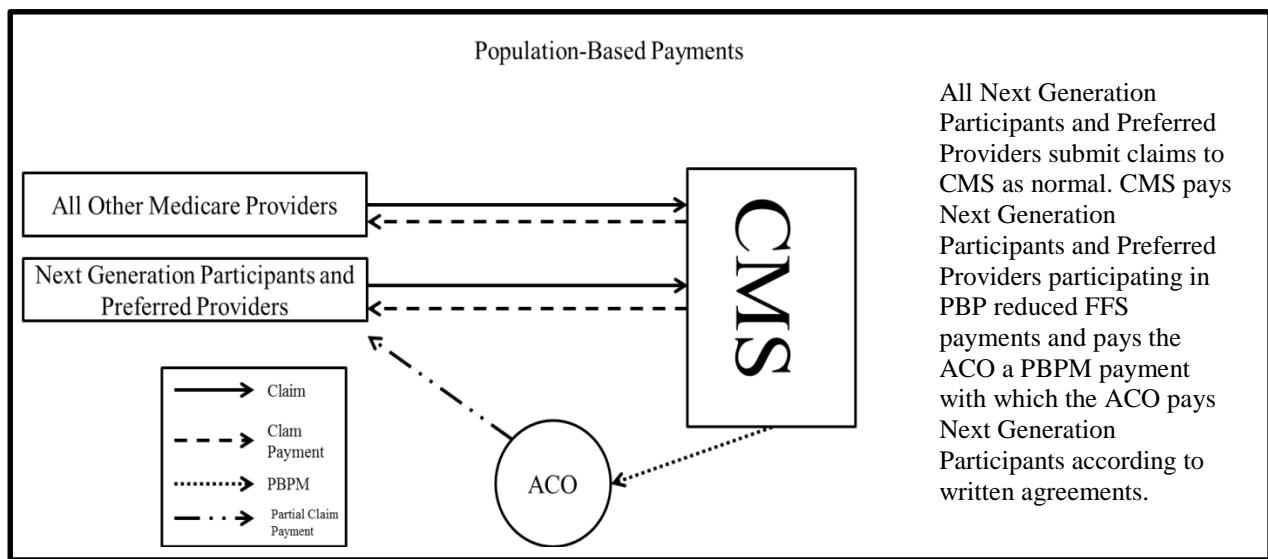
Not all Next Generation Participants and Preferred Providers must agree to receive Reduced FFS Payments for the ACO to participate in PBP and not all Next Generation Participants and Preferred Providers billing under a TIN must agree to receive Reduced FFS Payments for the TIN to participate in PBP. Next Generation Participants and Preferred Providers participating in PBP must agree to permit CMS to reduce their Medicare reimbursement for aligned beneficiaries by the specified percentage.

A Next Generation ACO will determine a percentage reduction to the FFS payments of its Next Generation Participants and Preferred Providers participating in PBP. An ACO may opt to apply a different percentage reduction to different subsets of its Next Generation Participants and

Preferred Providers. CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments. When PBP-participating Next Generation Participants and Preferred Providers submit claims to CMS for services rendered to aligned beneficiaries, the payment will be reduced by the agreed upon amount.

The reductions to FFS payments do not affect the calculation of Shared Savings/Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the fee reduction. The reconciliation of PBP payments and reductions in FFS payments determines the net amount owed by either CMS or the Next Generation ACO as the difference between the total PBP payment amount paid during the Performance Year and the actual amount of the FFS reductions for PBP-participating Next Generation Participants and Preferred Providers.

**Figure 6.2 Population-Based Payments Conceptual**



iv. **Payment Mechanism 4: All-Inclusive Population-Based Payments**

All-Inclusive Population-Based Payments (AIPBP) will be determined by estimating total annual expenditures for care furnished to aligned beneficiaries by Next Generation Participants and Preferred Providers who have agreed to participate in AIPBP and CMS will pay that projected amount to the ACO in a PBPM payment. A Next Generation ACO participating in AIPBP will be responsible for paying claims for its Next Generation Participants and Preferred Providers with which the ACO has written agreements regarding participation in AIPBP. ACOs will not be required to pay 100 percent of FFS rates to Next Generation Participants and Preferred Providers participating in AIPBP; ACOs may have alternative compensation arrangements with these providers consistent with all applicable laws. Next Generation Participants and Preferred Providers that have agreed to participate in AIPBP 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 Next Generation Participants and Preferred Providers participating in AIPBP, the requirements for which will be detailed in the Model Participation Agreement.

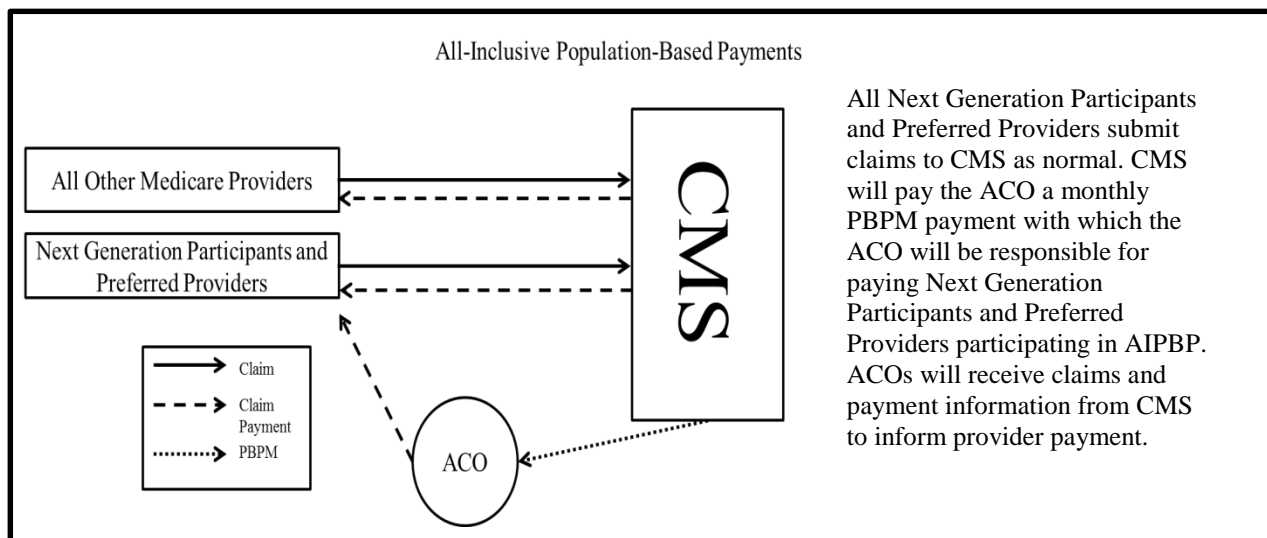
On an ongoing basis, CMS will send Next Generation ACOs claims information for those services for which the Next Generation ACO is responsible for making payment. These reports will be in addition to those described in Section IX below. Additional financial requirements for ACOs participating in AIPBP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

CMS will continue to pay normal FFS claims for care provided to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers not covered by an AIPBP agreement, as well as care furnished to aligned beneficiaries by Medicare providers/suppliers that are not Next Generation Participants or Preferred Providers.

AIPBP is a payment mechanism and does not affect the Next Generation ACO’s benchmark. As with all of the Next Generation payment mechanisms, Next Generation ACOs will also have a separately calculated benchmark, which determines the savings in which the ACO may share or the losses for which the ACO is accountable. While CMS will not be actually making payment on a subset of FFS claims for aligned beneficiaries, CMS will use the FFS amount that would have been paid in conducting financial reconciliation. CMS will separately reconcile the AIPBP.

Monthly AIPBP amounts will be calculated prior to the start of the performance year by estimating the proportion of care to be delivered by Next Generation Participants and Preferred Providers that have agreed to participate in AIPBP and accept a 100% FFS reduction. At the end of year, CMS will reconcile the estimation versus claims that were actually reduced. This reconciliation may result in monies owed from the ACO to CMS, or vice versa. This accounting is separate from the savings and losses calculation (similar to the PBP payment mechanism).

**Figure 6.3 All-Inclusive Population-Based Payments 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 AIPBP. 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 have in place a financial guarantee sufficient to cover potential losses. 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 covered under Part A in January of the base- or performance-year and in every month of the base- or performance-year in which the beneficiary is alive;
- Have no months of coverage under only Part A;
- Have no months of coverage under only Part B;
- Have no months of coverage under a Medicare Advantage or other Medicare managed care plan;
- Have no months in which Medicare was the secondary payer; and,
- Be a resident of the United States.

Alignment is performed prior to the start of each performance year, and alignment eligibility will be determined on a quarterly basis throughout the performance year. A beneficiary may be alignment-eligible in the base year but not a performance year and may be alignment-eligible in a performance year but not the base year.

Beneficiaries are also not eligible for inclusion in financial settlement (i.e., will be excluded from the aligned population) if:

1. The Next Generation Beneficiary was a resident of a county that was part of the ACO's service area in the last month of the 2-year alignment period but was a resident of a county that was not part of the ACO's service area in the performance-year.
2. During the base- or Performance-Year (respectively, for base-year and performance-year aligned beneficiaries) at least 50% of Qualified Evaluation and Management (QEM) services used by the Next Generation Beneficiary were from providers practicing outside the ACO's service area.

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

Next Generation Beneficiaries are identified prospectively, *prior to the start of the Performance Year*. Similarly, the beneficiaries who are aligned in each base-year for the purpose of calculating the baseline expenditure are identified on the basis of each beneficiary's use of QEM services in the 2-year alignment period ending *prior* to the start of the base-year. The 2-year alignment period is the two years ending 6 months prior to the start of the given Performance Year. For 2017, the 2-year alignment period is July 1, 2014 through June 30, 2016.

Alignment of a beneficiary is determined by comparing:

1. The weighted allowable charge for all QEM services that the beneficiary received from each NGACOs' Next Generation Participants;
2. The weighted allowable charge for all QEM services that the beneficiary received from each physician practice (including institutional practices) whose members are not participating in an NGACO.

A beneficiary is aligned with the NGACO or the non-NGACO ACO physician practice from which the beneficiary received the largest amount of QEM services during the 2-year alignment period. A beneficiary will generally be aligned with a Next Generation ACO if he or she received the plurality of QEM services during the 2-year alignment window from Next Generation Participants.

Alignment for a base- or performance-year uses a two-stage alignment algorithm.

1. **Alignment based on primary care services provided by primary care specialists.** If 10% or more of the allowable charges incurred on QEM services received by a beneficiary during the 2-year alignment period are obtained from physicians and practitioners with a primary care specialty then alignment is based on the allowable charges incurred on QEM services provided by primary care specialists.
2. **Alignment based on primary care services provided by selected non-primary care specialties.** If less than 10% of the QEM services received by a beneficiary during the 2-year alignment period are provided by primary care specialists, then alignment is based on the QEM services provided by physicians and practitioners with certain non-primary specialties.

Provider specialty is determined by the specialty code that is assigned to the claim during claim processing, in the case of physician claims, or by the specialty associated with the NPI of the physician or NPP in the Medicare provider enrollment database in the case of certain FQHC, RHC and Method II CAH claims.

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 (CY 2016), and repeated annually in each subsequent Performance Year, Next Generation ACOs may seek approval by CMS to offer certain Medicare beneficiaries the option to confirm or deny their care relationships with specific Next Generation Participants. Alignment for beneficiaries who voluntarily align to a Next Generation ACO will be effective the subsequent year. A beneficiary who completes the Voluntary Alignment Form will have the option to reverse that decision or change the identified care relationship.

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

If an ACO joins the Next Generation Model after participating in another Medicare ACO initiative with voluntary alignment during the year prior to the Next Generation ACO's first performance year, the ACO 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 2016 could retain those voluntarily-aligned beneficiaries for Next Generation PY2 if the ACO enters the Next Generation Model in 2017.

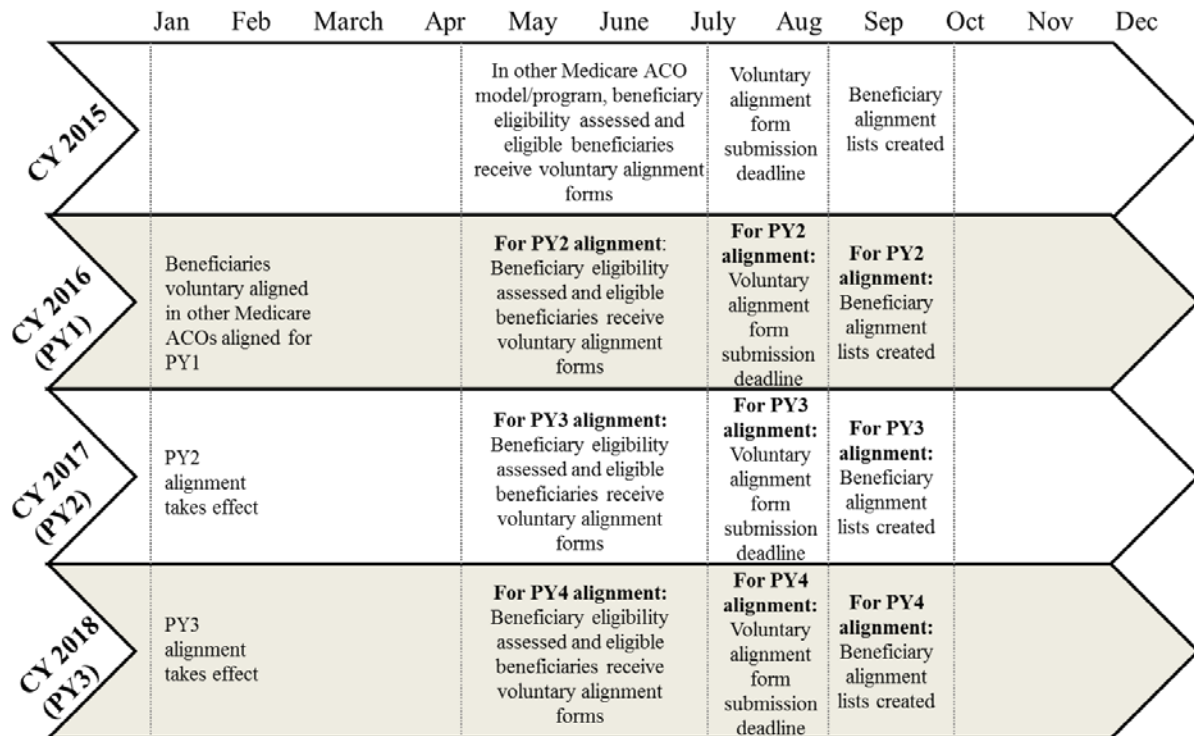
In advance of the voluntary alignment confirmation process, ACOs will be required to send a CMS-approved Voluntary Alignment Form with instructions directly to beneficiaries with information regarding voluntary alignment and the potential benefit enhancements associated with alignment to Next Generation 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 Next Generation Participants 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, except that Next Generation Participants may answer beneficiary questions in a manner that will be specified by CMS in the Participation Agreement. CMS will implement certain program integrity safeguards and monitoring measures and may require Next Generation ACOs and/or Next Generation Participants 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; (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 6.4 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 has designed policies using 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 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 has incorporated 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 Participants or Preferred Providers.

### **5. 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 eligible Next Generation beneficiaries to be admitted to qualified Next Generation Participants or Preferred Providers either directly or with an inpatient stay of fewer than three days.

A Next Generation beneficiary will be eligible for admission in accordance with this waiver if: (1) the beneficiary does not reside in a SNF or long-term care setting at the time of the admission to a SNF or swing-bed hospital; and (2) the beneficiary meets all other CMS criteria for SNF or swing-bed hospital 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 SNFs and swing-bed hospitals with which they will partner in this waiver. Partner SNFs and swing-bed hospitals may be either Next Generation Participants or Preferred Providers. Through the application and implementation plan, Next Generation ACOs may be asked to describe how the identified Next Generation Participants and Preferred Providers 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, the SNFs 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.

### **6. 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 Participants 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.

## **7. 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 Professionals or Preferred Providers (who are physicians or other practitioners). Licensed clinicians means auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1), or otherwise appropriately certified under applicable state law to perform the services ordered by the supervising physician or other practitioner.

Claims for these visits will only be allowed following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility and will be limited to no more than one visit in the first 10 days following discharge and one additional time in the first 30 days following discharge. 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. 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 the ACO’s Next Generation Participants and Preferred Providers. All Next Generation Beneficiaries will automatically participate in this benefit enhancement and be eligible for this reward payment beginning in 2016. These payments 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 developed by CMS. CMS expects that the reward amount will be approximately \$70 per-beneficiary per-year, paid annually, and expects to set the threshold at least at 75% of all Parts A and B care from Next Generation Participants and Preferred Providers. The methodology for calculating the percentage of ACO care will be described in guidance documentation and communicated to Next Generation Beneficiaries during 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: \$70/year
- Illustrative ACO Care Threshold: 75%

- Beneficiary A is aligned to Next Generation ACO Alpha. During the year, she receives 80% of her care from ACO Alpha’s Next Generation Participants and Preferred Providers. She receives a \$70 payment from CMS.

### **E. 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. 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 closely 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 closely follow the MSSP quality measure set. The Next Generation Model will not use the electronic health record (EHR) measure (ACO-11: Percent of PCPs Who Successfully Meet Meaningful Use Requirements). 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 (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/CY 2017, the initial prospective Benchmark for NGACOs that started in the Model in 2016 will be based on a quality score of 100% as PY1 quality scores will not be available at the time that the Benchmark is calculated. When PY1 quality scores are calculated at mid-year PY2, CMS will update the Performance Year Benchmark for these NGACOs. For NGACOs with agreements effective January 1, 2017, the initial and mid-year update to the quality score will be 100%.

For PY3, the prospectively-set quality score component will be based on the quality score from PY1, for NGACOs that started in the Model in 2016, and will be based on 100% for NGACOs that started in the Model in 2017. PY2 quality scores will be calculated in mid-2018. When PY2 quality scores become available, CMS will update the Performance Year Benchmark to reflect the PY2 quality score.

The Benchmark that is used in financial settlement will be once again updated to include an adjusted discount that reflects the actual performance-year quality score attained by the NGACO. For NGACOs with agreements that commence effective January 1, 2017, the PY2/CY2017 quality score used to calculate the final adjusted discount will be 100% if all quality data reporting requirements described in the Participation Agreement have been met.

## **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 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 for identifying and addressing compliance problems related to the ACO's operations and performance;
- Compliance training programs for the ACO and its Next Generation Participants and Preferred Providers;
- A method for employees or contractors of the ACO, Next Generation Participants, 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.
- A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.
- The ACO's compliance plan must be in compliance with all applicable laws and regulations and be updated periodically to reflect changes in those laws and regulations.

## **B. CMS Monitoring**

CMS will employ a range of methods to monitor and assess compliance by the Next Generation ACO, its Next Generation Participants and Preferred Providers with the terms of the participation agreement, 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;
- Interviews with any individual or entity participating in ACO Activities, including members of the ACO leadership and management, Next Generation Participants, and Preferred Providers;
- Interviews with Next Generation Beneficiaries and their caregivers;
- Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Next Generation Participants and Preferred Providers;
- Site visits to the ACO and its Next Generation Participants and Preferred Providers; and
- Documentation requests sent to the ACO, its Next Generation Participants, and/or Preferred Providers, including surveys and questionnaires.

CMS will conduct comprehensive annual audits related to compliance with the participation agreement and more limited targeted or ad-hoc audits as necessary.

## **C. Remedial Actions**

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

- ACO education on how to operate in compliance with relevant standards;
- Request for Corrective Action Plan (CAP) detailing how an ACO will rectify noncompliance;
- Suspension or data sharing rights if data sharing is implicated in the violation;
- Suspension or termination of infrastructure payments or other payments due to the ACO;
- Suspension or termination of the use of one or more benefit enhancements;
- Termination of the ACO from the Next Generation Model;
- Suspension or termination of the availability of any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act;
- A demand that the ACO remove a Next Generation Participant or Preferred Provider from the Participant List or Preferred Provider List and to terminate its agreement, immediately or within a timeframe specified by CMS, with such Next Generation Participant or Preferred Provider with respect to this Model; and
- Prohibition of the ACO from distributing Shared Savings to a Next Generation Participant or Preferred Provider.

## **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 for the sole purposes of developing and implementing activities related to coordinating care and improving the quality and efficiency of care for Next Generation Beneficiaries.

Upon request from the ACO, CMS will provide (1) data on aligned Next Generation Beneficiaries that will include individually identifiable demographic and Medicare eligibility status information and various summary reports with data relevant to ACO operations and performance in the Model; and (2) detailed claims data files that will include individually identifiable claim and claim line data for services furnished by Medicare-enrolled providers and suppliers to aligned Next Generation Beneficiaries.

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 Next Generation Participants.

The data and reports provided to the ACO shall not include individually identifiable data for Next Generation Beneficiaries who have opted out of data sharing with the ACO and 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 aligned 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 for answers to 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 AIPBP payment mechanism will receive claims and payment information from CMS for the services furnished to Next Generation beneficiaries by Next Generation Participants and Preferred Providers. 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: Quarterly and Annual Utilization; Monthly Expenditures; Beneficiary Data Sharing Preferences; and Beneficiary Alignment.

### **1. Monthly**

ACOs will receive standard monthly and year-to-date financial reports on the most recent and

cumulative expenditures for selected categories of services for aligned beneficiaries. This aggregate information will not include individually identifiable information and will incorporate de-identified data from Next Generation Beneficiaries who have opted out of data sharing. This report summarizes claims based on the previous month's expenditures but includes no claims run-out. Finally, a monthly claims lag report will show the differences between claim and date of service.

## **2. Quarterly**

CMS will provide quarterly baseline benchmark reports (BBRs) to ACOs to monitor ACO financial performance throughout the year. The BBRs will not contain individually identifiable data. The design and data source used to generate the BBRs is also used for the final year-end financial settlement report. In the event that data contained in the BBRs conflicts with data provided from any other source, the data in the BBRs will control with respect to year-end financial settlement.

## **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 by CMS and/or its designees, 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. The ACO must require its Next Generation Participants and Preferred Providers to participate and cooperate in any such independent evaluation activities conducted by CMS and/or its designees.

## **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 has developed 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](mailto: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 payment mechanisms. 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 Next Generation Participants and Preferred Providers.

## **XIII. Duration of Agreement**

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

In choosing whether to offer an ACO the additional two performance years, 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 prior performance years. 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. Next Generation ACOs are required to participate in the learning system by attending periodic conference calls and meetings and actively sharing tools and ideas.

## **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 (1) organizational structure, including identification of the members of the ACO’s governing body and the ACO’s Next Generation Participants and Preferred Providers; (2) Shared Savings and Shared Losses information; and (3) performance on the quality measures described in Appendix E. 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 Next Generation Participant or Preferred Provider, 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 input and to reflect the agency’s experience with the Model. 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](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](mailto:NextGenerationACOModel@cms.hhs.gov).

#### Section A. Organization and Contact Information

1. Applicant Name

Organization Name:  
Doing Business As (if applicable):  
Organization Type:  
Organization TIN/EIN:  
Street Address:  
City:  
State:  
ZIP Code:  
Website (if applicable):

2. Applicant Primary Contact

Primary Contact's First Name:  
Primary Contact's Last Name:  
Title/Position:  
Business Phone Number:  
Business Phone Number Extension:  
Alternative Phone Number (e.g., cell phone):  
E-mail Address (you may submit only one application per e-mail address):  
Is the Primary Contact's address the same as the organization's address entered above?  
If no:  
Street Address:  
City:  
State:  
ZIP Code:

3. Secondary Contact

Secondary Contact's First Name:  
Secondary Contact's Last Name:  
Title/Position:  
Business Phone Number:  
Business Phone Number Extension:  
Alternative Phone Number (e.g., cell phone):  
E-mail Address:  
Is the Secondary Contact's address the same as the organization's address entered above?

If no  
Street Address:  
City:  
State:  
ZIP Code:

Section B. Letter of Intent

4. Did the Applicant ACO submit an LOI last year?
  - a. Did the Applicant ACO submit an application to the Model?
  - b. Please indicate Applicant name
  - c. What was the result of your application?
5. Please indicate if the Applicant ACO, or any of its proposed Next Generation Participants, is currently participating in or has applied to any of the initiatives listed below:
  - Accountable Health Communities
  - ACO Investment Model
  - Advance Payment ACO Model
  - Bundled Payments for Care Improvement 1
  - Bundled Payments for Care Improvement 2
  - Bundled Payments for Care Improvement 3
  - Bundled Payments for Care Improvement 4
  - Comprehensive Care for Joint Replacement
  - Comprehensive ESRD Care Initiative
  - Comprehensive Primary Care Initiative
  - Independence at Home Demonstration
  - Intravenous Immune Globulin (IVIG) Demonstration
  - Maryland All-Payer Hospital Model
  - Medicare Care Choices Model
  - Medicare Shared Savings Program
  - Nursing Home Value-Based Purchasing Demonstration
  - Oncology Care Model
  - Pioneer ACO Model
  - Private, For-Profit Demo Project for the Program of All-Inclusive Care for the Elderly(PACE)
  - State Innovation Models Initiative: Model Design Awards Round One
  - State Innovation Models Initiative: Model Design Awards Round Two
  - State Innovation Models Initiative: Model Testing Awards Round One
  - State Innovation Models Initiative: Model Testing Awards Round Two
  - Transforming Clinical Practice Initiative

6. Medicare ACO Name (Please put N/A if this is not applicable):
7. If a Medicare ACO, what is the ID number (e.g., P123 or A123)? (Please put N/A if this is not applicable.) If the Applicant ACO has more than one Medicare ACO ID, please specify all IDs. (Multiple IDs must be separated by commas).
8. If a Medicare ACO, does the Applicant ACO anticipate the entire ACO to transition to the Next Generation ACO Model? (No TINs/Participants will remain in the ACO's current Medicare ACO initiative).
9. If a Medicare ACO, does the Applicant ACO anticipate only some TINs/Participants to transition to the Next Generation ACO Model? (Some TIN/Participants will remain in the current initiative while others will join the Next Generation ACO Model).
  - 8a. Does the Applicant ACO anticipate TIN changes for the transitioning participants?
10. Current Medicare Shared Savings Program Track. Please Select.
11. End of Current Initiative Agreement
12. Is the Applicant ACO or any of the proposed ACO Participants currently participating in an ACO with a payer other than Medicare?
13. How many of the counties your proposed ACO will service are considered rural? (If not applicable, enter "0.")
14. Please provide us with your expected number of aligned Medicare beneficiaries in 2017. (Enter only whole numbers. Please leave out commas).

## 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.

**All-Inclusive Population-Based Payments:** A payment mechanism wherein the Next Generation ACO receives a per-beneficiary per-month payment for projected total annual expenditures for services provided to aligned Next Generation Beneficiaries by Next Generation Participants or Preferred Providers who have agreed to participate in AIPBP. The ACO is responsible for paying claims for services furnished to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers with whom the Next Generation ACO has written agreements regarding AIPBP. CMS will withhold some money to cover anticipated care delivered by other providers. AIPBP only represents a payment mechanism; Next Generation ACOs separately select a risk arrangement.

**BENEFIT ENHANCEMENTS:** In the Next Generation ACO Model, CMS has used 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 ACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

**DISCOUNT:** The discount is a calculated adjustment to 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 Participant 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 BENEFICIARY:** A Medicare beneficiary who has been aligned to a Next Generation ACO as described in Section VI.B.

**NEXT GENERATION PARTICIPANT:** An individual or entity that: (1) is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202); (2) is identified on the ACO's list of Next Generation Participants by name, National Provider Identifier (NPI), TIN, Legacy TIN (if applicable), and CMS Certification Number (CCN) (if applicable); (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; and (4) is not a Prohibited Participant and (5) has agreed to participate in the Model, pursuant to a written agreement with the ACO to report quality data through the ACO, and to comply care improvement objective and Model quality performance standards. Certain design elements associated with a Next Generation ACO will automatically apply to its Next Generation Participants. These include, for

example, beneficiary alignment, quality reporting through the ACO, payment mechanisms, benefit enhancements, and care improvement objectives.

**OTHER MONIES OWED:** A monetary amount that represents a reconciliation of monthly payments made by CMS during a Performance Year, including payments made through Alternative Payment Mechanisms, and is neither Shared Savings nor Shared Losses. For example, Next Generation ACOs may elect a payment mechanism in which they receive monthly per-beneficiary payments that require reconciliation at the end of the Performance Year. Any excess payments will be recouped from the ACO as Other Monies Owed, 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. Shared Savings or Losses are determined by comparing an ACO's spending to its benchmark.

**POPULATION-BASED PAYMENTS:** A payment mechanism wherein the ACO Next Generation Participants and/or Preferred Providers 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.

**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); (2) is identified on the ACO's list of Preferred Providers by name, National Provider Identifier (NPI), TIN, Legacy TIN (if applicable), and CMS Certification Number (CCN) (if applicable); (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; (4) is not a Prohibited Participant; and (5) has agreed to participate in the Model pursuant to a written agreement with the ACO. ACOs may allow certain benefit enhancements that are available to aligned beneficiaries to 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.

**Prohibited Participant:** An individual or entity that is: (1) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier, (2) an ambulance supplier, (3) a drug or device manufacturer, or (4) excluded or otherwise prohibited from participation in Medicare or Medicaid.

**RURAL ACO:** A Next Generation ACO is considered rural if at least 40 percent of the zip codes in its service area are determined to be rural according to the definition used by the Health Resources and Services Administration (HRSA) Office of Rural Health Policy. Such definition includes all non-Metropolitan counties, census tracts inside Metropolitan counties with Rural-Urban Commuting Area (RUCA) codes 4-10, and census tracts with RUCA codes 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people per square mile. See: <http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx>

**SHARED LOSSES:** Any monetary amount owed to CMS by the ACO according to the applicable risk arrangement and due to expenditures for Medicare Part A and B items and services furnished to aligned Next Generation Beneficiaries in excess of the ACO's Medicare expenditure Benchmark for the applicable performance year.

**SHARED SAVINGS:** The monetary amount owed to the ACO by CMS in accordance with the applicable risk arrangement and due to expenditures for Medicare Part A and B items and services furnished to aligned Next Generation Beneficiaries lower than the benchmark for the applicable performance year.

**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 Participant. Beneficiaries who indicate that a Next Generation Participant is their main provider generally 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; (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 Benchmark 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, so long as they report on the quality measures.

	Baseline (CY2014)	Benchmark
<b>ACO baseline (CY2014) expenditure:</b>	<b>\$876.54</b>	<b>\$876.54</b>
<b>Projected PY1/CY2016 regional trend adjustment:</b>		<b>\$30.36</b>
Projected PY1/CY2016 regional trend:	3.46%	
<b>Trended baseline<sup>1</sup></b>		<b>\$906.90</b>
<b>PY1 baseline risk adjustment factor<sup>2</sup></b>		<b>1.010</b>
<b>Risk-adjusted trended baseline<sup>3</sup></b>		<b>\$915.97</b>
<b>Adjusted NGACO discount</b>		
Standard discount	3.00%	<b>3.00%</b>
National baseline efficiency adjustment to the standard discount	-0.04%	-0.04%
National efficiency ratio	0.993	
Regional baseline efficiency adjustment to the standard discount	-0.13%	-0.13%
Regional efficiency ratio	0.987	
Quality adjustment to the standard discount		-1.00%
Quality- and efficiency-adjusted discount		<b>1.84%</b>
<b>LESS: NGACO discount<sup>4</sup></b>		<b>\$16.85</b>
<b>Benchmark<sup>5</sup></b>		<b>\$899.12</b>

<sup>1</sup> The ACO baseline plus the regional trend adjustment ( $906.90 = 876.54 + 30.36 = 876.54 \times (1 + 0.0346)$ ).

<sup>2</sup> The ratio of the PY1 risk score to the base-year risk score (subject to a  $\pm 3\%$  limit). The example assumes the PY1 risk score is 1% higher than the base-year risk score, therefore a risk adjustment factor of 1.010.

<sup>3</sup> The product of the trended baseline and the risk adjustment factor ( $915.97 = 906.90 \times 1.010$ ).

<sup>4</sup> The NGACO discount is equal to the risk-adjusted trended baseline multiplied by quality- and efficiency-adjusted discount ( $\$899.12 = 0.0184 \times \$915.97$ ).

<sup>5</sup> The benchmark is equal to the risk-adjusted trended baseline less the NGACO discount ( $\$899.12 = \$915.97 - \$16.85$ ).

## 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 Participants participating in PBP should account for 75% of Next Generation 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 Participants 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 Next Generation Participants, Preferred Providers 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 Next Generation Participants and Preferred Providers participating in PBP. After the performance year it is determined that 70% of care was



performed by Next Generation Participants and Preferred Providers 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.

### **AIPBP (available beginning in PY2)**

- An ACO has 25,000 beneficiaries and elects to participate in AIPBP. Using historic claims, CMS projects that the ACO's AIPBP-participating Next Generation Participants and Preferred Providers accounted for 60% of Next Generation beneficiaries' spending and the historic FFS expenditure was \$10,000 per beneficiary in the historic period..
- Using the historic expenditure per beneficiary and the percentage of care furnished by AIPBP-participating Next Generation Participants and Preferred Providers, this ACO will be paid \$500 per-beneficiary, per-month (\$10,000 annual expenditure multiplied by 60% and divided by 12). The ACO will be paid \$150,000,000 over the course of the year for its 25,000 beneficiaries.
- Using the benchmark methodology described in this RFA, the ACO has a benchmark of \$300,000,000. Over the course of the year, CMS adjudicates \$295,000,000 in FFS claims for Next Generation Beneficiaries. To calculate savings/losses against the benchmark, CMS will use the amount that would have been paid for claims for AIPBP-participating Next Generation Participants and Preferred Providers in addition to the claims CMS did continue to pay for non-AIPBP services. This ACO achieved savings of \$5,000,000.
- A separate reconciliation is conducted for AIPBP:
  - Scenario 1: Upon reconciliation, it is determined that AIPBP-participating Next Generation Participants and Preferred Providers submitted claims for \$151,000,000. CMS must pay the ACO an additional \$1,000,000 in other monies owed so that the amount paid to the ACO equals the exact amount of claims reduced in the Performance Year.
  - Scenario 2: Upon reconciliation, it is determined that AIPBP-participating Next Generation Participants and Preferred Providers submitted claims for \$149,000,000.. The ACO must pay CMS \$1,000,000 in other monies owed so that the amount paid to the ACO equals the exact amount of claims reduced in the Performance Year.

## Appendix E: Next Generation Model Quality Measures

The following quality measures are the measures for use in establishing quality performance standards in the first year of the Model (CY 2016).

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance PY1
<b>AIM: Better Care for Individuals</b>				
Patient/Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	R
	ACO - 2	CAHPS: How Well Your Doctors Communicate	Survey	R
	ACO - 3	CAHPS: Patients' Rating of Doctor	Survey	R
	ACO - 4	CAHPS: Access to Specialists	Survey	R
	ACO - 5	CAHPS: Health Promotion and Education	Survey	R
	ACO - 6	CAHPS: Shared Decision Making	Survey	R
	ACO - 7	CAHPS: Health Status/Functional Status	Survey	R
	ACO - 34	CAHPS: Stewardship of Patient Resources	Survey	R
Care Coordination/Patient Safety	ACO - 8	Risk-Standardized, All Condition Readmission	Claims	R
	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Claims	R
	ACO - 36	All-Cause Unplanned Admissions for Patients	Claims	R

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance PY1
		with Diabetes		
	ACO - 37	All-Cause Unplanned Admissions for Patients with Heart Failure	Claims	R
	ACO - 38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	R
	ACO - 9	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)	Claims	R
	ACO - 10	Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 )	Claims	R
	ACO 39	Documentation of Current Medications in the Medical Record	CMS Web Interface	R
	ACO 13	Falls: Screening for Future Fall Risk	CMS Web Interface	R
<b>AIM: Better Care for Populations</b>				
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	R
	ACO - 15	Pneumonia Vaccination Status for Older Adults	CMS Web Interface	R
	ACO - 16	Preventive Care and Screening: Body Mass	CMS Web Interface	R

<b>Domain</b>	<b>ACO Measure #</b>	<b>Measure Title</b>	<b>Method of Data Submission</b>	<b>Pay for Performance Phase In</b> <b>R—Reporting</b> <b>P—Performance</b> <b>PY1</b>
		Index (BMI) Screening and Follow Up		
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	R
	ACO - 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	CMS Web Interface	R
	ACO - 19	Colorectal Cancer Screening	CMS Web Interface	R
	ACO - 20	Breast Cancer Screening	CMS Web Interface	R
	ACO - 21	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented	CMS Web Interface	R
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	R
Clinical Care for At Risk Population - Depression	ACO – 40	Depression Remission at Twelve Months	CMS Web Interface	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Composite (All or Nothing Scoring):	CMS Web Interface	R
	ACO - 41	ACO - 27: Diabetes Mellitus: Hemoglobin A1c  Poor Control ACO - 41:		

<b>Domain</b>	<b>ACO Measure #</b>	<b>Measure Title</b>	<b>Method of Data Submission</b>	<b>Pay for Performance Phase In</b> <b>R—Reporting</b> <b>P—Performance</b> <b>PY1</b>
		Diabetes: Eye Exam		
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure	CMS Web Interface	R
Clinical Care for At Risk Population - Ischemic Vascular Disease	ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	CMS Web Interface	R
Clinical Care for At Risk Population - Heart Failure	ACO - 31	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	CMS Web Interface	R
Clinical Care for At Risk Population – Coronary Artery Disease	ACO - 33	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)	CMS Web Interface	R

## Appendix F: Applicant Selection Criteria and Scoring Template

Selection Domain	Applicant Selection Criteria	Points
<b>Organizational Structure</b>	<p>To earn the full amount of points in each domain, the applicant must:</p> <ul style="list-style-type: none"> <li>• Demonstrate a history of collaboration between Providers/Suppliers and/or a credible plan for how the Next Generation Participants will work together in the Model;</li> <li>• 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 Next Generation Participants that demonstrates a clear commitment to providing high quality, coordinated care to beneficiaries.</li> </ul>	10
<b>Leadership and Management</b>	<ul style="list-style-type: none"> <li>• 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;</li> <li>• Have a multi-stakeholder board comprised of well-qualified individuals that adequately and collectively represent the interests of patients and providers;</li> <li>• 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;</li> <li>• 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;</li> <li>• If applicable, demonstrate good conduct in prior CMS programs and/or demonstrations.</li> </ul>	10
<b>Financial Plan and Risk-Sharing Experience</b>	<ul style="list-style-type: none"> <li>• Demonstrate experience in the past 3 years with outcomes-based arrangements (that meet stated outcomes-based contracting definition);</li> <li>• If applicable, demonstrate good performance in past CMS programs, demonstrations, or both;</li> <li>• Demonstrate past experience with outcomes-based contracts for a minimum of 10,000 lives;</li> <li>• Document significant degrees of financial risk and revenue derived from outcomes-based contracts;</li> <li>• Document reductions in medical expenditures achieved through previous outcomes-based contracts;</li> <li>• Demonstrate a credible plan for converting the preponderance of revenue to outcomes-based contracts;</li> <li>• 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.</li> </ul>	30
<b>Patient Centeredness</b>	<ul style="list-style-type: none"> <li>• Demonstrate the ability to engage beneficiaries and their caregivers in shared decision making, taking into account patient preferences and choices;</li> <li>• Have a feasible plan to establish mechanisms to conduct patient outreach and education on the benefits of care coordination;</li> <li>• Demonstrate the ability to effectively involve beneficiaries in care transitions to improve the continuity and quality of care across settings;</li> </ul>	20

<b>Selection Domain</b>	<b>Applicant Selection Criteria</b>	<b>Points</b>
	<p>To earn the full amount of points in each domain, the applicant must:</p> <ul style="list-style-type: none"> <li>• Demonstrate the ability to engage and activate beneficiaries at home to improve self-management;</li> <li>• Have mechanisms to evaluate patient satisfaction with access and quality of care, including choice of providers and choice in care settings.</li> </ul>	
<b>Clinical Process Improvement, Care Coordination, and Data Capacity</b>	<p>Clinical Process Improvement (10 points)</p> <ul style="list-style-type: none"> <li>• Present a strong, credible, coordinated, and feasible plan to realize the three-part aims of better health, better care, and lower costs;</li> <li>• Provide credible plan for incorporating medication management into the care coordination approach;</li> <li>• Demonstrate past experience designing, implementing, and assessing the effectiveness of specific care improvement interventions.</li> </ul> <p>Care Coordination (10 points)</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• Demonstrate a history of collaboration among major stakeholders in the community being served, including incorporation of relevant social services in care plans and management;</li> <li>• Demonstrate a compelling plan to succeed in the areas of quality improvement and care coordination.</li> </ul> <p>Data Capacity (10 points)</p> <ul style="list-style-type: none"> <li>• Provide a clear and detailed plan for a majority of eligible professionals in the organization to meet EHR meaningful use criteria and requirements;</li> <li>• Have population health management tools and functions or concrete plans to develop and invest in such tools and functions;</li> <li>• Have the ability, or credible plans to develop the ability, to electronically exchange patient records across Next Generation Participants and other providers in the community to ensure continuity of care;</li> <li>• Have the ability to, or credible plan to gain the ability to, share performance feedback on a timely basis with participating providers.</li> </ul>	30
<b>Total</b>		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](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](mailto:NextGenerationACOModel@cms.hhs.gov).

### Background Information

#### 1. ACO Organization Information

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

#### 2. 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 Next Generation Participants 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 Next Generation Participants, 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 provide an executive summary describing Applicant ACO. This includes, the Applicant ACO's: composition, including the number of hospitals, number of skilled nursing facilities, types of providers/suppliers (primary care and types of specialists); geographic service area including where most of the Applicant ACO's patients reside, if the service area encompasses urban, suburban, and/or rural locations, and if the area includes underserved beneficiaries. Please include any other applicable narrative describing the ACO.
6. 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.
7. Using the provided template, please upload an Excel spreadsheet identifying all the proposed Next Generation Participants **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).  
The participant list template is available here: [Download Template](#)
- i. Using the form provided, please upload a signed provider notification attestation form.  
The form is available here: [Download Form](#)
8. Using the provided template, please upload an Excel spreadsheet identifying all of the Applicant ACO's geographic service areas.  
The geographic service areas template is available here: [Download Template](#)
9. 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

**10. Using the form provided, please upload a signed data request and attestation form.**

**The form is available here: Download Form**

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
12. Secondary Contact? Yes/No

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 Next Generation Participants, 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 Next Generation Participants; 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. For providers participating in your ACO, please report the following. The term “primary employer” below refers to the employer for whom the physician delivers health services (not just Medicare patients) and that the physician considers to be their primary place of employment (e.g. accounts for the majority of the physician’s income).
  - i. The total number of physicians participating in your ACO :
  - ii. The total number of ACO participating physicians for whom the ACO is their primary employer. Physicians whose primary employer is a hospital or group practice directly owned by the ACO or one of its subsidiaries should be treated as physicians whose primary employer is the ACO.

- iii. The total number of ACO participating physicians for whom a non-ACO hospital (e.g. hospital that is not directly owned by the ACO or one of its subsidiaries) is their primary employer.
  - iv. The total number of ACO participating physicians whose primary employer is a non-ACO group practice (e.g. group practice that is not directly owned by the ACO or one of its subsidiaries) with 10 or more physicians.
  - v. The total number of ACO participating physicians whose primary employer is a non-ACO group practice (e.g. group practice that is not directly owned by the ACO or one of its subsidiaries) with less than 10 physicians.
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. Legal Entity and Governing Body**

1. For Next Generation ACOS that are formed by two or more Next Generation Participants, the ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers. If, however, the Next Generation ACO is a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement or is a Medicare Shared Savings Program ACO, then the ACO legal entity may be the same as that of the existing legal entity, provided all other requirements are met. Please select one:
  - i. Applicant Next Generation ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers.
  - ii. Applicant ACO is a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement or is a Medicare Shared Savings Program ACO and Applicant ACO will be the same as that of the existing legal entity.
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 Next Generation Participants 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. CMMI model applications will also require all applicants to disclose any sanctions, investigations, probations, actions or corrective action plans that the applicant, its physicians/practitioners, its owners or managers, and/or other participating organizations, entities, or individuals, including the applicant's Next Generation Participants and Preferred Providers, are currently undergoing or have undergone in the last five years. Please provide this information using the table below.

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 Next Generation Participants 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. Please also indicate the number of covered lives in outcomes-based contracts with any of the applicant ACO's proposed Next Generation Participants.
2. 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 Next Generation Participants ) in the last fiscal year derived from outcomes-based contracts.

Note: ACO total revenues include: (1) basic payments received by all A proposed Next Generation Participants for clinical services (e.g., Fee-for-Service, per member per year, per member per month, and per episode); (2) supplemental payments all proposed Next Generation participants 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 proposed Next Generation Participants. 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 proposed Next Generation Participants were included, which services were included).
3. What is the business model for your organization as you transition from the financial incentives of FFS medicine to those of risk-based and outcomes-based contracts? How has this been informed by your experience to date with risk-based and outcomes-based contracts?
4. 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.
5. 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 [Next Generation Participants 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), Next Generation Participants and Preferred Providers 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 ACO would be interested in receiving All-Inclusive Population-Based Payments (AIPBP). [AIPBP 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 Participants and Preferred Providers with whom the ACO has written agreements regarding AIPBP.]

- i. Yes
- ii. No
- iii. If **YES**, please describe which payment system the ACO would use to operationalize AIPBP and the types of arrangements the ACO would enter into with the ACO's Next Generation Participants and Preferred Providers.

### 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 Participants 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, 2015. Please provide any additional information regarding the ability of Applicant ACO's eligible professionals to meet the Meaningful Use requirements.
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 EHR/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 Next Generation Participants' 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 Next Generation Participants' 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 Next Generation Participants 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 (2014-2016) 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.

### Benefit Enhancements Implementation

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 a waiver of the requirement for a three-day inpatient stay prior to SNF admission:
  - i. Yes
  - ii. No
  - iii. Maybe in PY3 or later
2. Please describe how a waiver of the 3-Day SNF Rule will help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
3. Please describe any Applicant ACO and/or proposed Next Generation Participant 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 and its proposed Next Generation Participants and Preferred Providers would be interested in billing for post-discharge home visits:
  - i. Yes
  - ii. No
  - iii. Maybe in PY3 or later
2. Please describe how reimbursement for post-discharge home visits will help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
3. Please describe any Applicant ACO or proposed Next Generation Participant 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 and its proposed Next Generation Participants and Preferred Providers would be interested in greater flexibility in performing telehealth services:
  - i. Yes
  - ii. No
  - iii. Maybe in PY3 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. 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?

#### Beneficiary Coordinated Care Reward

A. 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.

### **Deferred Next Generation ACO Model Application**

#### 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 ACO. 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 Next Generation Participants 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 Next Generation Participants, 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 provide an executive summary describing Applicant ACO. This includes, the Applicant ACO's: composition, including the number of hospitals, number of skilled nursing facilities, types of providers (primary care and types of specialists); geographic service area including where most of the Applicant ACO's patients reside, if the service area encompasses urban, suburban, and/or rural locations, and if the area includes underserved beneficiaries. Please include any other applicable narrative describing the ACO.
6. Using the provided template, please upload an Excel spreadsheet identifying all of the Applicant ACO's geographic service areas.
7. Using the provided template, please upload an Excel spreadsheet identifying all the proposed Next Generation Participants **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).  
The participant list template is available here: [Download Template](#)
- i. Using the form provided, please upload a signed provider notification attestation form.  
The form is available here: [Download Form](#).

### 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
12. Secondary Contact?
  12. First Name
  13. Last Name
  14. Title/Position
  15. Business Phone Number
  16. Business Phone Number Ext.
  17. Alternate Phone Number
  18. E-mail Address
  19. Street Address
  20. City
  21. State
  22. Zip Code

B. 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

C. 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. Does the Applicant ACO have a leadership team exclusive to the Next Generation ACO?
  - i. Yes
  - ii. No
3. 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 are formed by two or more Next Generation Participants, the ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers. If, however, the Next Generation ACO is a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement or is a Medicare Shared Savings Program ACO, then the ACO legal entity may be the same as that of the existing legal entity, provided all other requirements are met. Please select one:
  - i. Applicant Next Generation ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers.
  - ii. Applicant ACO is a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement or is a Medicare Shared Savings Program ACO and Applicant ACO will be the same as that of the existing legal entity.
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 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 Next Generation Participants, 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, 2013 – December 31, 2015).

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 Next Generation Participants have no investigations, sanctions, penalties, or corrective action plans in the past three years.

Financial Experience and Information

A. 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

B. 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. Please indicate intended risk arrangement:
  - i. Risk Arrangement A: Shared Performance Risk
  - ii. Risk Arrangement B: Full Performance Risk
- 3. Please indicate intended payment mechanism. Payment mechanism is separate from risk arrangement. It dictates the method of payment for 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 [Next Generation Participants 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), Next Generation Participants and Preferred Providers will have FFS claims payments reduced by an agreed upon percentage. The ACO will receive a monthly payment commensurate with percentage taken out of FFS payments to Next Generation Participants and Preferred Providers.]
- 4. Please indicate if the Applicant ACO would be interested in receiving All Inclusive Population Based Payments (AIPBP). [AIPBP 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 participants. Next Generation ACOs will be responsible for paying claims for its Next Generation Participants and Preferred Providers with whom the ACO has written agreements regarding AIPBP.]
  - 1. Yes
  - 2. No
  - 3. If **YES**, please describe which payment system the ACO would use to operationalize AIPBP and the types of arrangements the ACO would enter into with Next Generation Participants and Preferred Providers.

### 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 Participants 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 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, 2015. Please provide any additional information regarding the ability of Applicant ACO's eligible professionals to meet the Meaningful Use requirements.

### Benefit Enhancements Implementation

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 a waiver of the requirement for a three-day inpatient stay prior to SNF admission:
  - i. Yes
  - ii. No
  - iii. Maybe in PY3 or later

#### B. Post-Discharge Home Visits

1. Please indicate if the Applicant ACO and its proposed Next Generation Participants and Preferred Providers would be interested in billing for post-discharge home visits:
  - i. Yes
  - ii. No
  - iii. Maybe in PY3 or later

#### C. Telehealth

1. Please indicate if the Applicant ACO and its proposed Next Generation Participants and Preferred Providers would be interested in greater flexibility in performing telehealth services:
  - i. Yes
  - ii. No
  - iii. Maybe in PY3 or later