



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation  
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**Next Generation ACO Model  
Participation Agreement  
(Second Amended and Restated Participation Agreement for 2016 Starters)**

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SECOND AMENDED AND RESTATED  
PARTICIPATION AGREEMENT

This second amended and restated participation agreement is between the CENTERS FOR MEDICARE & MEDICAID SERVICES (“**CMS**”) and V125 - Trinity Health ACO, Inc., an accountable care organization (“**ACO**”).

CMS is the agency within the U.S. Department of Health and Human Services (“**HHS**”) that is charged with administering the Medicare and Medicaid programs.

The ACO is an entity that has been approved by CMS to operate a Medicare accountable care organization (“**Medicare ACO**”). A Medicare ACO is an entity formed by certain health care providers that accepts financial accountability for the overall quality and cost of medical care furnished to Medicare fee-for-service beneficiaries assigned to the entity.

Typically, the health care providers participating in a Medicare ACO continue to bill Medicare under the traditional fee-for-service system for services rendered to Beneficiaries. However, the Medicare ACO may share in any Medicare savings achieved with respect to the aligned beneficiary population if the Medicare ACO satisfies minimum quality performance standards. The Medicare ACO may also share in any Medicare losses recognized with respect to the aligned beneficiary population. Medicare ACOs participating in a two-sided risk model are liable to CMS for a portion of the Medicare expenditures that exceed a benchmark.

CMS is implementing the Next Generation ACO Model (“**Model**”) under section 1115A of the Social Security Act (“**Act**”), which authorizes CMS, through its Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program expenditures while maintaining or improving the quality of beneficiaries’ care.

The purpose of the Next Generation ACO Model is to test an alternative Medicare ACO payment model. Specifically, this model will test whether health outcomes improve and Medicare Parts A and B expenditures for Medicare fee-for-service beneficiaries decrease if Medicare ACOs (1) accept a higher level of financial risk compared to existing Medicare ACO payment models, and (2) are permitted to select certain innovative Medicare payment arrangements and to offer certain additional benefit enhancements to their assigned Medicare fee-for-service beneficiaries.

The ACO submitted an application to participate in the Next Generation ACO Model, and CMS has approved the ACO for participation in the model.

In December 2015, the parties executed a participation agreement governing their rights and obligations under the Model (“**Agreement**”). In December 2016, the parties executed an amended and restated participation agreement amending the agreement for the second Performance Year to incorporate All-Inclusive Population-Based Payments, streamline data sharing requirements, refine certain requirements regarding the Participant List and the Preferred Provider List

CMS wishes to amend the terms of the Agreement to incorporate the addition of an option to offer certain telehealth services using asynchronous store and forward technologies as part of the Telehealth Expansion Benefit Enhancement, increase the number of home visits available to beneficiaries following discharge from an acute inpatient hospital, inpatient

psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility under the Post-Discharge Home Visits Benefit Enhancement, and make various other clarifying and technical amendments for the third Performance Year of the Agreement.

The parties therefore amend and restate the Agreement as follows:

## **I. Agreement Term and Renewal**

- A. The Agreement became effective when it was signed by both parties (the “**Effective Date**”). The amendments hereby made to the Agreement will be effective as of January 1, 2018. The Agreement will conclude at the end of the third Performance Year of the Agreement (the “**Initial Term**”) or at the end of a Renewal Period if offered by CMS and accepted by the ACO in accordance with Section I.C of this Agreement, unless sooner terminated by either party in accordance with Section XIX.
- B. The first Performance Year of this Agreement began on January 1, 2016 (the “**Start Date**”) and ended on December 31, 2016. Subsequent Performance Years shall each be 12 months in duration, beginning on January 1.
- C. CMS may offer to renew this Agreement for a period of an additional two Performance Years (the “**Renewal Period**”). In deciding whether to offer to renew this Agreement, CMS may consider the ACO’s actual spending in relation to the Performance Year Benchmark; the ACO’s quality score performance; the ACO’s history of compliance with the terms of this Agreement and Medicare program requirements; the results of a program integrity screening of the ACO, its Next Generation Participants, and its Next Generation Professionals; the ACO’s ability to repay in full any Shared Losses and Other Monies Owed; and such other criteria CMS deems relevant. If CMS offers to renew this Agreement, CMS shall make a written offer to renew this Agreement at least 60 days before the expiration of the Initial Term. The ACO shall accept or reject such offer in writing by a date and in a manner specified by CMS.

## **II. Definitions**

“**ACO Activities**” means activities related to promoting accountability for the quality, cost, and overall care for a patient population of aligned Medicare fee-for-service Beneficiaries, including managing and coordinating care for Next Generation Beneficiaries; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; or carrying out any other obligation or duty of the ACO under this Agreement. Examples of these activities include, but are not limited to, providing direct patient care to Next Generation Beneficiaries in a manner that reduces costs and improves quality; promoting evidence-based medicine and patient engagement; reporting on quality and cost measures under this Agreement; coordinating care for Next Generation Beneficiaries, such as through the use of telehealth, remote patient monitoring, and other enabling technologies; establishing and improving clinical and administrative systems for the ACO; meeting the quality performance standards of this Agreement; evaluating health needs of Next Generation Beneficiaries; communicating clinical knowledge and evidence-based medicine to Next Generation Beneficiaries; and developing standards for Beneficiary access and communication, including Beneficiary access to medical records.



**“AIPBP”** means the all-inclusive population-based payment Alternative Payment Mechanism in which CMS makes a monthly payment to the ACO reflecting an estimate, based on historical expenditures, of the percentage of total expected Medicare Part A and/or Part B FFS payments for Covered Services furnished to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers who have agreed to receive AIPBP Fee Reduction.

**“AIPBP Fee Reduction”** means the 100% reduction in Medicare FFS payments to selected Next Generation Participants and Preferred Providers, who have agreed to receive no payment from Medicare for Covered Services furnished to Next Generation Beneficiaries to account for the Monthly AIPBP Payments made by CMS to the ACO under AIPBP.

**“Alternative Payment Mechanism”** means an optional payment mechanism that may be selected by the ACO for a given Performance Year, under which CMS will make interim payments to the ACO during a Performance Year. The three Alternative Payment Mechanisms available for selection are Infrastructure Payments, PBP, and AIPBP.

**“At-Risk Beneficiary”** means a Beneficiary who—

- A. Has a high risk score on the CMS-Hierarchical Condition Category (HCC) risk adjustment model;
- B. Is considered high cost due to having two or more hospitalizations or emergency room visits each year;
- C. Is dually eligible for Medicare and Medicaid;
- D. Has a high utilization pattern;
- E. Has one or more chronic conditions;
- F. Has had a recent diagnosis that is expected to result in increased cost;
- G. Is entitled to Medicaid because of disability;
- H. Is diagnosed with a mental health or substance use disorder; or
- I. Meets such other criteria as specified in writing by CMS.

**“Beneficiary”** means an individual who is enrolled in Medicare.

**“Benefit Enhancements”** means the following additional benefits the ACO chooses to make available to Next Generation Beneficiaries through Next Generation Participants and Preferred Providers in order to support high-value services and allow the ACO to more effectively manage the care of Next Generation Beneficiaries: (1) 3-Day SNF Rule Waiver Benefit Enhancement (as described in Section XI.B and Appendix I); (2) Telehealth Expansion Benefit Enhancement (as described in Section XI.C and Appendix J); and (3) Post-Discharge Home Visits Benefit Enhancement (as described in Section XI.D and Appendix K).

**“CCN”** means a CMS Certification Number.

**“Coordinated Care Reward”** means payment from CMS to a Beneficiary to reward the Beneficiary for receiving qualifying services from Next Generation Participants and Preferred Providers in an ACO when the Beneficiary was a Next Generation Beneficiary aligned to that ACO.

**“Covered Services”** means the scope of health care benefits described in sections 1812 and 1832 of the Act for which payment is available under Part A or Part B of Title XVIII of the Act.

**“Days”** means calendar days unless otherwise specified.

**“Descriptive ACO Materials and Activities”** include, but are not limited to, general audience materials such as brochures, advertisements, outreach events, letters to Beneficiaries, web pages published on a web site, mailings, social media, or other activities conducted by or on behalf of the ACO or its Next Generation Participants or Preferred Providers, when used to educate, notify, or contact Beneficiaries regarding the Next Generation ACO Model. The following communications are not Descriptive ACO Materials and Activities: communications that do not directly or indirectly reference the Next Generation ACO Model (for example, information about care coordination generally would not be considered Descriptive ACO Materials and Activities); materials that cover Beneficiary-specific billing and claims issues; educational information on specific medical conditions; referrals for health care items and services; and any other materials that are excepted from the definition of “marketing” under the HIPAA Privacy Rule (45 CFR Part 160 & Part 164, subparts A & E).

**“FFS”** means fee-for-service.

**“Infrastructure Payments”** means the Alternative Payment Mechanism under which CMS makes monthly per-Next Generation Beneficiary payments to the ACO to support ACO Activities.

**“Legacy TIN or CCN”** means a TIN or CCN that a Next Generation Participant or Preferred Provider previously used for billing Medicare Parts A and B services but no longer uses to bill for those services, and includes a “sunsetting” Legacy TIN or CCN (a TIN or CCN that is no longer used for billing for Medicare Parts A and B services by any Medicare-enrolled provider or supplier) or an “active” Legacy TIN or CCN (a TIN or CCN that may be in use by a Medicare-enrolled provider or supplier that is not a Next Generation Participant or Preferred Provider).

**“Medically Necessary”** means reasonable and necessary as determined in accordance with section 1862(a) of the Act.

**“Monthly AIPBP Payment”** means the monthly payment made by CMS to an ACO under AIPBP.

**“Monthly PBP Payment”** means the monthly payment made by CMS to an ACO under PBP.

**“Next Generation Beneficiary”** means a Beneficiary who is aligned to the ACO for a given Performance Year using the methodology set forth in Appendix B and has not subsequently been excluded from the aligned population of the ACO.

**“Next Generation Participant”** means an individual or entity that:

- A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);
- B. Is identified on the Participant List in accordance with Section IV;
- C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
- D. Is not a Preferred Provider;

- E. Is not a Prohibited Participant; and
- F. Pursuant to a written agreement with the ACO, has agreed to participate in the Model, to report quality data through the ACO, and to comply with care improvement objectives and Model quality performance standards.

**“Next Generation Professional”** means a Next Generation Participant who is either:

- A. A physician (as defined in section 1861(r) of the Act); or
- B. One of the following non-physician practitioners:
  1. Physician assistant who satisfies the qualifications set forth at 42 CFR § 410.74(a)(2)(i)-(ii);
  2. Nurse practitioner who satisfies the qualifications set forth at 42 CFR § 410.75(b);
  3. Clinical nurse specialist who satisfies the qualifications set forth at 42 CFR § 410.76(b);
  4. Certified registered nurse anesthetist (as defined at 42 CFR § 410.69(b));
  5. Certified nurse midwife who satisfies the qualifications set forth at 42 CFR § 410.77(a);
  6. Clinical psychologist (as defined at 42 CFR § 410.71(d));
  7. Clinical social worker (as defined at 42 CFR § 410.73(a)); or
  8. Registered dietician or nutrition professional (as defined at 42 CFR § 410.134).

**“NPI”** means a national provider identifier.

**“Other Monies Owed”** means a monetary amount owed by either party to this Agreement 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. Such calculations shall be made in accordance with Appendix B and reconciliation shall be performed pursuant to Section XIV.B.

**“Participant List”** means the list that identifies each Next Generation Participant that is approved by CMS for participation in the Next Generation Model, specifies which Next Generation Participants, if any, have agreed to receive an AIPBP Fee Reduction or PBP Fee Reduction, and designates the Benefit Enhancements, if any, in which each Next Generation Participant participates, as updated from time to time in accordance with Sections IV.D and IV.E of this Agreement.

**“PBP”** means the population-based payment Alternative Payment Mechanism in which CMS makes a Monthly PBP Payment to the ACO reflecting an estimate, based on historical expenditures, of the percentage of total expected Medicare Part A and/or Part B FFS payments for Covered Services furnished to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers who have agreed to receive a PBP Fee Reduction.

**“PBP Fee Reduction”** means a partial reduction in Medicare FFS payments to selected Next Generation Participants and Preferred Providers who have agreed to receive such reduced payments for Covered Services furnished to Next Generation Beneficiaries to account for the Monthly PBP Payments made by CMS to the ACO under PBP.

**“Performance Year”** means the 12-month period beginning on January 1 of each year during the term of this Agreement, including both the Initial Term of this Agreement and any Renewal Period if offered by CMS and accepted by the ACO pursuant to Section I.C of this Agreement.

**“Performance Year Benchmark”** means the target expenditure amount to which actual Medicare Part A and Part B expenditures for Next Generation Beneficiaries during a Performance Year will be compared in order to calculate Shared Losses and Shared Savings as determined by CMS in accordance with Appendix B.

**“Preferred Provider”** means an individual or entity that:

- A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);
- B. Is identified on the Preferred Provider List in accordance with Section IV;
- C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
- D. Is not a Next Generation Participant;
- E. Is not a Prohibited Participant; and
- F. Has agreed to participate in the Model pursuant to a written agreement with the ACO.

**“Preferred Provider List”** means the list that identifies each Preferred Provider that is approved by CMS for participation in the Next Generation Model, specifies which Preferred Providers, if any, have agreed to receive an AIPBP Fee Reduction or PBP Fee Reduction, and designates the Benefit Enhancements, if any, in which each Preferred Provider participates, as updated from time to time in accordance with Section IV.D and IV.E of this Agreement.

**“Prohibited Participant”** means 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.

**“Reduced FFS Payment”** means the applicable Medicare FFS payment for Covered Services furnished by Next Generation Participants or Preferred Providers to Next Generation Beneficiaries, less the applicable AIPBP Fee Reduction or PBP Fee Reduction.

**“Risk Arrangement”** means the arrangement selected by the ACO that determines the portion of the savings or losses in relation to the Performance Year Benchmark that accrue to the ACO as Shared Savings or Shared Losses.

**“Rural ACO”** means an ACO in this Model for which at least 40 percent of the Federal Information Processing Standard (FIPS) codes in its service area are determined to be rural according to the definition of “rural” 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.

**“Savings/Losses Cap”** means the maximum percentage of Shared Savings or Shared Losses that will be paid to or owed by the ACO, as selected by the ACO in accordance with Section X.A.2.

and based upon the ACO's Performance Year Benchmark (e.g., if the ACO elects a 5% Savings/Losses Cap, the ACO would only share in savings up to 5% of its Performance Year Benchmark, even if it achieved savings equal to 6% of that Performance Year Benchmark and elected a 100% savings risk arrangement).

**"Shared Losses"** means the monetary amount owed to CMS by the ACO in accordance with the applicable Risk Arrangement and Appendix B due to expenditures for Medicare Part A and B items and services furnished to Next Generation Beneficiaries in excess of the Performance Year Benchmark.

**"Shared Savings"** means the monetary amount owed to the ACO by CMS in accordance with the applicable Risk Arrangement and Appendix B due to expenditures for Medicare Part A and B items and services furnished to Next Generation Beneficiaries lower than the Performance Year Benchmark.

**"TIN"** means a federal taxpayer identification number.

**"Voluntary Alignment"** means the process by which Beneficiaries may voluntarily align to the ACO as described in Section V.C and Appendix C.

**"Voluntary Alignment Form"** has the meaning set forth in Appendix C.

### **III. ACO Composition**

#### **A. ACO Legal Entity**

1. The ACO shall be a legal entity identified by a 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:
  - (a) Receiving and distributing Shared Savings;
  - (b) Repaying Shared Losses or Other Monies Owed to CMS;
  - (c) Establishing, reporting, and ensuring Next Generation Participant compliance with health care quality criteria, including quality performance standards; and
  - (d) Fulfilling ACO Activities identified in this Agreement.
2. If the ACO was 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.
3. If the ACO was 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 if the ACO satisfies the requirements of Section III.B.
4. The ACO is deemed to satisfy the requirements of Sections III.A.1 and III.A.2 if, as of the Effective Date, it was a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement or a Medicare Shared Savings Program ("**MSSP**") ACO pursuant to a participation agreement (as defined at 42 CFR § 425.20).
5. During the term of this Agreement, the ACO shall not participate in the 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.

## B. ACO Governance

### 1. General

- (a) The ACO shall maintain an identifiable governing body with sole and exclusive authority to execute the functions of the ACO and make final decisions on behalf of the ACO. The ACO shall have a governing body that satisfies the following criteria:
  - i. The governing body has responsibility for oversight and strategic direction of the ACO and is responsible for holding ACO management accountable for the ACO's activities;
  - ii. The governing body is separate and unique to the ACO, except as permitted under section III.A.3;
  - iii. The governing body has a transparent governing process;
  - iv. 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; and
  - v. The governing body shall receive regular reports from the designated compliance official of the ACO that satisfies the requirements of XVII.A.1.
- (b) The ACO shall provide each member of the governing body with a copy of this Agreement and any amendments thereto.

### 2. Composition and Control of the Governing Body

- (a) The ACO governing body shall include at least one Beneficiary served by the ACO who:
  - i. Does not have a conflict of interest with the ACO;
  - ii. Has no immediate family member with a conflict of interest with the ACO;
  - iii. Is not a Next Generation Participant or Preferred Provider; and
  - iv. 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.
- (b) The ACO governing body shall include at least one person with training or professional experience in advocating for the rights of consumers (“**Consumer Advocate**”), who may be the same person as the Beneficiary and who:

- i. Does not have a conflict of interest with the ACO;
  - ii. Has no immediate family member with a conflict of interest with the ACO;
  - iii. Is not a Next Generation Participant or Preferred Provider; and
  - iv. 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.
- (c) The ACO governing body shall not include a Prohibited Participant, or an owner, employee or agent of a Prohibited Participant.
- (d) If Beneficiary and/or Consumer Advocate representation on the ACO governing body is prohibited by state law, the ACO shall notify CMS and request CMS approval of an alternative mechanism to ensure that its policies and procedures reflect consumer and patient perspectives. CMS shall use reasonable efforts to approve or deny the request within 30 days.
- (e) The governing body members may serve in similar or complementary roles or positions for Next Generation Participants or Preferred Providers.
- (f) At least 75 percent control of the ACO's governing body shall be held by Next Generation Participants or their designated representatives. The Beneficiary and Consumer Advocate required under this Section shall not be included in either the numerator or the denominator when calculating the percent control. The ACO may seek an exception from the 75 percent control requirement by submitting a proposal to CMS describing the current composition of the ACO's governing body and how the ACO will involve Next Generation Participants in innovative ways in ACO governance. Any exception to the 75 percent control requirement will be at the sole discretion of CMS.

### 3. Conflict of Interest

The ACO shall have a conflict of interest policy that applies to members of the governing body and satisfies the following criteria:

- (a) Requires each member of the governing body to disclose relevant financial interests;
- (b) Provides a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
- (c) Addresses remedial actions for members of the governing body that fail to comply with the policy.

## C. **ACO Leadership and Management**

- 1. The ACO's operations shall 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.

2. Clinical management and oversight shall be managed by a senior-level medical director who is:
  - (a) A Next Generation Participant;
  - (b) Physically present on a regular basis at any clinic, office, or other location participating in the ACO; and
  - (c) A board-certified physician and licensed in a state in which the ACO operates.

#### **D. ACO Financial Arrangements**

1. The ACO shall not condition a Next Generation Participant's or Preferred Provider's participation in the Model, directly or indirectly, on referrals of items or services provided to Beneficiaries who are not aligned to the ACO.
2. The ACO shall not require that Next Generation Beneficiaries be referred only to Next Generation Participants or Preferred Providers or to any other provider or supplier. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Next Generation Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Next Generation Beneficiary's best medical interests in the judgment of the referring party.
3. The ACO shall not condition the eligibility of an individual or entity to be a Next Generation Participant or Preferred Provider on the individual's or entity's offer or payment of cash or other remuneration to the ACO or any other individual or entity.
4. The ACO, its Next Generation Participants, and/or Preferred Providers shall not take any action to limit the ability of a Next Generation Participant or Preferred Provider to make decisions in the best interests of the Beneficiary, including the selection of devices, supplies and treatments used in the care of the Beneficiary.
5. The ACO shall notify CMS within 15 days after becoming aware that any Next Generation Participant or Preferred Provider is under investigation or has been sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges). If a Next Generation Participant or Preferred Provider is under investigation or has been sanctioned but not excluded from Medicare program participation, CMS may take any of the actions set forth in Section XIX.
6. By the date specified in Section III.D.7, below, the ACO shall have a written agreement with each of the individuals and entities that are approved by CMS to be Next Generation Participants or Preferred Providers that complies with the following criteria:



- (a) The only parties to the agreement are the ACO and the Next Generation Participant or Preferred Provider.
- (b) The agreement requires the Next Generation Participant or Preferred Provider to agree to participate in the Model, to engage in ACO Activities, to comply with the applicable terms of the Model as set forth in this Agreement, and to comply with all applicable laws and regulations (including, but not limited to, those specified at Section XVII.D). The ACO shall provide each Next Generation Participant and Preferred Provider with a copy of this Agreement.
- (c) The agreement expressly sets forth the Next Generation Participant's or Preferred Provider's obligation to comply with the applicable terms of this Agreement, including provisions regarding the following: participant exclusivity, quality measure reporting, and continuous care improvement objectives for Next Generation Participants; Voluntary Alignment; Beneficiary freedom of choice; Benefit Enhancements; the Coordinated Care Reward; participation in evaluation, shared learning, monitoring, and oversight activities; the ACO compliance plan; and audit and record retention requirements.
- (d) The agreement requires the Next Generation Participant or Preferred Provider to update its Medicare enrollment information (including the addition and deletion of Next Generation Professionals that have reassigned to the Next Generation Participant or Preferred Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.
- (e) The agreement requires the Next Generation Participant or Preferred Provider to notify the ACO of any changes to its Medicare enrollment information within 30 days after the change.
- (f) The agreement requires the Next Generation Participant or Preferred Provider to notify the ACO within seven days of becoming aware that it is under investigation or has been sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).
- (g) The agreement permits the ACO to take remedial action against the Next Generation Participant or Preferred Provider (including the imposition of a corrective action plan, denial of incentive payments such as Shared Savings distributions, and termination of the ACO's agreement with the Next Generation Participant or Preferred Provider) to address noncompliance with the terms of the Model or program integrity issues identified by CMS.
- (h) The agreement is for a term of at least one year, but permits early termination if CMS requires the ACO to remove the Next Generation Participant or Preferred Provider pursuant to Section XIX.A.1.
- (i) The agreement requires the Next Generation Participant to complete a close-out process upon termination or expiration of the agreement that requires the Next Generation Participant to furnish all quality measure reporting data.

7. The ACO shall have fully executed written agreements in place that meet the requirements set forth in Section III.D.6 by the following dates:
  - (a) By the Start Date in the case of agreements with individuals and entities that were approved by CMS before the Start Date to be Next Generation Participants.
  - (b) By the Start Date in the case of agreements with individuals or entities approved by CMS before the Start Date to be Preferred Providers on the list specified in Section IV.C.4, or by February 1, 2016 in the case of an ACO that elected to defer participation of Preferred Providers until February 1, 2016. If the ACO elected to defer participation of Preferred Providers, none of the individuals or entities approved by CMS to be Preferred Providers and identified on the list specified in Section IV.C.4 may participate in the Model until February 1, 2016. If the ACO has elected such deferral, it must, by no later than the Start Date of the Model, notify each individual or entity on the list identified in Section IV.C.4 that the ACO has elected to defer participation of Preferred Providers and that the ACO's Preferred Providers will begin participation on February 1, 2016, regardless of when the written agreement is signed.
  - (c) By the date the ACO certifies its Participant List and Proposed Preferred Provider List in accordance with Section IV.E in the case of agreements with individuals and entities approved by CMS to be Next Generation Participants and Preferred Providers effective on the first day of the second or any subsequent Performance Year.
  - (d) For agreements with individuals or entities approved by CMS to be Next Generation Participants or Preferred Providers effective on a day other than the first day of a Performance Year, by the date the ACO requests the addition of the individual or entity to the Participant List or Preferred Provider List.
8. The ACO shall not distribute Shared Savings to any Next Generation Participant or Preferred Provider that has been terminated pursuant to Section XIX.A.1.
9. CMS provides no opinion on the legality of any contractual or financial arrangement that the ACO, a Next Generation Participant, or a Preferred Provider has proposed, implemented, or documented. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

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

### **A. General**

1. Next Generation Participants and Preferred Providers will be included on the Participant List or Preferred Provider List only upon the prior written approval of CMS.
2. CMS shall maintain the Participant List and Preferred Provider List in a manner that permits the ACO to review the list.
3. The ACO shall maintain current and historical Participant Lists and Preferred Provider Lists in accordance with Section XVIII.
4. CMS may periodically monitor the program integrity history of an ACO's Next Generation Participants or Preferred Providers. CMS may remove an individual or entity from the Participant List or Preferred Provider List, or subject the ACO to additional monitoring pursuant to Section XIX.A.1 on the basis of the results of a periodic program integrity screening or information obtained regarding an individual's or entity's history of program integrity issues. CMS shall notify the ACO if it chooses to remove an individual or entity from the Participant List or Preferred Provider List, and such notice shall specify the effective date of removal.

### **B. Initial Participant List**

1. The parties acknowledge that the ACO submitted to CMS a proposed list of Next Generation Participants, identified by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable).
2. CMS states that it has reviewed the proposed list of Next Generation Participants and conducted a program integrity screening on the proposed Next Generation Participants.
3. CMS states that it has submitted to the ACO a list of individuals and entities that it approved to be Next Generation Participants. The ACO states that it reviewed the list and made any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Model as of the Start Date pursuant to a written agreement.
4. The ACO states that it has submitted to CMS an initial Participant List that the ACO has certified is a true, accurate and complete list identifying all of the ACO's Next Generation Participants approved by CMS to participate in the Model as of the Start Date and with whom the ACO will have a fully executed written agreement meeting the requirements in Section III.D.6. The ACO further states that the initial Participant List specifies which Next Generation Participants, if any, have agreed to receive a PBP Fee Reduction, and designates the Benefit Enhancements, if any, in which each Next Generation Participant has agreed to participate.

5. The ACO shall update the initial Participant List in accordance with Sections IV.D and IV.E.

### **C. Initial Preferred Provider List**

1. The parties acknowledge that the ACO submitted to CMS a proposed list of Preferred Providers identified by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable), and the Benefit Enhancements, if any, in which each individual or entity had agreed to participate.
2. CMS states that it has reviewed the proposed list of Preferred Providers and conducted a program integrity screening on the proposed Preferred Providers.
3. CMS states that it has submitted to the ACO a list of individuals and entities that it has approved to be Preferred Providers. The ACO states that it has reviewed the list and made any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Model.
4. The ACO states that it has submitted to CMS an initial Preferred Provider List that the ACO has certified is a true, accurate and complete list identifying all of the ACO's Preferred Providers approved by CMS to participate in the Model as of the date specified in Section III.D.7.b.i, and with whom the ACO will have, by the date specified in Section III.D.7.b.i, a fully executed written agreement meeting the requirements in Section III.D.6. The ACO further states that the initial Preferred Provider List specifies the Benefit Enhancements, if any, in which each Preferred Provider has agreed to participate.
5. The ACO shall update the initial Preferred Provider List in accordance with Sections IV.D and IV.E.

### **D. Updating Lists During the Performance Year**

#### **1. Additions to a List**

- (a) *Additions to the Participant List for the 2016 Performance Year.* For the Performance Year that begins January 1, 2016, the ACO shall not request the addition of a Next Generation Participant to take effect on a date other than the first day of a Performance Year (“during the Performance Year”).
- (b) *Additions to the Participant List for Subsequent Performance Years.* Beginning with the Performance Year that begins January 1, 2017, the ACO shall not add a Next Generation Participant without prior written approval from CMS. If the ACO wishes to add an individual or entity to the Participant List effective on a date during a Performance Year, it shall submit a request to CMS in a form and manner and by a deadline specified by CMS. CMS may accept requests for additions to the Participant List during a Performance Year only under the following circumstances:
  - i. The request for addition is submitted to CMS between January 1 and July 31 of the Performance Year in which the addition would take effect;

- ii. In the case of a request to add a physician or non-physician practitioner to the Participant List, the ACO certifies that the individual (1) currently bills for items and services he or she furnishes to Beneficiaries under a Medicare billing number assigned to the TIN of an entity that is currently a Next Generation Participant, and (2) did not bill for such items and services under the TIN of the same Next Generation Participant at the time the ACO submitted its initial Participant List pursuant to Section IV.B or its most recent Proposed Participant List pursuant to Section IV.E.1, whichever is applicable to the Performance Year in which the addition would take effect;
- iii. The ACO certifies that it has a fully executed written agreement with the individual or entity it wishes to add to the Participant List and that the agreement meets the requirements of Section III.D.6; and
- iv. The ACO certifies that it has furnished a written notice to each proposed Next Generation Participant that is a physician or non-physician practitioner and to the executive of the TIN through which such individual bills Medicare indicating that the ACO has proposed to add such individual to the ACO's Participant List. The notice to the TIN must identify by name and NPI each individual who is identified on the request for addition as billing through the TIN.

CMS may reject the request on the basis that the individual or entity fails to satisfy the requirements of paragraph (A) or paragraphs (C) through (F) of the definition of "Next Generation Participant," or on the basis of information obtained from a program integrity screening. If CMS approves the request, the individual or entity will be added to the Participant List effective on the date the addition is approved by CMS.

- (c) *Preferred Provider List Additions.* The ACO shall not add an individual or entity to the Preferred Provider List during a Performance Year without prior written approval from CMS. If the ACO wishes to add an individual or entity to the Preferred Provider List during a Performance Year, it shall submit a request to CMS in the form and manner and by a deadline specified by CMS. In Performance Year 2017 and subsequent Performance Years, CMS may accept requests for additions to the Preferred Provider list during a Performance Year only under the following circumstances:
  - i. The request for the addition is submitted to CMS between January 1 and September 30 of the Performance Year in which the addition would take effect;
  - ii. The ACO certifies that it has a fully executed written agreement with the individual or entity it wishes to add to the Preferred Provider List and that the agreement meets the requirements of Section III.D.6; and
  - iii. The ACO certifies that it has furnished a written notice to the executive of the TIN through which such individual bills Medicare indicating that the ACO has proposed to add the individual to the ACO's Preferred Provider

List. The notice to the TIN must identify by name and NPI each individual who is identified on the request for addition as billing through the TIN. The ACO must also certify that it has furnished a written notice to the executive of each entity that it wishes to add to its Preferred Provider List.

CMS may reject the request on the basis that the individual or entity fails to satisfy the requirements of paragraph (A) or paragraphs (C) through (F) of the definition of “Preferred Provider,” or on the basis of information obtained from a program integrity screening. If CMS approves the request, the individual or entity will be added to the Preferred Provider List effective on the date the addition is approved by CMS.

## 2. [Removals from a List](#)

In a form and manner specified by CMS, the ACO shall notify CMS no later than 30 days after an individual or entity has ceased to be a Next Generation Participant or Preferred Provider and shall include in the notice the date on which the individual or entity ceased to be a Next Generation Participant or Preferred Provider. The removal of the individual or entity from the Participant List or Preferred Provider List will be effective on the date the individual or entity ceased to be a Next Generation Participant or Preferred Provider. An individual or entity ceases to be a Next Generation Participant or Preferred Provider when it is no longer a Medicare-enrolled provider or supplier, when its agreement with the ACO to participate in the Model terminates, or when it ceases to bill for items and services furnished to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations.

## 3. [Updating Enrollment Information](#)

The ACO shall ensure that all changes to enrollment information for Next Generation Participants and Preferred Providers, including changes to reassignment of the right to receive Medicare payment, are reported to CMS consistent with 42 CFR § 424.516.

# E. [Annual Updates to Participant List and Preferred Provider List](#)

## 1. [Proposed Participant List and Proposed Preferred Provider List](#)

Prior to the end of each Performance Year, unless otherwise instructed by CMS, the ACO shall submit to CMS by a date and in a manner specified by CMS proposed lists identifying each individual or entity that the ACO expects to participate in the Model as a Next Generation Participant or Preferred Provider effective at the start of the next Performance Year (“**Proposed Participant List**” and “**Proposed Preferred Provider List**,” respectively). CMS shall specify a submission deadline for the Proposed Participant List that is no later than 165 days before the start of the next Performance Year. CMS shall specify a submission deadline for the Proposed Preferred Provider List that is not later than 45 days before the start of the next Performance Year. The Proposed Participant

List must identify each individual or entity by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable). The Proposed Preferred Provider List must identify each individual or entity by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable), and identify which individuals and entities, if any, have agreed to receive a PBP Fee Reduction or AIPBP Fee Reduction and specify the Benefit Enhancements, if any, in which each individual or entity has agreed to participate. The ACO shall certify that the Proposed Participant List and the Proposed Preferred Provider List are each a true, accurate, and complete list of individuals and entities that have agreed to be Next Generation Participants and Preferred Providers, subject to CMS approval, effective January 1 of the relevant Performance Year.

2. [ACO Notice to Proposed Next Generation Participants](#)

At least 14 days prior to submitting its Proposed Participant List to CMS, the ACO shall furnish written notification to each individual or entity the ACO wishes to include on the Proposed Participant List. Such notice shall –

- (a) State that the individual or entity and any relevant TINs through which it bills Medicare will be identified on the Proposed Participant List; and
- (b) State that participation in the Model may preclude the individual or entity from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.

3. [ACO Notice to TINs](#)

At least 30 days prior to submitting its Proposed Participant List and Proposed Preferred Provider List to CMS, the ACO shall furnish written notification to the executive of any TIN through which an individual or entity on the Proposed Participant List or Proposed Preferred Provider List bills Medicare. Such notification must:

- (a) Include a list identifying by name and NPI each individual or entity that will be identified on the ACO's Proposed Participant List or Proposed Preferred Provider List as billing through the entity's TIN; and
- (b) Inform the executive of the TIN that a Next Generation Participant's participation in the ACO may preclude the entire TIN from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.

4. [Review, Certification, and Finalization of the Participant List and Preferred Provider List](#)

- (a) With respect to each individual and entity identified on the Proposed Participant List and Proposed Preferred Provider List, CMS shall conduct a program integrity screening, including a review of the individual's or entity's

history of Medicare program exclusions, current or prior law enforcement investigations, or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.

- (b) CMS may reject any individual or entity on a Proposed Participant List or a Proposed Preferred Provider List on the basis of the results of this program integrity screening, history of program integrity issues, or:
  - i. for any individual or entity on a Proposed Participant List, if CMS determines that the individual or entity does not satisfy the criteria in paragraph (A) or paragraphs (C) through (E) of the definition of “Next Generation Participant”; or
  - ii. for any individual or entity on a Proposed Preferred Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraph (A) or paragraphs (C) through (F) of the definition of “Preferred Provider.”
- (c) No later than 115 days before the end of the Performance Year, CMS will send the ACO a preliminary list of individuals and entities that CMS has tentatively approved to be Next Generation Participants effective at the start of the next Performance Year.
- (d) No later than 90 days before the end of the Performance Year, the ACO shall, after a review of the list of tentatively approved Next Generation Participants, submit a revised Proposed Participant List with any necessary corrections, including the removal of any individuals or entities that have not agreed to participate in the Model pursuant to a written agreement with the ACO, or that are otherwise ineligible to participate. No additions to the list are permitted at this time. The ACO shall certify that the submitted list is a true, accurate, and complete list of the individuals and entities that have agreed to be Next Generation Participants effective January 1 of the relevant Performance Year.
- (e) No later than 60 days before the end of the Performance Year, CMS will send the ACO a list of individuals and entities that CMS has approved to be Next Generation Participants effective at the start of the next Performance Year. The ACO may not request the addition of any individual or entity to this list until after the start of the next Performance Year.
- (f) No later than 45 days before the end of the Performance Year, the ACO shall submit to CMS a true, accurate, and complete list of Next Generation Participants and Preferred Providers who have agreed to participate in AIPBP Fee Reduction, PBP Fee Reduction, and Benefit Enhancement information, as applicable, for each individual and entity identified on the Participant List referenced in Section IV.E.4(e) the ACO received from CMS and the Proposed Preferred Provider List referenced in Section IV.E.1.
- (g) No later than 15 days before the end of the Performance Year, CMS will send the ACO a final Participant List identifying all individuals and entities that CMS has approved to be Next Generation Participants effective at the start of the next Performance Year (now including PBP Fee Reduction or AIPBP Fee



Reduction and Benefit Enhancement information, as applicable) and a final Preferred Provider List identifying all individuals and entities that CMS has approved to be Preferred Providers (including PBP Fee Reduction or AIPBP Fee Reduction and Benefit Enhancement information, as applicable) effective at the start of the next Performance Year. The ACO shall update such lists in accordance with this Agreement.

#### **F. Non-Duplication and Exclusivity of Participation**

1. The ACO and its Next Generation Participants may not participate in any other Medicare shared savings initiatives, as described in Appendix A.
2. CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and in the implementing regulations at 42 CFR § 425.114(a) regarding participation in a model tested under section 1115A of the Act that involves shared savings as they apply to Preferred Providers, subject to the conditions and requirements set forth in Appendix A.
3. The ACO and its Next Generation Participants and Preferred Providers are bound by the participation overlap provisions set forth in Appendix A.

### **V. Beneficiary Alignment, Engagement, and Protections**

#### **A. Beneficiary Alignment**

1. CMS shall, according to the methodology set forth in Appendix B, use an analysis of evaluation and management services furnished by Next Generation Professionals to Beneficiaries to align Beneficiaries to the ACO for the purposes of the Next Generation ACO Model.
2. Absent unusual circumstances, CMS does not adjust the alignment of Next Generation Beneficiaries to the ACO for a Performance Year due to the addition or removal of a Next Generation Participant from the Next Generation Participant List during the Performance Year, pursuant to Section IV.D or Section XIX.A. CMS has sole discretion to determine whether unusual circumstances exist that should warrant such adjustments.

#### **B. Alignment Minimum**

1. The ACO shall maintain an aligned population of at least 10,000 Next Generation Beneficiaries during each Performance Year, unless the ACO is a Rural ACO.
2. If the ACO is a Rural ACO, the ACO shall maintain an aligned population of at least 7,500 Next Generation Beneficiaries during each Performance Year.
3. If at any time during a Performance Year, the ACO's aligned population falls below the applicable minimum, CMS shall notify the ACO, request a corrective action plan (CAP) pursuant to Section XIX, and require the ACO to satisfy the applicable minimum aligned population requirement by a date specified by CMS. If the ACO's aligned population remains below the applicable minimum required

under this section by the specified date, CMS may take further remedial action and/or terminate this Agreement pursuant to Section XIX.

## **C. Voluntary Alignment**

### **1. General**

If the ACO elects to participate in Voluntary Alignment for a Performance Year according to Section X.A, CMS shall conduct Voluntary Alignment in accordance with Appendix C, subject to the provisions in this Section V.C.

### **2. Influencing or Attempting to Influence the Beneficiary**

- (a) The ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities are prohibited from providing gifts or other remuneration to Beneficiaries as inducements for influencing a Beneficiary's decision to complete or not complete a Voluntary Alignment Form.
- (b) The ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities shall not, directly or indirectly, commit any act or omission, nor adopt any policy, that coerces or otherwise influences a Beneficiary's decision to complete or not complete a Voluntary Alignment Form, including but not limited to the following:
  - i. Offering of anything of value to the Beneficiary;
  - ii. Including the Voluntary Alignment Form and instructions with any other materials or forms, including but not limited to materials requiring the signature of the Beneficiary; and
  - iii. Withholding or threatening to withhold medical services or limiting or threatening to limit access to care.
- (c) For purposes of Section V.H.2, any items or services provided in violation of this Section V.C.2 will not be considered to have a reasonable connection to the medical care of the Beneficiary.

### **3. Enforcement**

In addition to the actions available under Section XIX, failure to comply with the provisions of this Section may result in retroactive reversal of any alignment of Next Generation Beneficiaries to the ACO that occurred solely pursuant to this section.

## **D. Beneficiary Notifications**

- 1. In a form and manner and by a date specified by CMS, the ACO shall provide Next Generation Beneficiaries notice in writing that they have been aligned to the ACO for the Performance Year.

2. CMS shall provide the ACO with a template letter, indicating letter content that the ACO shall not change, as well as places in which the ACO may insert its own original content.
3. Pursuant to Section V.E, the ACO shall obtain CMS approval of the final notification letter content, which includes the ACO's own original content, prior to sending letters to Next Generation Beneficiaries.

#### **E. Descriptive ACO Materials and Activities**

1. The ACO shall not use, and shall prohibit its Next Generation Participants and Preferred Providers from using Descriptive ACO Materials or Activities until reviewed and approved by CMS.
2. Descriptive ACO Materials or Activities are deemed approved 10 business days following their submission to CMS if:
  - (a) The ACO certifies in writing its compliance with all the requirements under this Section V.E; and
  - (b) CMS does not disapprove the Descriptive ACO Materials or Activities.
3. CMS may issue written notice of disapproval of Descriptive ACO Materials or Activities at any time, including after the expiration of the 10 day review period.
4. The ACO, Next Generation Participants, Preferred Providers, or any other individuals or entities performing functions or services related to ACO activities, as applicable, must immediately discontinue use of any Descriptive ACO Materials or Activities disapproved by CMS.
5. Any material changes to CMS-approved Descriptive ACO Materials and Activities must be reviewed and approved by CMS before use.
6. The ACO shall retain copies of all written and electronic Descriptive ACO Materials and Activities and appropriate records for all other Descriptive ACO Materials and Activities provided to Next Generation Beneficiaries in a manner consistent with Section XVIII.

#### **F. Availability of Services**

1. The ACO shall require its Next Generation Participants and Preferred Providers to make Medically Necessary Covered Services available to Next Generation Beneficiaries in accordance with applicable laws, regulations and guidance. Next Generation Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR Part 405, Subpart I.
2. The ACO and its Next Generation Participants and Preferred Providers shall not take any action to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services with the purpose of trying to ensure alignment in a future Performance Year.

## **G. Beneficiary Freedom of Choice**

1. Consistent with Section 1802(a) of the Act, neither the ACO nor any Next Generation Participant, Preferred Provider, or other individuals or entities performing functions or services related to ACO Activities shall commit any act or omission, nor adopt any policy, that inhibits Next Generation Beneficiaries from exercising their freedom to obtain health services from providers and suppliers who are not Next Generation Participants or Preferred Providers. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Next Generation Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Next Generation Beneficiary's best medical interests in the judgment of the referring party.
2. Notwithstanding the foregoing, the ACO may communicate to Next Generation Beneficiaries the benefits of receiving care with the ACO. All such communications shall be deemed Descriptive ACO Materials and Activities. CMS may provide the ACO with scripts, talking points or other materials explaining these benefits.

## **H. Prohibition on Beneficiary Inducements**

### **1. General Prohibition**

Except as set forth in Section V.H.2, the ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions and services related to ACO Activities are prohibited from providing gifts or other remuneration to Beneficiaries to induce them to receive items or services from the ACO, Next Generation Participants, or Preferred Providers, or to induce them to continue to receive items or services from the ACO, Next Generation Participants or Preferred Providers.

### **2. Exception**

- (a) Consistent with the provisions of Section V.H.1, and subject to compliance with all other applicable laws and regulations, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities may provide in-kind items or services to Beneficiaries if the following conditions are satisfied:
  - i. There is a reasonable connection between the items and services and the medical care of the Beneficiary;
  - ii. The items and services are preventive care items and services or advance a clinical goal for the Beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition; and

- iii. The in-kind item or service is not a Medicare-covered item or service for the Beneficiary on the date the in-kind item or service is furnished to that Beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a Benefit Enhancement is considered a Medicare-covered item or service, regardless of whether the ACO has selected to participate in such Benefit Enhancement for the Performance Year pursuant to Section XI.A.
- (b) For each in-kind item or service provided by a Next Generation Participant or Preferred Provider under V.H.2.a, above, the ACO shall maintain records of the following:
- i. The nature of the in-kind item or service;
  - ii. The identity of each Beneficiary that received the in-kind item or service;
  - iii. The identity of the individual or entity that furnished the in-kind item or service; and
  - iv. The date the in-kind item or service was furnished.

## **I. HIPAA Requirements**

1. The ACO acknowledges that it is a covered entity or a business associate, as those terms are defined in 45 CFR § 160.103, of Next Generation Participants or Preferred Providers who are covered entities.
2. The ACO shall have all appropriate administrative, technical, and physical safeguards in place before the start of the first Performance Year to protect the privacy and security of protected health information (“**PHI**”) in accordance with 45 CFR § 164.530(c).
3. The ACO shall maintain the privacy and security of all Model-related information that identifies individual Beneficiaries in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of PHI by covered entities, as well as applicable state laws and regulations.

## **VI. Data Sharing and Reports**

### **A. General**

1. Subject to the limitations discussed in this Agreement, and in accordance with applicable law, in advance of each Performance Year and at any other time deemed necessary by CMS, CMS will offer the ACO an opportunity to request certain data and reports, which are described in Sections VI.B, VI.C, and Appendix D of this Agreement.
2. The data and reports provided to the ACO under the preceding paragraph will omit individually identifiable data for Next Generation Beneficiaries who have opted out of data sharing with the ACO, as described in Section VI.D. of this

Agreement. The data and reports provided to the ACO will also omit substance use disorder data for any Next Generation Beneficiaries who have not opted into substance use disorder data sharing, as described in Section VI.E. of this Agreement.

## **B. Provision of Certain Claims Data**

1. CMS believes that the care coordination and quality improvement work of the ACO (that is acting on its own behalf as a HIPAA covered entity (“CE”) or who is a business associate (“BA”) acting on behalf of its Next Generation Participants or Preferred Providers that are HIPAA CEs) would benefit from the receipt of certain beneficiary-identifiable claims data on Next Generation Beneficiaries. CMS will therefore offer to the ACO an opportunity to request specific beneficiary-identifiable claims data by completing the HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet (Appendix D). All requests for beneficiary-identifiable claims data will be granted or denied at CMS’ sole discretion based on CMS’ available resources, the limitations in this Agreement, and applicable law.
2. In offering this beneficiary-identifiable claims data, CMS does not represent that the ACO or any Next Generation Participant or Preferred Provider has met all applicable HIPAA requirements for requesting data under 45 CFR § 164.506(c)(4). The ACO and its Next Generation Participants and Preferred Providers should consult with their own counsel to make those determinations prior to requesting this data from CMS.
3. The beneficiary-identifiable claims data available is the data described in Appendix D.
4. The parties mutually agree that, except for data covered by Section VI.B.13 below, CMS retains all ownership rights to the data files referred to in Appendix D, and the ACO does not obtain any right, title, or interest in any of the data furnished by CMS.
5. The ACO represents, and in furnishing the data files specified in Appendix D CMS relies upon such representation, that such data files will be used solely for the purposes described in this Agreement. The ACO agrees not to disclose, use or reuse the data except as specified in this Agreement or except as CMS shall authorize in writing or as otherwise required by law. The ACO further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement.
6. The ACO intends to use the requested information as a tool to deliver seamless, coordinated care for Next Generation Beneficiaries to promote better care, better health, and lower growth in expenditures. Information derived from the CMS files specified in Appendix D may be shared and used within the legal confines of the ACO and its Next Generation Participants and Preferred Providers in a manner consistent with paragraph 7 below to enable the ACO to improve care integration and be a patient-centered organization.

7. The ACO may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation, but shall not disseminate individually identifiable original or derived information from the files specified in Appendix D to anyone who is not a HIPAA CE Next Generation Participant or Preferred Provider in a treatment relationship with the subject Next Generation Beneficiary(ies); a HIPAA BA of such a CE Next Generation Participant or Preferred Provider; the ACO's BA, where that ACO is itself a HIPAA CE; the ACO's sub-BA, which is hired by the ACO to carry out work on behalf of the CE Next Generation Participants or Preferred Providers; or a non-participant HIPAA CE in a treatment relationship with the subject Next Generation Beneficiary(ies). When using or disclosing PHI or personally identifiable information ("PII"), obtained from files specified in Appendix D, the ACO must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. The ACO shall further limit its disclosure of such information to the types of disclosures that CMS itself would be permitted make under the "routine uses" in the applicable systems of records listed in Appendix D.

Subject to the limits specified above and elsewhere in this Agreement and applicable law, the ACO may link individually identifiable information specified in Appendix D (including directly or indirectly identifiable data) or derivative data to other sources of individually-identifiable health information, such as other medical records available to the ACO and its Next Generation Participants or Preferred Providers. The ACO may disseminate such data that has been linked to other sources of individually identifiable health information provided such data has been de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b).

8. The ACO agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I--Responsibilities for Protecting and Managing Federal Information Resources ([https://www.whitehouse.gov/omb/circulars\\_default](https://www.whitehouse.gov/omb/circulars_default)) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (<http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf>); and, NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (<http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf>). The ACO acknowledges that the use of unsecured telecommunications, including the Internet, to transmit directly or indirectly identifiable information from the files specified in Appendix D or any such derivative data files is strictly



prohibited. Further, the ACO agrees that the data specified in Appendix D must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in Appendix D other than as provided in this Agreement without written approval from CMS, unless such movement, transmission or disclosure is required by a law.

9. The ACO agrees to grant access to the data and/or the facility(ies) in which the data is maintained to the authorized representatives of CMS or DHHS Office of Inspector General, including at the site of the custodian indicated in Appendix D, for the purpose of inspecting to confirm compliance with the terms of this Agreement.
10. The ACO agrees that any use of CMS data in the creation of any document concerning the purpose specified in this section and Appendix D must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.
11. The ACO agrees to report any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2850 or by email notification at [cms\\_it\\_service\\_desk@cms.hhs.gov](mailto:cms_it_service_desk@cms.hhs.gov) within one hour. Furthermore, the ACO agrees to cooperate fully in any federal incident security process that results from such improper use or disclosure.
12. The parties mutually agree that the individual named in Appendix D is designated as Custodian of the CMS data files on behalf of the ACO and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, and for the establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use or disclosure. Furthermore, such Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in this Agreement as a condition of receiving such data. The ACO agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.
13. Data disclosed to the ACO pursuant to Appendix D may be retained by the ACO until the conclusion or termination of this Agreement. The ACO is permitted to retain any individually identifiable health information from such data files or derivative data files after the conclusion or termination of the Agreement if the ACO is a HIPAA CE, and the data has been incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom the ACO provides such data in the course of carrying out the Model initiative may also retain such data if the recipient entity is a HIPAA CE or BA and the data is incorporated into the subject Beneficiaries' medical records that are part of a designated record set



under HIPAA. The ACO shall destroy all other data and send written certification of the destruction of the data files and/or any derivative data files to CMS within 30 days following the conclusion or termination of the Agreement. Except for disclosures for treatment purposes, the ACO shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph. These retention provisions survive the conclusion or termination of the Agreement.

14. All references to data disclosed pursuant to, or specified in, Appendix D shall be construed to include data provided pursuant to, or specified in, the Data Use Agreement that was part of the Next Generation Participation Agreement that was executed in December, 2015.

### C. De-Identified Reports

CMS will provide the following reports to the ACO, which will be de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b):

1. Monthly Financial Reports

These reports will include monthly and year-to-date information on total Medicare expenditures and expenditures for selected categories of services for Next Generation Beneficiaries. This aggregate information will not include individually identifiable health information and will incorporate de-identified data from Next Generation Beneficiaries who have opted out of data sharing.

2. Quarterly Benchmark Reports

CMS will provide quarterly benchmark reports (“**BRs**”) to the ACO to monitor ACO financial performance throughout the year. The BRs will not contain individually identifiable data. The design and data source used to generate the BRs is also used for the final year-end settlement report, as described in Section XIV.C. In the event that data contained in the BRs conflicts with data provided from any other source, the data in the BRs will control with respect to settlement under Section XIV.B of the Agreement.

### D. Beneficiary Rights to Opt Out of Data Sharing

1. The ACO shall provide Next Generation Beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences via 1-800-MEDICARE. Beginning in Performance Year 2017 and subsequent Performance Years, such communications shall note that, even if a Next Generation Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for quality improvement purposes.
2. The ACO shall allow Next Generation Beneficiaries to reverse a data sharing preference at any time by calling 1-800-MEDICARE.

3. CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in this Model or who have previously declined data sharing under the MSSP or the Pioneer ACO Model.
4. The ACO may affirmatively contact a Next Generation Beneficiary who has elected to decline claims data sharing no more than one time in a given Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Next Generation Beneficiaries outside of a clinical setting.
5. In the event that a Next Generation Professional is terminated from the ACO for any reason, if that departing Next Generation Professional is the sole Next Generation Professional in the ACO to have submitted claims for a particular Next Generation Beneficiary during the 12-month period prior to the effective date of the termination, CMS will administratively opt the Next Generation Beneficiary out of all claims data-sharing under this Section VI within 30 days of the effective date of the termination, unless—
  - (a) The Next Generation Beneficiary affirmatively consents to continued data sharing of such claims with the ACO through an authorization that meets the requirements under 45 CFR § 164.508(b); or
  - (b) The Next Generation Beneficiary has become the patient of another Next Generation Professional participating in the ACO.
6. Notwithstanding the foregoing, an ACO shall receive claims data regarding substance use disorder treatment only if the Next Generation Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved form pursuant to Section VI.E of this Agreement.
7. CMS will administratively opt a Next Generation Beneficiary back into such claims data sharing if: (a) he or she was administratively opted out of data sharing solely due to the termination of a Next Generation Professional from the given ACO; (b) he or she is aligned to the ACO for a subsequent Performance Year; and (c) he or she does not affirmatively opt out of data sharing according to this Section VI.C.

#### **E. Beneficiary Substance Use Disorder Data Opt-In**

1. The ACO may inform each newly-aligned Next Generation Beneficiary, in compliance with applicable law:
  - (a) That he or she may elect to allow the ACO to receive beneficiary-identifiable data regarding his or her utilization of substance use disorder services;
  - (b) Of the mechanism by which the Next Generation Beneficiary can make this election; and
  - (c) That 1-800-Medicare will answer any questions regarding sharing of data regarding utilization of substance use disorder services.

2. A Next Generation Beneficiary may opt in to substance use disorder data sharing only by submitting a CMS-approved substance use disorder opt in form to the ACO. The ACO shall promptly send the opt-in form to CMS.

## **VII. Care Improvement Objectives**

### **A. General**

1. The ACO shall implement processes and protocols that relate to the following objectives for patient-centered care:
  - (a) Promotion of evidence-based medicine, such as through the establishment and implementation of evidence-based guidelines at the organizational or institutional level. An evidence-based approach would also regularly assess and update such guidelines.
  - (b) Processes to ensure Beneficiary/caregiver engagement, and the use of shared decision making processes by Next Generation Participants that take into account Beneficiaries' unique needs, preferences, values, and priorities. Measures for promoting Beneficiary engagement include, but are not limited to, the use of decision support tools and shared decision making methods with which the Beneficiary can assess the merits of various treatment options in the context of his or her values and convictions. Beneficiary engagement also includes methods for fostering what might be termed "health literacy" in Beneficiaries and their families.
  - (c) Coordination of Beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote Beneficiary monitoring, and other enabling technologies).
  - (d) Providing Beneficiaries access to their own medical records and to clinical knowledge so that they may make informed choices about their care.
  - (e) Ensuring individualized care for Beneficiaries, such as through personalized care plans.
  - (f) Routine assessment of Beneficiary and caregiver and/or family experience of care and seek to improve where possible.
  - (g) Providing care that is integrated with the community resources Beneficiaries require.
2. The ACO shall require its Next Generation Participants to comply with and implement these designated processes and protocols, and shall institute remedial processes and penalties, as appropriate, for Next Generation Participants that fail to comply with or implement a required process or protocol.

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

1. CMS may require the ACO 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 provision, 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.

2. Notwithstanding other sections of this Agreement, failure to comply with Section VII.B.1 may result in CMS imposing appropriate remedial actions under Section XIX.A but shall not be cause for CMS to terminate this Agreement.

## **VIII. ACO Quality Performance**

### **A. Quality Scores**

CMS shall use the ACO's quality scores calculated under this Section to determine, in part, the ACO's Performance Year Benchmark according to the methodology described in Appendix B.

### **B. Quality Measures**

CMS shall assess quality performance using the quality measures set forth in Appendix F and the quality measure data reported by the ACO. Notwithstanding Section XXI.D, CMS may amend the quality measures to be used in a Performance Year without the consent of the ACO prior to the beginning of the Performance Year. CMS shall notify the ACO of any measure set change prior to the beginning of each Performance Year.

### **C. Quality Measure Reporting**

1. Except as set forth in Section VIII.C.2, the ACO shall completely, timely, and accurately report quality measures for each Performance Year and shall require its Next Generation Participants to cooperate in quality measure reporting. Complete reporting means that the ACO meets all of the reporting requirements including timely reporting the requested data for all measures.
2. The ACO shall not report quality measures data on behalf of its Next Generation Participants for a Performance Year if the ACO terminates its agreement pursuant to Section XIX.D.3, and the termination is effective no later than 30 days after February 28 of that Performance Year.
3. CMS shall use the following sources for quality reporting:
  - (a) ACO reporting via the Group Practice Reporting Option (GPRO) Web Interface tool;
  - (b) ACO reporting of results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other patient experience surveys;
  - (c) Medicare claims submitted for items and services furnished to Next Generation Beneficiaries; and
  - (d) Any other relevant data shared between the ACO and CMS pursuant to this Agreement.

4. For each Performance Year, the ACO is responsible for procuring a CMS-approved vendor to conduct the CAHPS or other patient experience surveys. The ACO is responsible for paying for the surveys and for ensuring that the survey results are transmitted to CMS by a date and in a manner established by CMS.

#### **D. Quality Performance Scoring**

1. CMS shall use the ACO's performance on each of the quality measures to calculate the ACO's total quality score according to a methodology to be determined by CMS prior to the start of each Performance Year.
2. Prior to the start of each Performance Year, CMS shall notify the ACO of the methodology for calculating the quality performance benchmarks and the methodology for calculating the ACO's total quality score for that Performance Year. Notwithstanding Section XXI.D, CMS may amend these methodologies without the consent of the ACO prior to the beginning of each Performance Year.
3. Starting in the ACO's second Performance Year in the Model, if applicable, the ACO's quality score may be adjusted downward based on quality measure validation ("QMV") findings. Prior to the end of the ACO's first Performance Year and, if applicable, the end of any subsequent Performance Year, CMS will provide additional information regarding how the quality score will be adjusted based on the QMV findings for that Performance Year.

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

Beginning in 2017, the ACO and its Next Generation Participants shall use certified Electronic Health Record Technology (CEHRT), as such term is defined under 42 CFR § 414.1305, in a manner sufficient to meet the applicable requirements of 42 CFR § 414.1415(a)(1)(i), including any amendments thereto.

### **X. ACO Selections and Approval**

#### **A. ACO Selections**

For each Performance Year, in a manner and by one or more deadlines determined by CMS, the ACO shall submit to CMS its selections for the following:

1. The ACO's selected Risk Arrangement from the alternatives described in Appendix B;
2. The ACO's selected Savings/Losses Cap, between 5.0% and 15%;
3. The ACO's selected Alternative Payment Mechanism, if any;
4. The Benefit Enhancements, if any, that the ACO selects to offer through its Next Generation Participants and Preferred Providers;
5. The ACO's decision with respect to participation in Voluntary Alignment pursuant to Section V.C and Appendix C of this Agreement;

6. Beginning for Performance Year 2018 (or for Performance Year 2017 if the ACO executed Amendment No. 3 to the Next Generation ACO Participation Agreement during 2017), and for subsequent Performance Years, the ACO's expenditure cap selection (capped expenditures or uncapped expenditures) as described in section 3.8 of Appendix B of the Agreement. The ACO's expenditure cap selection will apply to both baseline and Performance Year expenditures calculations; and
7. For Performance Year 2017, the ACO's selection whether to be subject to the coding factor adjustment policy described in Section 6.3 of Appendix B of this Agreement. In the event that no selection is made by the ACO, the policy of "re-normalization" of risk scores, described in Section 6.2 of Appendix B of this Agreement, will be applied for Performance Year 2017.

#### **B. Risk Arrangement, Savings/Losses Cap, and Expenditure Cap Approval**

The ACO's Risk Arrangement, Savings/Losses Cap selection, and expenditure cap selection, if applicable, for the first Performance Year, and for each subsequent Performance Year, shall be deemed approved unless rejected in writing by CMS within 30 days after submission.

#### **C. Alternative Payment Mechanism Approval**

1. If the ACO selects an Alternative Payment Mechanism for a Performance Year, CMS shall send the ACO written notice of approval or rejection of the selected Alternative Payment Mechanism within 15 days after the ACO's submission of its Alternative Payment Mechanism selection. In the event that CMS does not send such written notice within 15 days after the ACO's submission of its selection, the ACO's selection shall be deemed approved.
2. CMS shall assess the ACO's Alternative Payment Mechanism selection according to Section XIV and the eligibility criteria set forth in Appendix G, H, or N, whichever is relevant.

### **XI. Benefit Enhancements**

#### **A. General**

1. The ACO may select to provide one or more Benefit Enhancements for a Performance Year. The ACO shall submit an "**Implementation Plan**" to CMS in a manner and by a date determined by CMS for each Benefit Enhancement for the first time that Benefit Enhancement is selected under Section X by the ACO, in advance of any Performance Year during which a material amendment to a Benefit Enhancement previously elected under Section X will take effect, and at such other times specified by CMS.
2. If the ACO selects to provide one or more Benefit Enhancements for a Performance Year, the ACO's Next Generation Participants and Preferred Providers, as indicated on the relevant Participant List and Preferred Provider List under Section IV, may submit claims for services furnished pursuant to a Benefit

Enhancement as described in this Section during the Performance Year for which the ACO selected to provide the Benefit Enhancement. Appendices I, J, and K shall apply to this Agreement only if the ACO selected under Section X to provide the relevant Benefit Enhancement for the given Performance Year.

3. CMS may require the ACO to report data on the use of Benefit Enhancements to CMS. Such data shall be reported in a form and in a manner to be determined by CMS.

#### **B. 3-Day SNF Rule Waiver Benefit Enhancement**

1. Appendix I shall apply to this Agreement for any Performance Year for which the ACO has selected the 3-Day SNF Rule Waiver Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the 3-Day SNF Rule Waiver Benefit Enhancement.
2. The ACO shall require that, in order to be eligible to submit claims for services furnished to Next Generation Beneficiaries pursuant to the 3-Day SNF Rule Waiver Benefit Enhancement, an entity must be:
  - (a) A Next Generation Participant or Preferred Provider; and
  - (b) A skilled-nursing facility (“SNF”) or a hospital or critical access hospital that has swing-bed approval for Medicare post-hospital extended care services (“Swing-Bed Hospital”); and
  - (c) Designated on the Participant List or Preferred Provider List as participating in the 3-Day SNF Rule Waiver Benefit Enhancement; and
  - (d) Approved by CMS according to the criteria described in Appendix I.
3. If CMS notifies the ACO that a SNF or Swing-Bed Hospital has not been approved for participation in the 3-Day SNF Rule Waiver Benefit Enhancement under this Section XI.B, but the provider is otherwise eligible to be a Next Generation Participant or Preferred Provider, the ACO may either remove the provider from the Participant List or Preferred Provider List, or amend the relevant list to reflect that the provider will not participate in the 3-Day SNF Rule Waiver Benefit Enhancement. The ACO shall amend the relevant list no later than 30 days after the date of the notice from CMS.

#### **C. Telehealth Expansion Benefit Enhancement**

1. Appendix J shall apply to this Agreement for any Performance Year for which the ACO has selected the Telehealth Expansion Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the Telehealth Expansion Benefit Enhancement.
2. In order to be eligible to bill for telehealth services furnished pursuant to the Telehealth Expansion Benefit Enhancement, an individual or entity must be:
  - (a) A Next Generation Professional or a physician or non-physician practitioner listed at 42 CFR § 410.78(b)(2) who is a Preferred Provider; and



- (b) Authorized under relevant Medicare rules and applicable state law to bill for telehealth services; and
  - (c) Designated on the Participant List or Preferred Provider List as participating in the Telehealth Expansion Benefit Enhancement; and
  - (d) Approved by CMS according to the criteria described in this Section XI.C.2 and Appendix J.
3. If CMS notifies the ACO that a Next Generation Professional or a physician or non-physician practitioner who is a Preferred Provider has not been approved for participation in the Telehealth Expansion Benefit Enhancement under this Section XI.C, but the provider is otherwise eligible to be a Next Generation Participant or Preferred Provider, the ACO may either remove the provider from the Participant List or Preferred Provider List, or amend the relevant list to reflect that the provider will not participate in the Telehealth Expansion Benefit Enhancement. The ACO shall amend the relevant list no later than 30 days after the date of the notice from CMS.
  4. In order to be eligible to bill for teledermatology or teleophthalmology furnished using asynchronous store and forward technologies, as that term is defined under section 42 CFR § 410.78(a)(1), an individual must be:
    - (a) Approved to bill for telehealth services pursuant to the Telehealth Expansion Benefit Enhancement under Section XI.C.2(d); and
    - (b) A physician; and
    - (c) Enrolled in Medicare with a Medicare physician specialty of dermatologist (C7) or ophthalmologist (C18).
  5. The ACO shall ensure that Next Generation Participants and Preferred Providers do not substitute telehealth services for in-person services when in-person services are more clinically appropriate.
  6. The ACO shall ensure that Next Generation Participants and Preferred Providers only furnish Medically Necessary telehealth services and do not use telehealth services to prevent or deter a Beneficiary from seeking or receiving in-person care when such care is Medically Necessary.

#### **D. Post-Discharge Home Visits Benefit Enhancement**

1. Appendix K shall apply to this Agreement for any Performance Year for which the ACO has selected the Post-Discharge Home Visits Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the Post-Discharge Home Visits Benefit Enhancement.
2. In order to be eligible to submit claims for post-discharge home visits furnished to Next Generation Beneficiaries pursuant to the Post-Discharge Home Visits Benefit Enhancement, the supervising physician or other practitioner must be:



- (a) A Next Generation Professional or a physician or non-physician practitioner who is a Preferred Provider; and
  - (b) Eligible under Medicare rules to submit claims for “incident to” services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and
  - (c) Designated on the Next Generation Participant List or Preferred Provider List as participating in the Post-Discharge Home Visit Benefit Enhancement.
3. The individual performing services under this Benefit Enhancement must be “auxiliary personnel” as defined at 42 CFR § 410.26(a)(1).
  4. The ACO shall ensure that post-discharge home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

#### **E. Requirements for Termination of Benefit Enhancements**

1. The ACO must obtain CMS consent before voluntarily discontinuing any Benefit Enhancement during a Performance Year.
2. In the event that during a Performance Year a Benefit Enhancement will cease to be in effect with respect to the ACO or any Next Generation Participant or Preferred Provider pursuant to Section XIX, the effective date of such termination shall be the date specified by CMS in the notice to the ACO.
  - (a) Within 30 days after the effective date of termination, the ACO shall send notice in writing to the affected Beneficiaries and/or Next Generation Beneficiaries. Such notification shall state that following a date that is 90 days after the effective date of termination or the end of the Performance Year, whichever is sooner, services furnished under the Benefit Enhancement will no longer be covered by Medicare and the Beneficiary may be responsible for the payment of such services.
  - (b) CMS shall cease coverage of claims for a terminated Benefit Enhancement 90 days after the effective date of such termination.
3. In the event that the ACO elects to discontinue a Benefit Enhancement for a subsequent Performance Year through the selection process under Section X of this Agreement, the ACO shall notify all its Next Generation Participants and Preferred Providers no later than 30 days prior to the start of that Performance Year.

#### **F. Termination of Benefit Enhancements upon Termination**

If this Agreement is terminated by either party prior to the end of a Performance Year, CMS shall terminate the ACO’s Benefit Enhancements and the ACO shall notify its Next Generation Beneficiaries in accordance with Section XI.E. The ACO shall also notify its Next Generation Participants and Preferred Providers within 10 business days after the effective date of the termination.

## **XII. Coordinated Care Reward**

## **A. Reward Payment**

CMS may make direct Coordinated Care Reward payments directly to eligible Beneficiaries and Next Generation Beneficiaries. CMS will determine the methodology for calculating which Beneficiaries and Next Generation Beneficiaries are eligible to receive the payment, the amount of the payment, and the manner in which the payment will be issued.

## **B. ACO Obligations and Limitations Regarding the Coordinated Care Reward**

1. In any Performance Year in which CMS elects to make Coordinated Care Reward payments, the ACO shall ensure that all Next Generation Participants and Preferred Providers will, upon any Next Generation Beneficiary's inquiry about the Coordinated Care Reward, provide an accurate and current list of all Next Generation Participants and Preferred Providers, either in hard copy or by reference to the ACO's website, to the Next Generation Beneficiary.
2. In any Performance Year in which CMS elects to make Coordinated Care Reward payments, the ACO shall ensure that all Next Generation Beneficiaries will be directed by the ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to 1-800-MEDICARE to obtain additional information about the Coordinated Care Reward.
3. In any Performance Year in which CMS elects to make Coordinated Care Reward payments, the ACO and its Next Generation Participants and Preferred Providers may communicate in writing with Next Generation Beneficiaries regarding the Coordinated Care Reward. Any such written materials must comply with the requirements under Section V.E of this Agreement.
4. In any Performance Year in which CMS elects to make Coordinated Care Reward payments, the ACO shall ensure that any communication with Next Generation Beneficiaries regarding the Coordinated Care Reward, whether by the ACO, a Next Generation Participant, Preferred Provider, or other individuals or entities performing functions or services related to ACO Activities clearly conveys that CMS is solely responsible for the terms and payment of the Coordinated Care Reward and that the reward does not limit Beneficiaries' freedom of choice of Medicare providers and suppliers.
5. The ACO shall not, and shall ensure that its Next Generation Participants, Preferred Providers, and any other individuals or entities performing services related to ACO Activities do not, provide gifts or other remuneration to Next Generation Beneficiaries as inducements for receiving the Coordinated Care Reward or to influence a Next Generation Beneficiary's decision to qualify for the Coordinated Care Reward.

## **XIII. ACO Benchmark**

## A. Prospective Benchmark

1. For each Performance Year, CMS shall determine the ACO's Performance Year Benchmark according to the methodology in Appendix B.
2. No later than 15 days before the beginning of each Performance Year, CMS shall provide the ACO with a report ("**Performance Year Benchmark Report**") consisting of the ACO's Performance Year Benchmark.
3. On a quarterly basis during each Performance Year, CMS shall provide the ACO with a financial report ("**Quarterly Financial Report**"). The Quarterly Financial Report may comprise adjustments to the Performance Year Benchmark resulting from updated information regarding any factors that affect the Performance Year Benchmark calculation in Appendix B.

## B. Trend Adjustments

1. CMS may, at CMS's sole discretion, retroactively modify the projected trend used in calculating the Performance Year Benchmark if CMS determines that exogenous factors, such as a natural disaster, epidemiologic event, legislative change and/or other similarly unforeseen circumstance during the Performance Year, renders the projected trend invalid for assessing the expected level of spending between the base year and Performance Year in the population of NGACO reference beneficiaries, as such term is defined under Section 3.6 of Appendix B of this Agreement.
2. If CMS retroactively modifies the projected trend pursuant to Section XIII.B.1, CMS will adjust the Performance Year Benchmark according to the methodology in Section 5.2 of Appendix B of this Agreement.
3. CMS will notify the ACO of any adjustments to the Performance Year Benchmark made pursuant to this Section XIII.B.
4. In order to accommodate the trend adjustment, CMS may at its sole discretion delay settlement under Section XIV.C of this Agreement for the affected Performance Year for no more than 60 days.
5. Except for calculations made as part of a settlement reopening conducted pursuant to Section XIV.C.4, CMS may not adjust the Performance Year Benchmark under this Section XIII.B after the issuance of the settlement report as described in Section XIV.C for the relevant Performance Year.

## C. Risk Score Coding Factor Adjustment

1. Subject to Section XIII.C.4, beginning for Performance Year 2018 and subsequent Performance Years (and for Performance Year 2017 if the ACO selected to be subject to the coding factor adjustment policy pursuant to Section X.A.7), CMS may, at CMS' sole discretion, retroactively modify the projected coding factor to be used in adjusting the ACO's Performance Year HCC risk score, if the Final Observed Risk Trend for the applicable Performance Year, calculated by CMS in accordance with Section 6.3 or Appendix B of this

Agreement, is found to be greater than 3.0 percentage points higher or lower than the projected coding factor.

2. If CMS retroactively modifies the projected coding factor pursuant to Section XIII.C.1, CMS will make a conforming retroactive modification to the ACO's Performance Year Benchmark as described in section 6.3 of Appendix B of this Agreement.
3. CMS will notify the ACO of any adjustment to the Performance Year Benchmark made pursuant to this Section XIII.C.
4. Except for recalculations made as part of a settlement reopening conducted pursuant to Section XIV.C.4, CMS may not adjust the Performance Year Benchmark under this Section XIII.C after the issuance of the settlement report as described in Section XIV.C for the relevant Performance Year.

## **XIV. Payment**

### **A. General**

For each Performance Year, CMS shall pay the ACO in accordance with (i) the Alternative Payment Mechanism, if any, for which CMS has approved the ACO under Section X.C; (ii) the Risk Arrangement for which the ACO has been approved or deemed approved by CMS under Section X.B; (iii) Appendix B; (iv) Section XIII; and (v) this Section XIV.

### **B. Alternative Payment Mechanisms**

#### **1. General**

- (a) The ACO may elect to receive only one Alternative Payment Mechanism. The ACO shall select such Alternative Payment Mechanism, if any, and CMS shall approve or reject the ACO's selection, in accordance with Section X.C and the applicable appendix of this Agreement.
- (b) Beginning in Performance Year 2017 and subsequent Performance Years, by the deadline specified by CMS, the ACO shall submit to CMS a financial disclosure statement demonstrating sufficient financial reserves to repay Other Monies Owed incurred as a result of participation in an Alternative Payment Mechanism.

#### **2. Infrastructure Payments**

- (a) If the ACO selects and CMS approves participation in Infrastructure Payments, CMS shall make payments to the ACO in accordance with the methodology in Appendix G.
- (b) The ACO shall spend the amounts received as Infrastructure Payments only on ACO Activities.

- (c) The ACO shall repay CMS all Infrastructure Payments it received during a Performance Year as Other Monies Owed at the Performance Year settlement under Section XIV.C or through settlement reports issued at such other times as provided under Section XIV.C.

### 3. Population-Based Payments (PBP)

- (a) If the ACO wishes to participate in PBP, it must select PBP as an Alternative Payment Mechanism. Beginning in Performance Year 2017 and subsequent Performance Years, such election must be in accordance with Section I.A. of Appendix H, and CMS shall review and respond to the ACO's selection in accordance with Sections I.A and I.B. of Appendix H.
- (b) If CMS approves the ACO's selection to participate in PBP, CMS shall make Monthly PBP Payments to the ACO in accordance with the methodology in Appendix H. Each party shall comply with the terms of Appendix H that are applicable to that party.
- (c) During Performance Year 2016, Preferred Providers shall not be eligible to receive Reduced FFS Payments.
- (d) As part of settlement for a Performance Year under Section XIV.C, CMS shall calculate the difference between the total amount of Monthly PBP Payments that CMS paid the ACO during the Performance Year and the total amount of PBP Fee Reductions. Such calculations shall be made in accordance with Appendix H. Any difference would constitute Other Monies Owed and may be subject to recoupment or offset in accordance with Appendix H and Section XIV.C of this Agreement. For purposes of Performance Year 2016:
  - i. If the amount CMS paid in Monthly PBP is greater than the total amount by which FFS payments were reduced, the ACO shall pay CMS the difference as Other Monies Owed.
  - ii. If the amount CMS paid in Monthly PBP is less than the total amount by which FFS payments were reduced, CMS shall pay the ACO the difference as Other Monies Owed.
  - iii. If, as a result of provider appeals or additional claims adjustments after the initial PBP reconciliation as described in Section XIV.B.3, CMS pays an amount in excess of the Reduced FFS Payment for any item or service furnished to a Next Generation Beneficiary by a Next Generation Participant receiving Reduced FFS Payments, the ACO shall owe CMS the difference between the total amount CMS actually paid for such item or service and the total amount of the Reduced FFS Payment for such claim. Such difference would constitute Other Monies Owed and be subject to recoupment during settlement under Section XIV.C.

### 4. All-Inclusive Population-Based Payments (AIPBP)

- (a) If the ACO wishes to participate in AIPBP for Performance Year 2017 or a subsequent Performance Year, it must select AIPBP as an Alternative

Payment Mechanism in accordance with Section I.A of Appendix N. CMS shall review and respond to the ACO's selection in accordance with Sections I.A and I.B of Appendix N.

- (b) If CMS approves the ACO's selection to participate in AIPBP, CMS shall make Monthly AIPBP Payments to the ACO in accordance with the methodology in Appendix N. Each party shall comply with the terms of Appendix N that are applicable to that party.
- (c) As part of settlement for a Performance Year under Section XIV.C, CMS shall calculate the difference between the total Monthly AIPBP Payments that CMS paid to the ACO during the Performance Year and the total amount of AIPBP Fee Reductions. Such calculations shall be made in accordance with Appendix N. Any difference would constitute Other Monies Owed and may be subject to recoupment or offset in accordance with Appendix N and Section XIV.C of this Agreement.

## C. Settlement

### 1. General

- (a) Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses and the amount of Other Monies Owed. CMS shall calculate Shared Savings, Shared Losses, and Other Monies Owed according to the methodology in Appendix B, Appendix G, Appendix H, Appendix I, Appendix J, Appendix K, and Appendix N.
- (b) CMS shall make reasonable efforts to issue the settlement report for each Performance Year no later than 240 days after the end of the Performance Year.
- (c) Any amounts determined to be owed as a result of a settlement or revised settlement upon reopening shall be paid in accordance with Section XIV.C.5.

### 2. Error Notice

- (a) The settlement report will be deemed final 30 days after the date it is issued, unless the ACO submits to CMS written notice of an error in the mathematical calculations in the settlement report within 30 days after the settlement report is issued (“**Timely Error Notice**”).
- (b) Upon receipt of a Timely Error Notice, CMS shall review the calculations in question and any mathematical issues raised by the ACO in its written notice.
- (c) If CMS issues a written determination that the settlement report is correct, the settlement report is final on the date the written determination is issued.
- (d) If CMS issues a revised settlement report, the revised settlement report is final on the date it is issued.

- (e) There shall be no further administrative or judicial review of the settlement report or a revised settlement report.

### 3. Deferred Settlement

- (a) The ACO may elect, in a manner and by a date specified by CMS, to defer settlement for a period not to exceed 180 days (“**Deferred Settlement**”).
- (b) As a condition of Deferred Settlement, CMS may require the ACO to increase the amount of its financial guarantee under Section XIV.D in an amount and by a date determined by CMS.

### 4. Settlement Reopening

- (a) For a given Performance Year, for a period of one year following issuance of the settlement report for that Performance Year, or until issuance of the settlement report for the subsequent Performance Year, whichever comes earlier, CMS reserves the right to reopen the settlement report in order to include payments or recoupments specified in Section 3.9 of Appendix B that were not included in the initial settlement, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO.
- (b) CMS reserves the right, for a period of six years following the end of the term or termination of this Agreement, to reopen a final settlement report in order to recalculate the amounts owed, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO if, as a result of later inspection, evaluation, investigation, or audit, it is determined that the amount due to the ACO by CMS or due to CMS by the ACO has been calculated in error due to CMS data source file errors, computational errors, or other similar CMS technical errors.
- (c) The parties shall pay any amounts determined to be owed as a result of a reopening under this Section XIV.C.4 in accordance with Section XIV.C.5.
- (d) CMS may reopen and revise a settlement report at any time in the event of fraud or similar fault by the ACO, a Next Generation Participant or Preferred Provider.

### 5. Payment of Amounts Owed

- (a) If CMS owes the ACO Shared Savings or Other Monies Owed as a result of a final settlement, or revised settlement upon reopening, CMS shall pay the ACO in full within 30 days after the date on which the relevant settlement report is deemed final, except that CMS shall not make any payment of Shared Savings if this Agreement is terminated by CMS pursuant to Section XIX, and CMS may reduce amounts owed to the ACO under this Agreement by amounts owed by the ACO under this Agreement or any other CMS program or initiative.



- (b) If the ACO owes CMS Shared Losses or Other Monies Owed as a result of a final settlement, or revised settlement upon reopening, the ACO shall pay CMS in full within 30 days after the relevant settlement report is deemed final.
- (c) If CMS does not timely receive payment in full, the remaining amount owed will be considered a delinquent debt subject to the provisions of Section XIV.E.

#### 6. Transition from the ACO Investment Model (AIM)

If the ACO participated in AIM prior to the Start Date, the ACO shall be responsible for repayment of all Pre-Paid Shared Savings (as such term is defined in the AIM Agreement) owed to CMS according to the terms of the AIM Agreement. Notwithstanding the terms of the AIM Agreement, CMS may deduct such amounts from any Shared Savings earned by the ACO during settlement under the Next Generation ACO Model.

#### D. **Financial Guarantee**

1. The ACO must have the ability to repay all Shared Losses and Other Monies Owed for which it may be liable under the terms of this Agreement and shall provide a financial guarantee for each Performance Year in accordance with the terms set forth in Appendix L.
2. The ACO shall submit such documentation of such financial guarantee for the first Performance Year to CMS by a date determined by CMS, and thereafter in accordance with Appendix L.
3. Any changes made to a financial guarantee must be approved in advance by CMS.
4. Nothing in this Agreement or its Appendices shall be construed to limit the ACO's liability to pay any Shared Losses or Other Monies Owed in excess of the amount of the financial guarantee.

#### E. **Delinquent Debt**

1. If CMS does not receive payment in full by the date payment is due, CMS shall pursue payment under the financial guarantee required under Section XIV.D and may withhold payments otherwise owed to the ACO under this Agreement or any other CMS program or initiative.
2. If the ACO fails to pay the amounts due CMS in full within 30 days after the date of a demand letter or settlement report, CMS shall assess simple interest on the unpaid balance at the rate applicable to other Medicare debts under 45 CFR § 30.18 and 42 CFR § 405.378. Interest shall be calculated in 30-day periods and shall be assessed for each 30-day period that payment is not made in full.
3. CMS and the U.S. Department of the Treasury may use any applicable debt collection tools available to collect the total amount owed by the ACO.



## **XV. Participation in Evaluation, Shared Learning Activities, and Site Visits**

### **A. Evaluation Requirement**

#### **1. General**

- (a) The ACO shall participate and cooperate in any independent evaluation activities conducted by CMS and/or its designees aimed at assessing the impact of the Model on the goals of better health, better health care, and lower Medicare per capita costs for Next Generation Beneficiaries. The ACO shall 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.
- (b) The ACO shall ensure that it has written agreements and/or legal relationships with any individuals and entities performing functions and services related to ACO Activities, that are necessary to ensure CMS or its designees can carry out evaluation activities.

#### **2. Primary Data**

In its evaluation activities, CMS may collect qualitative and quantitative data from the following sources:

- (a) Site visits;
- (b) Interviews with Next Generation Beneficiaries and their caregivers;
- (c) Focus groups of Next Generation Beneficiaries and their caregivers;
- (d) Interviews with ACO, Next Generation Participant and Preferred Provider staff;
- (e) Focus groups with ACO, Next Generation Participant and Preferred Provider staff;
- (f) Direct observation of Beneficiary interactions with Next Generation Participant and Preferred Provider staff, care management meetings among Next Generation Participant and Preferred Provider staff, and other activities related to the ACO's participation in the Model; and
- (g) Surveys.

#### **3. Secondary Data**

In its evaluation activities, CMS may use data or information submitted by the ACO as well as claims submitted to CMS for items and services furnished to Next Generation Beneficiaries. This data may include, but is not limited to:

- (a) Survey data from CAHPS surveys;
- (b) Clinical data such as lab values;
- (c) Medical records; and

(d) ACO Implementation Plans.

## **B. Shared Learning Activities**

1. The ACO shall participate in CMS-sponsored learning activities designed to strengthen results and share learning that emerges from participation in the Model.
2. The ACO shall participate in periodic conference calls, site visits, and virtual or in-person meetings, and actively share resources, tools and ideas as prescribed by CMS.

## **C. Site Visits**

1. The ACO shall cooperate in periodic site visits by CMS and/or its designees in order to facilitate evaluation, shared learning activities, or the fulfilment of the terms of this Agreement.
2. CMS shall schedule site visits with the ACO no fewer than 15 days in advance. To the extent practicable, CMS will attempt to accommodate the ACO's request for particular dates in scheduling site visits. However, the ACO may not request a date that is more than 60 days after the date of the initial site visit notice from CMS.
3. The ACO shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during site visits.
4. Notwithstanding the foregoing, CMS may perform unannounced site visits at the office of any Next Generation Participant or Preferred Provider at any time to investigate concerns about the health or safety of Next Generation Beneficiaries or other program integrity issues.
5. Nothing in this Agreement shall be construed to limit or otherwise prevent CMS from performing site visits permitted by applicable law or regulations.

## **D. Rights in Data and Intellectual Property**

1. CMS may use any data obtained pursuant to the Next Generation ACO Model to evaluate the Model and to disseminate quantitative results and successful care management techniques, to other providers and suppliers and to the public. Data to be disseminated may include results of patient experience of care and quality of life surveys as well as measures based upon claims and medical records. The ACO will be permitted to comment on evaluation reports for factual accuracy but may not edit conclusions or control the dissemination of reports.
2. Notwithstanding any other provision in this Agreement, all proprietary trade secret information and technology of the ACO or its Next Generation Participants and Preferred Providers is and shall remain the sole property of the ACO, the Next Generation Participant, or Preferred Provider and, except as required by federal law, shall not be released by CMS without the express written consent of

the ACO. The regulation at 48 CFR § 52.227-14, “Rights in Data-General” is hereby incorporated by reference into this Agreement. CMS does not acquire by license or otherwise, whether express or implied, any intellectual property right or other rights to the ACO’s, Next Generation Participants’, or Preferred Providers’ proprietary information or technology.

3. The ACO acknowledges that it has submitted to CMS a form identifying specific examples of what it considers proprietary and confidential information currently contained in its program that should not be publicly disclosed. This form is attached as Appendix M.

## **XVI. Public Reporting and Release of Information**

### **A. ACO Public Reporting and Transparency**

The ACO shall report the following information on a publicly accessible website maintained by the ACO. CMS may publish some or all of this information on the CMS website.

1. Organizational information including all of the following:
  - (a) Name and location of the ACO;
  - (b) Primary contact information for the ACO;
  - (c) Identification of all Next Generation Participants and Preferred Providers;
  - (d) Identification of all joint ventures between or among the ACO and any of its Next Generation Participants and Preferred Providers;
  - (e) Identification of the ACO’s key clinical and administrative leaders and the name of any company by which they are employed; and
  - (f) Identification of members of the ACO’s governing body and the name of any entity by which they are employed.
2. Shared Savings and Shared Losses information, including:
  - (a) The amount of any Shared Savings or Shared Losses for any Performance Year;
  - (b) The proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for Beneficiaries; and
  - (c) The proportion of Shared Savings distributed to Next Generation Participants and Preferred Providers.
3. The ACO’s performance on the quality measures described in Appendix F.

### **B. ACO Release of Information**

1. The ACO, its Next Generation Participants, and its Preferred Providers shall obtain prior approval from CMS during the term of this Agreement and for six months thereafter for the publication or release of any press release, external report or statistical/analytical material that materially and substantially references

the ACO's participation in the Model or the ACO's financial arrangement with CMS. External reports and statistical/analytical material may include, but are not limited to, papers, articles, professional publications, speeches, and testimony.

2. All external reports and statistical/analytical material that are subject to this Section XVI.B must include the following statement on the first page: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

## **XVII. Compliance and Oversight**

### **A. ACO Compliance Plan**

1. The ACO shall have a compliance plan that includes at least the following elements:
  - (a) A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body;
  - (b) Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;
  - (c) A method for employees or contractors of the ACO, its Next Generation Participants and 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 official;
  - (d) Compliance training for the ACO and its Next Generation Participants and Preferred Providers;
  - (e) A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.
2. 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 and Oversight Activities**

1. CMS shall conduct monitoring activities to evaluate compliance by the ACO, its Next Generation Participants, and its Preferred Providers with the terms of this Agreement. Such monitoring activities may include, without limitation:
  - (a) Interviews with any individual or entity participating in ACO Activities, including members of the ACO leadership and management, Next Generation Participants, and Preferred Providers;
  - (b) Interviews with Next Generation Beneficiaries and their caregivers;
  - (c) Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Next Generation Participants, and its Preferred Providers;

- (d) Site visits to the ACO and its Next Generation Participants and Preferred Providers; and
  - (e) Documentation requests sent to the ACO, its Next Generation Participants, and/or its Preferred Providers, including surveys and questionnaires.
2. In conducting monitoring and oversight activities, CMS or its designees may use any relevant data or information including, without limitation, all Medicare claims submitted for items or services furnished to Next Generation Beneficiaries.
  3. CMS shall, to the extent practicable and as soon as practicable, provide the ACO with a comprehensive schedule of planned comprehensive annual audits related to compliance with this Agreement.
    - (a) Such schedule does not preclude the ability of CMS to conduct more limited, targeted or ad hoc audits as necessary.
    - (b) CMS may alter such schedule without the consent of the ACO. CMS shall notify the ACO within 15 days of altering such schedule.

### **C. ACO Compliance with Monitoring and Oversight Activities**

The ACO shall cooperate with, and the ACO shall require its Next Generation Participants, its Preferred Providers and other individuals and entities performing functions and services related to ACO Activities to cooperate with all CMS monitoring and oversight requests and activities.

### **D. Compliance with Laws**

#### **1. Agreement to Comply**

- (a) The ACO shall comply with, and shall require all Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to comply with the applicable terms of this Agreement and all applicable statutes regulations, and guidance, including without limitation: (a) federal criminal laws; (b) the False Claims Act (31 U.S.C. § 3729 et seq.); (c) the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the civil monetary penalties law (42 U.S.C. § 1320a-7a); and (e) the physician self-referral law (42 U.S.C. § 1395nn).
- (b) This Agreement does not waive any obligation of the ACO or the ACO's Next Generation Participants or Preferred Providers to comply with the terms of any other CMS contract, agreement, model, or demonstration.

#### **2. State Recognition**

During all Performance Years of this Agreement, the ACO shall be in compliance with applicable state licensure requirements in each state in which it operates regarding risk-bearing entities unless it has provided a written attestation to CMS that it is exempt from such state laws. If the ACO is exempt from such laws, it shall submit a certification to CMS no later than 60 days after the Start Date or after the date on which it becomes exempt from any such laws.

### 3. Reservation of Rights

- (a) Nothing contained in this Agreement or in the application process for the Next Generation ACO Model is intended or can be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of Inspector General, or CMS of any right to institute any proceeding or action for violations of any statutes, rules or regulations administered by the Government, or to prevent or limit the rights of the Government to obtain relief under any other federal statutes or regulations, or on account of any violation of this Agreement or any other provision of law. This Agreement cannot be construed to bind any Government agency except CMS and this Agreement binds CMS only to the extent provided herein.
- (b) The failure by CMS to require performance of any provision of this Agreement does not affect CMS's right to require performance at any time thereafter, nor does a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

### 4. Office of Inspector General of the Department of Health and Human Services (OIG) Authority

None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the ACO or its Next Generation Participants and Preferred Providers.

### 5. Other Government Authority

None of the provisions of this Agreement limit or restrict any other Government authority that is permitted by law to audit, evaluate, investigate, or inspect the ACO or its Next Generation Participants and Preferred Providers.

## **E. Certification of Data and Information**

1. With respect to data and information generated or submitted to CMS by the ACO, Next Generation Participants, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities, the ACO shall ensure that an individual with the authority to legally bind the individual or entity submitting such data or information certifies the accuracy, completeness, and truthfulness of that data and information to the best of his or her knowledge, information, and belief. Such certifications are a condition of receiving Shared Savings and Other Monies Owed.
2. At the end of each Performance Year, an individual with the legal authority to bind the ACO must certify to the best of his or her knowledge, information, and belief:
  - (a) That the ACO, its Next Generation Participants, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities are in compliance with program requirements; and

- (b) The accuracy, completeness, and truthfulness of all data and information that are generated or submitted by the ACO, Next Generation Participants, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities, including any quality data or other information or data relied upon by CMS in determining the ACO's eligibility for, and the amount of Shared Savings, or the amount of Shared Losses or Other Monies Owed.

## **XVIII. Audits and Record Retention**

### **A. Right to Audit and Correction**

The ACO agrees, and must require all of its Next Generation Participants and its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to agree, that the Government, including CMS, HHS, and the Comptroller General or their designees, has the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the ACO and its Next Generation Participants, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities that pertain to the following:

1. The ACO's compliance with the terms of this Agreement, including provisions that require the ACO to impose duties or requirements on Next Generation Participants or Preferred Providers;
2. Whether Next Generation Participants and Preferred Providers complied with the duties and requirements imposed on them by the ACO pursuant to the terms of this Agreement;
3. The quality of the services performed under this Agreement;
4. The ACO's right to, and distribution of, Shared Savings; and
5. The ability of the ACO to bear the risk of potential losses and the obligation and ability of the ACO to repay any Shared Losses or Other Monies Owed to CMS.

### **B. Maintenance of Records**

The ACO agrees, and must require all Next Generation Participants, Preferred Providers, and individuals and entities performing functions or services related to ACO Activities to agree, to the following:

1. To maintain and give the Government, including CMS, HHS, and the Comptroller General or their designees, access to all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the following: the ACO's compliance with the terms of this Agreement, including provisions that require the ACO to impose duties or requirements on Next Generation Participants or Preferred Providers; whether Next Generation Participants or Preferred Providers complied with the duties and requirements imposed on them by the ACO pursuant



to the terms of this Agreement; the quality of services furnished under this Agreement; the ACO's right to, and distribution of, Shared Savings; and the ability of the ACO to bear the risk of potential losses and the obligation and ability of the ACO to repay any Shared Losses or Other Monies Owed to CMS.

2. To maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:
  - (a) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the ACO at least 30 calendar days before the normal disposition date; or
  - (b) There has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its Next Generation Participants, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities, in which case the records shall be maintained for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

## **XIX. Remedial Action and Termination**

### **A. Remedial Action**

1. If CMS determines that any provision of this Agreement may have been violated, CMS may take one or more of the following actions:
  - (a) Notify the ACO and, if appropriate, the Next Generation Participant, and/or Preferred Provider of the violation;
  - (b) Require the ACO to provide additional information to CMS or its designees;
  - (c) Conduct on-site visits, interview Beneficiaries, or take other actions to gather information;
  - (d) Place the ACO on a monitoring and/or auditing plan developed by CMS;
  - (e) Require the ACO to 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;
  - (f) Require the ACO to terminate its relationship with any other individual or entity performing functions or services related to ACO Activities;
  - (g) Prohibit the ACO from distributing Shared Savings to a Next Generation Participant or Preferred Provider;
  - (h) Request a corrective action plan (“CAP”) from the ACO that is acceptable to CMS, in which case, the following requirements apply:



- i. The ACO shall submit a CAP for CMS approval by a deadline established by CMS; and
  - ii. The CAP must address what actions the ACO will take (or will require any Next Generation Participant, Preferred Provider or other individual or entity performing functions or services related to ACO Activities to take) within a specified time period to ensure that all deficiencies will be corrected and that the ACO will be in compliance with the terms of this Agreement;
- (i) Amend this Agreement without the consent of the ACO to provide that any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act will be inapplicable;
  - (j) Amend this Agreement without the consent of the ACO to deny the use of any Alternative Payment Mechanism by the ACO or any Next Generation Participant or Preferred Provider and to require that the ACO terminate any agreements effectuating such Alternative Payment Mechanism by a date determined by CMS, in which case, the ACO (and any Next Generation Participant or Preferred Provider, if applicable) shall be paid under normal FFS following the effective date determined by CMS, and Other Monies Owed will be calculated and paid in accordance with Section XIV.C and Appendix B;
  - (k) Discontinue the provision of data sharing and reports to the ACO under Section VI;
  - (l) Amend this Agreement without the consent of the ACO to deny the use of one or more Benefit Enhancements by the ACO or any Next Generation Participant or Preferred Provider and to require that the ACO terminate any agreements effectuating such Benefit Enhancements by a date determined by CMS.
2. CMS may impose additional remedial actions or terminate this Agreement pursuant to Section XIX.B if CMS determines that remedial actions were insufficient to correct noncompliance with the terms of this Agreement.
  3. CMS may require the ACO to remove a Next Generation Participant or Preferred Provider from the ACO's Participant List or Preferred Provider List and terminate its written agreement with the removed Next Generation Participant or Preferred Provider if CMS determines that the Next Generation Participant or Preferred Provider:
    - (a) Has failed to comply with any Medicare program requirement, rule, or regulation;
    - (b) Has failed to comply with the ACO's CAP, the monitoring and/or auditing plan developed by CMS for the ACO, or other remedial action imposed by CMS; or
    - (c) Has taken any action that threatens the health or safety of a Beneficiary or other patient.

## B. Termination of Agreement by CMS

CMS may immediately or with advance notice terminate this Agreement if:

1. CMS determines that the Agency no longer has the funds to support the Model;
2. CMS modifies or terminates the Model pursuant to Section 1115A(b)(3)(B) of the Act;
3. CMS determines that the ACO:
  - (a) Has failed to comply with any term of this Agreement or any other Medicare program requirement, rule, or regulation;
  - (b) Has failed to comply with a monitoring and/or auditing plan;
  - (c) Has failed to submit, obtain approval for, implement or fully comply with the terms of a CAP;
  - (d) Has failed to demonstrate improved performance following any remedial action;
  - (e) Has taken any action that threatens the health or safety of a Beneficiary or other patient;
  - (f) Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model;
  - (g) Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency;
  - (h) Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action; or
  - (i) Assigns or purports to assign any of the rights or obligations under this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS.
4. CMS determines that one or more of the ACO's Next Generation Participants or Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model; or
5. The state in which the ACO operates enters into an arrangement with CMS that is based on a statewide global or per-capita Medicare payment.

### **C. Termination of Agreement by ACO**

The ACO may terminate this Agreement prior to the end of the Performance Year upon advance written notice to CMS. Such notice must specify the effective date of the termination, which date may be no sooner than 30 days following the date of that notice.

### **D. Financial Settlement upon Termination**

1. If this Agreement is terminated by either party, except as otherwise provided in this section, CMS shall conduct settlement for the entire Performance Year in which the Agreement is terminated in accordance with Section XIV.C.1 of this Agreement.
2. If this Agreement is terminated by CMS under Section XIX.B, CMS shall not make any payments of Shared Savings to the ACO, and the ACO shall remain liable for any Shared Losses, for the Performance Year in which termination becomes effective.
3. If the ACO voluntarily terminates this Agreement pursuant to Section XIX.C prior to the end of a Performance Year by providing notice to CMS on or before February 28 of that Performance Year, with an effective date no later than 30 days after the date of that notice, the ACO shall neither be eligible to receive Shared Savings nor liable for Shared Losses for such Performance Year. If the ACO voluntarily terminates this Agreement pursuant to Section XIX.C prior to the end of a Performance Year with an effective date greater than 30 days after February 28 but prior to the end of that Performance Year, the ACO shall not be eligible to receive Shared Savings but shall remain liable for Shared Losses for such Performance Year.
4. Upon termination or expiration of this Agreement, the ACO shall immediately pay all Other Monies Owed to CMS and shall remain liable for any amounts included in a settlement report issued for any Performance Year in accordance with Section XIV.C.5.

### **E. Notifications to Participants, Preferred Providers, and Beneficiaries upon Termination**

1. If this Agreement is terminated under Sections XIX.B or XIX.C, the ACO shall provide written notice of the termination to all Next Generation Participants and Preferred Providers. The ACO shall also post a notice of the termination on its ACO website. The ACO shall deliver such written notice in a manner determined by CMS and no later than 30 days before the effective date of termination unless a later date is specified by CMS. The ACO shall include in such notices any content specified by CMS, including information regarding data destruction and the discontinuation of Benefit Enhancements, as applicable.
2. The ACO may also provide written notice of the termination to Next Generation Beneficiaries. If the ACO elects to send a notice of termination to Next Generation Beneficiaries, the ACO shall deliver such notices in a manner

determined by CMS and no later than 30 days before the effective date of termination unless a later date is specified by CMS. The ACO shall include in such notices any content specified by CMS, including information regarding the discontinuation of Benefit Enhancements and the CCR, as applicable. Any notice to Next Generation Beneficiaries is subject to review and approval by CMS under Section V.E., as “Descriptive ACO Materials and Activities.”

## **XX. Limitation on Review and Dispute Resolution**

### **A. Limitations on Review**

There is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

1. The selection of organizations, sites, or participants to test models selected for testing or expansion under Section 1115A of the Act, including the decision by CMS to terminate this Agreement or to require the termination of any individual’s or entity’s status as a Next Generation Participant or Preferred Provider;
2. The elements, parameters, scope, and duration of such models for testing or dissemination;
3. Determinations regarding budget neutrality under Section 1115A(b)(3);
4. The termination or modification of the design and implementation of a model under Section 1115A(b)(3)(B);
5. Determinations about expansion of the duration and scope of a model under Section 1115A(c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection (c);
6. The selection of quality performance standards by CMS;
7. The assessment of the quality of care furnished by the ACO by CMS;
8. The alignment of Beneficiaries to the ACO by CMS; and
9. A final settlement report issued pursuant to Section XIV.C, including without limitation the determination by CMS of—
  - (a) the Historical Expenditure Baseline;
  - (b) the Performance Year Benchmark;
  - (c) the ACO Performance Year Expenditures;
  - (d) the ACO’s eligibility for Shared Savings or liability for Shared Losses or Other Monies Owed; and
  - (e) the amount of such Shared Savings, Shared Losses, and/or Other Monies Owed.

## B. **Dispute Resolution**

### 1. Right to Reconsideration

The ACO may request reconsideration of a determination made by CMS pursuant to this Agreement only if such reconsideration is not precluded by Section 1115A(d)(2) of the Act or this Agreement.

- (a) Such a request for reconsideration by the ACO must satisfy the following criteria:
  - i. The request must be submitted to a designee of CMS (“**Reconsideration Official**”) who—
    - A. Is authorized to receive such requests; and
    - B. Did not participate in the determination that is the subject of the reconsideration request.
  - ii. The request must contain a detailed, written explanation of the basis for the dispute, including supporting documentation.
  - iii. The request must be made within 30 days of the date of the determination for which reconsideration is being requested via email to CMS at the address specified in Section XXI.A or such other address as may be specified by CMS.
- (b) Requests that do not meet the requirements of Section XX.B.1(a) will be denied by the Reconsideration Official.
- (c) Within 10 business days of receiving a request for reconsideration, the Reconsideration Official will send to the ACO and to CMS a written acknowledgement of receipt of the reconsideration request. Such an acknowledgement will set forth:
  - i. The review procedures; and
  - ii. A schedule that permits each party to submit only one written position paper, including any supporting documentation, for consideration by the Reconsideration Official in support of the party’s position. The submission of any additional papers or supporting documentation will be at the sole discretion of the Reconsideration Official.

### 2. Standards for reconsideration.

- (a) The parties shall proceed diligently with the performance of this Agreement during the course of any dispute arising under the Agreement.
- (b) The reconsideration will consist of a review of documentation that is submitted timely and in accordance with the standards specified by the Reconsideration Official.

- (c) The burden of proof is on the ACO to demonstrate to the Reconsideration Official with clear and convincing evidence that the determination is inconsistent with the terms of the Agreement.

3. Reconsideration determination.

- (a) The reconsideration determination will be based only upon
  - i. Position papers and supporting documentation that are timely submitted to the Reconsideration Official and meet the standards for submission under Section XX.B.1(a); and
  - ii. Documents and data that were timely submitted to CMS in the required format before the agency made the determination that is the subject of the reconsideration request.
- (b) The Reconsideration Official will issue to CMS and to the ACO a written notification of the reconsideration determination. Absent unusual circumstances, such written notification will be issued within 60 days of receipt of timely filed position papers and supporting documentation.
- (c) Effect of the Reconsideration Determination
  - i. The determination of the Reconsideration Official is final and binding.
  - ii. The reconsideration review process under this Agreement shall not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by other Government agencies.

## **XXI. Miscellaneous**

### **A. Agency Notifications and Submission of Reports**

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this Agreement shall be submitted to the parties at the addresses set forth below.

CMS: Next Generation ACO Model  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Mailstop: WB-06-05  
Baltimore, MD 21244  
Email: NextGenerationACOModel@cms.hhs.gov

ACO: V125 Trinity Health ACO, Inc.  
20555 Victor Parkway  
Mailstop W3A  
Livonia, MI 48152  
sheila.johnson@trinity-health.org

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## **B. Notice of Bankruptcy**

In the event the ACO enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the ACO agrees to furnish, by certified mail, written notification of the bankruptcy to CMS. This notification shall be furnished within 5 calendar days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the court in which the bankruptcy petition was filed, and a listing of Government contracts, project agreements, contract officers, and project officers for all Government contracts and project agreements against which final payment has not been made. This obligation remains in effect until the expiration or termination of this Agreement and final payment by the ACO under this Agreement has been made.

## **C. Severability**

In the event that any one or more of the provisions of this Agreement is, for any reason, held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Agreement, and this Agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been included in the Agreement, unless the deletion of such provision or provisions would result in such a material change to the Agreement so as to cause continued participation under the terms of the Agreement to be unreasonable.

## **D. Entire Agreement; Amendment**

This Agreement, including all Appendices, constitutes the entire agreement between the parties. The parties may amend this Agreement or any Appendix hereto at any time by mutual written agreement; provided, however, that CMS may amend this Agreement or any Appendix hereto without the consent of the ACO as specified in this Agreement or Appendix, or for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, accreditation standards or licensing guidelines or rules. To the extent practicable, CMS shall provide the ACO with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

## **E. Survival**

Expiration or termination of this Agreement by any party shall not affect the rights and obligations of the parties accrued prior to the effective date of the expiration or termination of this Agreement, except as provided in this Agreement. The rights and duties under the following sections of this Agreement shall also survive termination of this Agreement and apply thereafter:

1. Section XVIII (Audits and Record Retention);
2. Section VI.B (Data Sharing and Reports);

3. Section VIII.C. (Quality Measure Reporting);
4. Section XVII.C (Compliance and Oversight);
5. Section XVII.E (Certification of Data and Information);
6. Section XV. A (Evaluation Requirement);
7. Section XIV (Payment);
8. Section XIX. D, E (Financial Settlement upon Termination; Notifications to Participants, Preferred Providers, and Beneficiaries upon Termination);
9. Section XXI. B (Notice of Bankruptcy);
10. Section XXI.H (Prohibition on Assignment);
11. Section XXI.I (Change in Control); and
12. Appendix B (Next Generation ACO Alignment and Financial Reconciliation).

Provisions of this Agreement that survive the expiration or termination of this Agreement, as specified in this Section XXI.E may be amended after the effective date of the expiration or termination of this Agreement with the mutual consent of the parties as necessary to achieve the purpose of the Next Generation ACO Model.

#### **F. Precedence**

If any provision of this Agreement conflicts with a provision of any document incorporated herein by reference, the provision of this Agreement shall prevail.

#### **G. Change of ACO Name**

If the ACO changes its name, the ACO shall forward to CMS a copy of the document effecting the name change, authenticated by the appropriate state official, and the parties shall execute an agreement reflecting the change of the ACO's name.

#### **H. Prohibition on Assignment**

Except with the prior written consent of CMS, the ACO shall not transfer, including by merger (whether the ACO is the surviving or disappearing entity), consolidation, dissolution, or otherwise: (1) any discretion granted it under this Agreement; (2) any right that it has to satisfy a condition under this Agreement; (3) any remedy that it has under this Agreement; or (4) any obligation imposed on it under this Agreement. The ACO shall provide CMS 90 days advance written notice of any such proposed transfer. This obligation remains in effect until the expiration or termination of this Agreement and final payment by the ACO under this Agreement has been made. CMS may condition its consent to such transfer on full or partial reconciliation of Shared Losses and Other Monies Owed. Any purported transfer in violation of this Section is voidable at the discretion of CMS.

#### **I. Change in Control**



CMS may terminate this Agreement or require immediate reconciliation and payment of Shared Losses and Other Monies Owed if the ACO undergoes a Change in Control. For purposes of this paragraph, a “Change in Control” shall mean: (1) the acquisition by any “person” (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Securities Exchange Act of 1934), directly or indirectly, of voting securities of the ACO representing more than 50% of the ACO’s outstanding voting securities or rights to acquire such securities; (2) upon any sale, lease, exchange or other transfer (in one transaction or a series of transactions) of all or substantially all of the assets of the ACO; or (3) a plan of liquidation of the ACO or an agreement for the sale or liquidation of the ACO is approved and completed. The ACO shall provide CMS 90 days advance written notice of a Change in Control. This obligation remains in effect until the expiration or termination of this Agreement and final payment by the ACO under this Agreement has been made.

**J. Certification**

The ACO executive signing this Agreement certifies to the best of his or her knowledge, information, and belief that the information submitted to CMS and contained in this Agreement (inclusive of Appendices), is accurate, complete, and truthful, and that he or she is authorized by the ACO to execute this Agreement and to legally bind the ACO on whose behalf he or she is executing this Agreement to its terms and conditions.

**K. Execution in Counterpart**

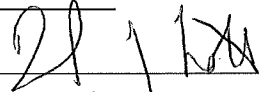
This Agreement and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a “.pdf” format data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or “.pdf” signature page were an original thereof.

[SIGNATURE PAGE FOLLOWS]

Each party is signing this Agreement on the date stated opposite that party's signature. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed this Agreement.

ACO: V125 - Trinity Health ACO

Date: 12/22/2017

By: 

Daniel J. Roth, MD  
Name of authorized signatory

Executive Vice President and Chief Clinical Officer  
Title

CMS:

Date: \_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_  
Name of authorized signatory

\_\_\_\_\_  
Title

Appendices

- A. Non-Duplication Waiver and Participant Exclusivity
- B. Next Generation ACO Alignment and Financial Reconciliation
- C. Voluntary Alignment
- D. HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet
- E. [RESERVED]
- F. Quality Measures
- G. Alternative Payment Mechanism - Infrastructure Payments
- H. Alternative Payment Mechanism - Population-Based Payment
- I. Benefit Enhancement - 3-Day SNF Rule Waiver
- J. Benefit Enhancement - Telehealth Expansion
- K. Benefit Enhancement - Post-Discharge Home Visits
- L. Financial Guarantees - Requirements and Guidance
- M. ACO Proprietary Information
- N. Alternative Payment Mechanism - All-Inclusive Population-Based Payment

## **Next Generation ACO Model**

### **Appendix A**

#### **Non-Duplication Waiver and Participant Overlap**

##### **I. Waiver**

In order to support the ACO's ability to enter into agreements with Medicare-enrolled providers and suppliers to participate as Preferred Providers, and thus enable the ACO to better care for its Next Generation Beneficiaries in an environment where increasing numbers of providers and suppliers are participating in ACOs under the Medicare Shared Savings Program and in other Medicare shared savings initiatives, CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and 42 CFR § 425.114(a) as they apply to Preferred Providers, subject to the requirements set forth in this Appendix A.

##### **II. ACO Overlap**

- A. The ACO may not simultaneously participate in any other Medicare shared savings initiatives (e.g., MSSP, Pioneer ACO Model, Comprehensive ESRD Care (CEC) Initiative).
- B. 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.

##### **III. Next Generation Participant and Preferred Provider Overlap**

- A. Pursuant to section 1899(b)(4)(A) of the Act, 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.
- B. A Next Generation Professional who is a primary care specialist as defined in Appendix B of this Agreement may not: (a) be identified as a Next Generation Participant by a different accountable care organization in this Model; (b) be an ACO participant, ACO provider/supplier or ACO professional in the MSSP; or (c) participate in another Medicare shared savings initiative, except as expressly permitted by CMS.
- C. A Next Generation Participant who is a non-primary care specialist as defined in Appendix B of this Agreement may be a Next Generation Participant in another accountable care organization in this Model, a Pioneer Provider/Supplier in the Pioneer ACO Model, or serve in an equivalent role in any other shared savings initiative in which such non-primary care specialists are not required to be exclusive to one participating entity.

D. A Preferred Provider may serve in the following roles provided all other applicable requirements are met:

1. Preferred Provider for one or more other accountable care organizations participating in this Model;
2. Subject to Section III.B of this Appendix, Next Generation Participant in one or more other accountable care organizations participating in this Model;
3. Pursuant to the waiver in Section I of this Appendix, an ACO participant, ACO provider/supplier and/or ACO professional in an accountable care organization in the MSSP; and/or
4. Role similar in function to a Next Generation Participant in another shared savings initiative.

## **Next Generation ACO Model Participation Agreement**

### **Appendix B**

#### **Next Generation ACO Alignment and Financial Reconciliation**

The document, “Next Generation ACO Model Benchmarking Methods Performance Years 1 through 3,” prepared by RTI International following this Appendix B cover sheet represents Appendix B “Next Generation ACO Alignment and Financial Reconciliation” in its entirety for Performance Year 2018 and subsequent Performance Years. The Next Generation ACO Alignment and Financial Reconciliation for Performance Year 2016 and Performance Year 2017 are governed by Appendix B of the Next Generation ACO Model Participation Agreement executed in December 2015, as amended during calendar year 2017, as if such appendix were included in this Second Amended and Restated Participation Agreement for 2016 Starters.

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# Next Generation ACO Model Benchmarking Methods Performance Years 1 through 3

December 8, 2017

Revision: 1.02.03

Document Number: RTI.NGACO.BNCH.1.02.03

Contact Number: HHSM-500-2014-0037I/HHSM-500-T0001

**Prepared for:**

Centers for Medicare & Medicaid Services (CMS)  
Center for Medicare & Medicaid Innovation  
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**Prepared by:**

RTI International

## Revision History

Revision	Date	Revisions
1.00	November 17, 2015	Final post-OGC review version
1.00.01	November 19, 2015	Revised §3.7.5 Revision to §5.3 Revision to §8.1
1.00.02	November 19, 2015	Revision to §3.7.1 Revision to §3.7.5 Revision to §3.7.9
1.00.03	December 14, 2015	Non-substantive copy editing corrections to §§2.0, 2.2, 2.4, 2.4.1, 2.4.2, 3.3, 3.4, 3.7.5, 4.0, 5.2, 5.3, 6.1, 6.2, 6.3, 6.4, 7.0, 7.1.1, 7.1.2, 7.2, 7.3, 8.0, 8.1, A.1, A.2.6, A.2.7, A.5. Deleted footnote in §5.4.1.
1.02.01	October 1, 2016	Addition of §3.7.6 Revision of §§2.4, 2.7, 3.9, 7.0, 7.1, 8.1, A.2.4, A.2.6, A.4, A.6
1.02.02	October 13, 2017	Addition of §§3.8.1, 3.8.2 Revision of §§2.4, 3.8, 5.1, 7.1.1, 7.1.2 Reservation of Appendix B, Appendix C, Appendix D
1.02.03	December 8, 2017	Addition of §§ 6.3.1, 6.3.2 Revision of §§2.3, 2.7, 6.1, 6.2, 6.3, 6.4

Reference documents

Document	Date	Title
	00/00/0000	



**Acronyms**

ACO	Accountable Care Organization
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
NGACO	Next Generation ACO

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## 1.0 Introduction

Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program (MSSP), the Next Generation ACO (NGACO) Model offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care. The purpose of the NGACO Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries.

The Model offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using 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 offers a choice of two risk arrangements that determine the portion of the savings or losses that accrue to the ACO. The risk arrangement applies to the difference between actual expenditures and the prospective benchmark.

This document describes the NGACO Model's benchmarking methodology. Section 2 is an overview of the methodology, and Section 3 provides definitions of key concepts. Each of the major components of the methodology is then described in greater detail in Sections 4 to 10.

## 2.0 Overview of the Next Generation ACO Model Benchmark

This Section provides an overview of the Performance Year Benchmark (or, for purposes of this methodology paper, "Benchmark"). This prospective benchmark is a core feature of the NGACO Model. The Performance Year Benchmark used in the NGACO Model is prospective because the trend that is used to project the ACO's baseline expenditure is set prior to the start of the Performance Year.<sup>1</sup>

The Performance Year Benchmark will be set initially using the expenditure, risk score, and quality data that are available at the time the Performance-Year trended baseline is calculated. The Benchmark will be updated at the time of financial reconciliation using the average Performance-Year risk scores of Next Generation Beneficiaries aligned to the NGACO for the Performance-Year and the quality score for the Performance-Year. Neither the baseline expenditure data nor the projected regional trend will be updated after the calculation of the Benchmark, except as allowed under the terms of the Participation Agreement between the NGACO and CMS.

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<sup>1</sup> The Next Generation ACO benchmark is prospective in the same way that a Medicare Advantage plan's negotiated rate is prospective. The base payment rate of a Medicare Advantage plan is determined through the prospective bidding process. However, the PBPM payment that the Medicare Advantage plan receives depends on the risk scores of enrolled beneficiaries, and the number of months that are paid under the Aged/Disabled and ESRD payment rates, neither of which is known definitively until after the end of the fiscal year. For example, the CY2016 revenue under the negotiated rates will not be known until mid-2017 when the final risk-score data for CY2016 enrollees is available.

In the first three Performance Years (calendar years 2016-2018), the Performance Year Benchmark will be calculated in four steps:

1. Step 1: Calculate the NGACO baseline expenditure for the entitlement category;
2. Step 2: Calculate the trended baseline by applying a projected regional trend component;
3. Step 3: Calculate the risk-adjusted trended baseline by applying a risk adjustment factor reflecting the difference between the average risk of the base-year aligned beneficiaries and the average risk of the performance-year aligned beneficiaries; and,
4. Step 4: Calculate the Benchmark by applying a quality- and efficiency-adjusted discount to the risk-adjusted trended baseline.

This document describes the NGACO benchmarking methodology. Section 2 is an overview of the methodology, section 3 defines key terms, and sections 4 through 10 describe in greater detail the calculation of the NGACO baseline, the trended baseline, risk adjustment, and the adjustments to the baseline that are made to arrive at the Benchmark.

### 2.1 NGACO baseline expenditure

The NGACO baseline expenditure is the expenditure incurred in a single baseline year (CY2014) by base-year (CY2014) aligned beneficiaries. The baseline expenditure will be calculated prior to the start of each performance year. CY2014 is the baseline year for the first three performance years. The baseline expenditure will be updated each year to reflect the ACO's Participant List for the given Performance Year.<sup>2</sup>

### 2.2 Projected regional trend

The NGACO baseline expenditure will be trended to each Performance Year. The expenditure Benchmark will incorporate a projected regional trend, which will be:

1. A national projected expenditure trend;
2. Adjusted to reflect the impact of Performance-Year Medicare geographic pricing factors on base-year expenditures.

The national projected trend will be developed using a method similar to that used by the Medicare Office of the Actuary to develop the Medicare Advantage county rate book. Under limited circumstances, CMS would adjust the projected trend in response to unforeseeable events such as legislative actions that have a substantial impact on Medicare FFS expenditures.

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<sup>2</sup> If the NGACO's Participant List is the same in all three Performance-Years, the NGACO baseline will be the same in all three Performance-Years. If an NGACO modifies its Participant List, the NGACO baseline expenditure will change because a different set of beneficiaries will be aligned in the base-year (CY2014).

## 2.3 Risk adjustment

To calculate the Performance Year Benchmark, the trended baseline expenditure will be risk adjusted to account for the difference in the risk (or expected cost) of the beneficiaries aligned with the NGACO in the base year and the Next Generation Beneficiaries aligned with the NGACO in the Performance Year.

This adjustment will be based on the difference in the average Medicare Hierarchical Condition Categories (HCC) risk scores of the base-year and Performance-Year aligned beneficiaries. The HCC risk score (using both demographic and diagnostic components) will be used for all aligned beneficiaries.

The risk adjustment applied to an ACO's trended baseline expenditure for those ACOs subject to re-normalization (described in section 6.2 of this Appendix B) will be limited to a maximum of  $\pm 3\%$  in HCC risk score growth relative to the base year. For the risk adjustment applied to an ACO's trended baseline expenditure for those ACOs subject to a coding factor adjustment (described in section 6.3 of this Appendix B), the downward adjustment will be limited to the ACO's base year HCC risk score (i.e., a floor of 0% in downward growth in Performance Year HCC risk score relative to the base year HCC risk score) and the upward adjustment will be limited to a maximum of 3% (i.e., a cap of 3% in upward growth in Performance Year HCC risk score relative to the base year HCC risk score). Financial settlement will be based on the Performance-Year risk scores of the Next Generation Beneficiaries aligned to the ACO during the Performance Year.<sup>3</sup>

## 2.4 Efficiency- and quality-adjusted discount

The Performance Year Benchmark will be calculated by applying to the risk-adjusted trended baseline an efficiency- and quality-adjusted discount that will range from 0.0% to 3.75%. The adjusted discount is:

1. A standard discount of 2.25%.
2. MINUS: A regional efficiency adjustment of  $\pm 1.0\%$
3. MINUS: A national efficiency adjustment of  $\pm 0.5\%$
4. MINUS: A quality adjustment to the standard discount of up to  $+1.0\%$

The minimum adjusted discount is, therefore, 0.0% and the maximum is 3.75% as shown in section 7.0.

### 2.4.1 Quality adjustment to the standard discount

The standard discount will be reduced by up to 1% depending on the quality score attained by the NGACO in the Performance-Year. The quality adjustment to the standard discount in PY1/CY2016 for an NGACO whose agreement is effective January 1, 2016, will be 100% if the NGACO submits all data required to calculate a quality score in PY1 as described in the Participation Agreement. The quality

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<sup>3</sup> CMMI will endeavor to make use of preliminary or mid-year risk scores for the Performance-Year aligned beneficiaries, when they become available, in quarterly financial reports.

adjustment to the standard discount in PY2/CY2017 for an NGACO whose agreement is effective January 1, 2017, will be 100% if the NGACO submits all data required to calculate a quality score in PY2.

The Performance-Year quality score for an ACO that does not report all data required to calculate the Performance-Year quality score or that does not otherwise satisfy quality scoring standards will be zero (0.00%). An ACO that has a quality score of zero will not be eligible to receive any savings bonus, but will be required to repay losses.

### 2.4.2 Efficiency adjustments to standard discount

The standard discount will be decreased or increased based on an ACO's efficiency in the base-year relative to its region and to the nation as a whole.

1. The regional efficiency adjustment to the standard discount will be  $\pm 1\%$ .
2. The national efficiency adjustment to the standard discount will be  $\pm 0.5\%$ .

The efficiency adjustments will be set prospectively on the basis of base-year (CY2014) experience.

## 2.7 Illustrative Example of Benchmark Calculation

Table 2.7 illustrates the benchmark calculation.

**Table 2.7. Calculation of Performance Year Benchmark for Aged/Disabled beneficiaries**

	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 national trend:	3.00%	
CY2016 GAF trend adjustment	0.45%	
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	2.25%	<b>2.25%</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>1.08%</b>
<b>LESS: NGACO discount<sup>4</sup></b>		<b>\$9.89</b>
<b>Benchmark<sup>5</sup></b>		<b>\$906.08</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 the applicable minimum/maximum HCC risk score growth for a given Performance Year). 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 x \$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).

### 3.0 Definitions

This section defines certain terms that are used throughout this document unless otherwise noted.

#### 3.1 Base and performance years

Performance Year 1 (PY1) is calendar year 2016 (CY2016).

Performance Year 2 (PY2) is calendar year 2017 (CY2017).

Performance Year 3 (PY3) is calendar year 2018 (CY2018).

The base year (BY) for the first three performance years is calendar year 2014 (CY2014).

#### 3.2 Entitlement categories

NGACO baseline and benchmark calculations are performed separately for:

1. Aged and Disabled (A/D) aligned beneficiaries (aligned beneficiaries eligible for Medicare by age or disability) who do not have End Stage Renal Disease (ESRD).
2. End stage renal disease (ESRD) aligned beneficiaries (aligned beneficiaries eligible for Medicare by ESRD).<sup>4</sup>

Each month of experience accrued during a year by an aligned beneficiary will be attributed to either the A/D or ESRD entitlement category.

#### 3.3 NGACO region

The ACO's region consists of all counties in which its base-year aligned beneficiaries reside. The ACO region is used in two components of the benchmark calculation:

1. The calculation of the regional trend; and,
2. The calculation of the regional efficiency adjustment to the standard discount.

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<sup>4</sup> ESRD status in a month is determined based on Medicare enrollment/eligibility files not dialysis claims. A beneficiary's experience accrues to the ESRD entitlement category if, during a month, the beneficiary was receiving maintenance dialysis for kidney failure or was in the 3-month period starting in the month when a kidney transplant was performed.

For these components of the benchmark calculation, a person-month weighted average of county-specific values (i.e., the regional trend and the standardized regional baseline expenditure) will be calculated.

### 3.4 Alignment-eligible beneficiaries

A beneficiary is alignment-eligible during the base- or Performance-Year if the beneficiary:

1. Is 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;
2. Has no months of coverage under only Part A;
3. Has no months of coverage under only Part B;
4. Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
5. Has no months in which Medicare was the secondary payer; and,
6. Was a resident of the United States.

Alignment is performed prior to the start of the Performance-Year, and alignment-eligibility will be determined on a quarterly basis throughout the Performance-Year.

Note that 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.

### 3.5 Aligned beneficiaries

Prior to the start of the Performance Year, the Next Generation Beneficiaries for the Performance Year will be identified using the Participant List for that Performance Year.<sup>5</sup> The same methods and Participant List will be used to identify two panels of aligned beneficiaries:

1. Those beneficiaries aligned with the NGACO in the base-year; and,
2. Those beneficiaries aligned with the NGACO in the Performance -Year.

To be included in the financial settlement, beneficiaries must be alignment-eligible during the Performance Year. A beneficiary who is not alignment-eligible in one or more months of the Performance-Year will be excluded from the aligned population of the ACO retroactive to the start of the Performance-Year.

Prior to financial settlement, Next Generation Beneficiaries will also be excluded 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.

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<sup>5</sup> Alignment methods are described in Appendix A.

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.

The same requirements apply to the base year. However, all alignment-eligibility requirements can be applied to beneficiaries aligned in the base-year at the time alignment is performed.

### 3.6 Reference beneficiaries

The reference beneficiaries, or population, for the base-year or Performance-Year will consist of all beneficiaries who are alignment-eligible in the base-year or Performance-Year.

### 3.7 Expenditure

Subject to the exceptions discussed below, the expenditure incurred by an alignment-eligible beneficiary, for purposes of financial calculations for any Performance Year or baseline period, is the sum of all Medicare payments on claims for services covered by Part A or Part B of Medicare. All services covered by Part A or Part B are used in financial calculations, including, but not limited to:

1. Inpatient claims;
2. Skilled Nursing Facility (SNF) claims;
3. Home Health Agency (HHA) claims;
4. Hospice claims.
5. Physician claims:
6. Outpatient claims; and,
7. Durable Medical Equipment (DME) claims.

The expenditure used in financial calculations is the total amount paid to providers on claims:

1. For services covered by Medicare Parts A and B;
2. That are incurred during the base- or Performance-Year; and
3. That are paid within 3 months of the close of the base- or Performance-Year.

The incurred date for a claim is determined by the date of service. The date of service is the "through date" of the period covered by the claim. In the case of claims for inpatient, outpatient, SNF, HHA and hospice claims, the "date of service" is the through date on the Part A claim header record. In the case of hospital physician, and DME claims, the date of service is the through date on the line item claim record.

The paid date for a claim is the effective date of the claim in conjunction with the date the claim is loaded into the Integrated Data Repository (IDR).

#### 3.7.1 Exclusion of certain provider payments

Medicare inpatient pass-through payment amounts (estimates) for inpatient services are excluded from expenditures.

Direct Graduate Medical Education, PQRS, eRx, and EHR incentive payments for eligible professionals, and EHR incentive payments to hospitals that are not reflected in provider payments under the FFS payment systems are excluded from expenditure calculations.

Uncompensated Care (UCC) payments are excluded from the baseline and performance-year expenditure of beneficiaries.

### **3.7.2 Indirect Medicare Education and Disproportionate Share Hospital payments**

Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments are included in calculation of the baseline and Performance-Year expenditure, but are excluded from the expenditure used in the calculation of the regional and national efficiency adjustments.<sup>6</sup>

### **3.7.3 Budget sequestration**

All financial calculations will be based on the amount of payment that would have been made to providers if sequestration had not been required (i.e., on a pre-sequestration basis).

### **3.7.4 Effect of Population-based Payment (PBP)**

Under the NGACO Model, an ACO can elect to participate in Population-Based Payments, under which certain Next Generation Participants may agree to receive Population Based Payment Fee Reductions, which will reduce their FFS payment reimbursements from CMS. These reductions in FFS payments will not be included in the calculation of the base-year or Performance-Year expenditure of the ACO (i.e., the baseline and Performance-Year expenditure will be the amount that would have been paid to the Next Generation Participant if the Population-Based Payment Fee Reductions had not been made).

### **3.7.5 Adjustment for performance-based provider payment incentives**

By November 2016, CMS will determine whether and how to adjust the NGACO Benchmark and Performance-Year expenditure so that performance-based provider payment incentives (including but not limited to value-based purchasing, physician payment value modifiers, PQRS, and incentives to promote meaningful use of electronic health records) do not under- or over-state savings or losses.

If determined to be necessary, the NGACO Benchmark and Performance-Year expenditure will be adjusted not earlier than Performance-Year 2 (CY2017), and quarterly financial reporting will identify these adjustments.

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<sup>6</sup> IME and DSH payments are excluded from the expenditure used to calculate the efficiency ratios because they are unrelated to an ACO's efficiency.

### **3.7.6. Bundled Payments for Care Improvement Initiative**

When determining the expenditures incurred by NGACO-aligned beneficiaries for purposes of financial reconciliation for a performance year, CMS will exclude Bundled Payments for Care Improvement (BPCI) initiative Net Payment Reconciliation Amounts only in those cases where including these BPCI Net Payment Reconciliation Amounts would be the sole reason that an ACO would incur shared losses or not qualify to receive shared savings. Consistent with Section 3.9 of this Appendix, in all other cases, the BPCI Net Reconciliation Amounts will be included in the determination of expenditures incurred by NGACO-aligned beneficiaries.

## **3.8 Expenditure cap selection**

Beginning for PY2/CY2017, NGACOs will have the option to select capped expenditures, as described in Section 3.8.1 of this Appendix, or uncapped expenditures, as described in Section 3.8.2 of this Appendix, pursuant to Section X.A.6 of this Agreement. An ACO's expenditure cap selection (capped expenditures or uncapped expenditures) for a Performance Year will apply to the calculations specified in Section 3.8.2 of this Appendix.

### **3.8.1 Capped expenditures**

If applicable, the capped expenditures for a base-year or Performance-Year, as applicable, that accrues to an entitlement category by the beneficiary is the lesser of:

1. The actual expenditure accrued to the entitlement category by the beneficiary during the year; and,
2. The expenditure cap that applies to the beneficiary for that entitlement category for that year.

The expenditure cap is based on the experience accrued by the beneficiary to the entitlement category. It is equal to the product of:

1. The PBPM cap on expenditures for the entitlement category for that year;
2. The number of months that the beneficiary accrued to the entitlement category during the base-year or Performance-Year, in which the ACO's expenditure cap selection is capped expenditures.

The PBPM cap on expenditures for a given entitlement category is the 99th percentile of the expenditure PBPM amount incurred by all alignment-eligible beneficiaries who accrue experience to the entitlement category during the year. Expenditure caps are based on national experience.

When required by a calculation (e.g., for a capped baseline or an efficiency ratio), the capped expenditure incurred by a beneficiary is determined separately by entitlement category based on the expenditures incurred by a beneficiary during months in which the beneficiary contributed experience to an entitlement category.

### **3.8.2 Uncapped expenditures**

If applicable, the uncapped expenditures for a base-year or Performance Year that accrues to the entitlement category by the beneficiary is the total Medicare Part A and Part B expenditures accrued to the entitlement category by the beneficiary during such base-year or Performance Year, as applicable. These uncapped expenditures will be used to calculate both the baseline expenditures and the Performance Year expenditures in a Performance Year in which the ACO's expenditure cap selection is uncapped expenditures.

All other calculations that require use of expenditures will be on a capped basis using the methods described in 3.8.1 (e.g., efficiency ratio calculation).

### **3.9 Provider payments made outside of standard claims systems**

Subject to Section 3.7.6 of this Appendix, payments and adjustments to payments for services provided to identifiable beneficiaries that are made outside the standard Part A and Part B claims systems will also be included in calculation of the ACO and reference baseline and performance-period expenditures.

### **3.10 Quality Measures**

Quality measures and performance standards in the NGACO Model will be aligned with those in MSSP and other CMS quality measurement efforts. For each Performance Year, the Model will generally follow quality domains, measures, benchmarking methodology, sampling, and scoring as reflected in the most recent final regulations for MSSP and the Physician Fee Schedule. Appendix F describes quality measurement for the NGACO Model.

## **4.0 NGACO benchmark for each entitlement category**

Separate benchmarks will be calculated for each entitlement category. The Benchmark for an entitlement category is calculated in four steps:

1. Step 1: Calculate the NGACO baseline expenditure for the entitlement category;
2. Step 2: Calculate the trended baseline by applying a projected regional trend component;
3. Step 3: Calculate the risk-adjusted trended baseline by apply a risk adjustment factor reflecting the difference between the average risk of the base-year aligned beneficiaries and the average risk of the performance-year aligned beneficiaries; and,
4. Step 4: Calculate the Benchmark by applying a quality- and efficiency-adjusted discount.

The baseline expenditure and projected regional trend are discussed in section 5. Risk adjustment is discussed in section 6. The calculation of the quality- and efficiency-adjusted discount is discussed in section 7. The use of the Benchmark in financial settlement is discussed in section 8.

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**5.0 Trended baseline**

The trended baseline for an entitlement category will be set prospectively on the basis of the NGACO's baseline expenditure for the entitlement category and a projected regional trend.

For a given Performance Year, the trended baseline for each entitlement category is the product of the NGACO baseline expenditure and the regional trend.

**5.1 NGACO baseline expenditure**

The baseline expenditure PBPM for an entitlement category is the total capped expenditures or uncapped expenditures, as selected by the ACO, accrued to the entitlement category by all base-year aligned beneficiaries divided by the total months accrued to the entitlement category by those beneficiaries.

**5.2 Projected regional trend**

A projected regional trend will be calculated for each entitlement category. It will be the product of:

1. A National projected FFS trend (expenditure percentage growth rate) for the entitlement category similar to that currently used by the Medicare Office of the Actuary (OACT) in its calculation of the Medicare Advantage county ratebook; and,
2. A regional GAF trend-adjustment that accounts for the impact of the performance-year Medicare geographic price factors on baseline expenditure.

The projected regional trend will be set prior to the start of the Performance Year and will be applied to final settlement without retrospective adjustments to account for the difference between projected and actual trend. Under limited circumstances, CMS may adjust the projected trend in response to unforeseeable events such as legislative actions that have a substantial impact on Medicare FFS expenditures.

**5.3 Projected national FFS trend**

The projected national FFS expenditure trend (percentage growth rate) will be determined using assumptions and methods similar to those used by the Medicare Office of the Actuary (OACT) to calculate the Medicare Advantage (MA) county ratebook. OACT calculates a projected FFS United States Per Capita Cost (USPCC), which is used in the calculation of the ratebook.<sup>7</sup> Adjustments to the projected

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<sup>7</sup> The methodology used by OACT to project the FFS spending is described in the Annual Report of the Trustees of the Federal Hospital insurance and Federal Supplementary Medical Insurance Trust Funds: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>. The projected FFS USPCC is used by OACT in the calculation of the Medicare Advantage county ratebook. The projected FFS USPCC for 2016 was published in the

FFS USPCC may be made to take into account differences in the expenditure trend of the FFS population as a whole, and the subset of FFS beneficiaries eligible to be aligned to ACOs (see Section 3.5). The beneficiaries eligible for alignment to an NGACO (i.e., NGACO reference beneficiaries) are the vast majority of FFS beneficiaries.

For each Performance Year the projected trend will be the projected percentage difference between the base year (CY2014) and:

1. In PY1: CY2016
2. In PY2: CY2017
3. In PY3: CY2018

The prospective projected trend will be set in the quarter prior to the start of the performance-year using OACT's most recent projection of FFS spending for the performance year. For example, in Performance Year 1 (2016), the trend is from 2014 through 2016, and will be set during the last quarter of 2015.

#### 5.4 GAF trend adjustment

Medicare FFS payments under most Medicare payment systems are adjusted to reflect the cost-of-doing-business in the local geographic area in which the provider operates. Examples of these Geographic Adjustment Factors (GAFs) are the Medicare area wage index (AWI) and the geographic practice cost index (GPCI). These local geographic price adjustments are updated annually.

The purpose of the GAF trend adjustment in the NGACO Model is to prevent the benchmark from being unfairly understated (or overstated) because of differences between the GAFs that Medicare used to calculate provider payments in the base-year (CY2014) and the performance-year.

Separate GAF trend-adjustments will be calculated for the Aged/Disabled and ESRD populations.

##### 5.4.1 Calculation of GAF trend adjustment factors

The GAF trend adjustment factor for a county is an estimate of the impact on base-year provider payments for services provided to reference beneficiaries residing in the county of the difference between the base-year Medicare GAFs and the performance year Medicare GAFs.

The GAF trend-adjustment factor for a county will be the ratio of:

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Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter published April 6: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>.



1. The county PBPM expenditure calculated after adjusting base year claims to reflect the impact on provider payments of the geographic pricing factors that Medicare will use in the performance year; to,
2. The actual incurred county PBPM expenditure (reflecting the geographic pricing factors that Medicare used to calculate provider payments in the base year).

The GAF-trend adjustment factor will be calculated prospectively for alignment-eligible beneficiaries in each county in the base year and will have no impact on the national FFS trend.

The GAF trend-adjustment factor for an ACO will be the person-month weighted average of county GAF-trend adjustment factors, where the weights are the ACO aligned beneficiary person months residing in each county.

#### 5.4.2 GAF trend-adjusted baseline claims

To calculate the GAF trend adjustment, baseline claims will be adjusted to reflect the impact of Performance-Year GAFs on baseline expenditures. Baseline claims will be adjusted using appropriately weighted performance year geographic pricing factors. For example:

- The geographic price adjustment under the Inpatient Prospective Payment System (IPPS), the Area Wage Index (AWI), is weighted by the proportion of cost that is attributable to labor.
- Under the Physician Fee Schedule, the three Geographic Practice Cost Indexes (GPCIs) are weighted by the corresponding relative value units.

Adjusted payment amounts using Performance-Year geographic pricing factors will be calculated for each the following types of claims:

1. Inpatient claims paid under Prospective Payment Systems.
2. Outpatient claims paid under the Hospital Outpatient Prospective Payment System (HOPPS).
3. Skilled Nursing Facility claims paid under the SNF Prospective Payment System.
4. Home Health claims paid under the HHA Prospective Payment System.
5. Hospice claims.
6. Physician claims paid under the Physician Fee Schedule.
7. Claims paid under the Renal Dialysis Prospective Payment System.

For all other claims, the adjusted payment amount will be equal to the amount actually paid.

## 6.0 Risk Adjustment of Trended Baseline

The trended baseline (see Section 5) will be risk adjusted to account for the difference between:

1. The average health status of the ACO's base-year aligned beneficiaries; and,
2. The average health status of Next Generation Beneficiaries aligned in the Performance Year.

This difference in risk will be measured using Centers for Medicare & Medicaid Services Hierarchical Condition Categories risk scores (HCC risk scores).

## 6.1 Risk scores

HCC risk scores are used to more accurately measure the expected expenditure for a beneficiary during the Performance Year based on the clinical conditions for which the beneficiary was treated in the prior year. CMS maintains prospective HCC risk models for the Medicare Advantage (MA) program. HCC risk models are prospective in the sense that diagnoses obtained from claims in the prior year are used to predict expenditure in the current year. For example, HCC risk models use diagnoses from claims for services provided in CY2013 to calculate the CY2014 HCC risk score, which represents the beneficiary's expected CY2014 expenditures. HCC risk scores are calculated for all Medicare beneficiaries, including Medicare FFS beneficiaries.

Beginning in 2017, eighteen separate HCC risk models are used by CMS for the MA program to predict the cost of different Medicare beneficiary subpopulations including:

<b>Distinct HCC</b>	<b>Benchmark</b>
Community – Aged – Full Benefit Dual	A&D
Community – Aged – Partial Benefit Dual	A&D
Community – Aged – Not Dual	A&D
Community – Disabled – Full Benefit Dual	A&D
Community – Disabled – Partial Benefit Dual	A&D
Community – Disabled – Not Dual	A&D
Institutional	A&D
New Enrollee	A&D
Dialysis	ESRD
Dialysis – New Enrollee	ESRD
Post-Graft (Transplant) – Month 1	ESRD
Post-Graft –Months 2 & 3	ESRD
Post-Graft – Months 4 – 9 – Community	A&D
Post-Graft – Months 10+ – Community	A&D
Post-Graft – Months 4 – 9 – Institutional	A&D
Post-Graft –Months 10+ – Institutional	A&D
Post-Graft – Months 4 – 9 – New Enrollee	A&D
Post-Graft –Months 10+ – New Enrollee	A&D

One or more of the HCC risk scores calculated using these HCC risk models may be applicable to a beneficiary during a given calendar year. For example, a beneficiary who has been living in the community may become a resident of a long-term care institution during the year. The HCC risk score from the applicable community-residing HCC risk model will be used for months in which the beneficiary was living in the community, while the applicable long-term institutional HCC risk model will be used to

calculate the HCC risk score for months in which the beneficiary is a long-term resident of a nursing facility.

For Performance Year 2016, the NGACO Model used a different set of HCC risk models for the base year as compared to the Performance Year to calculate the HCC risk scores for each such year. Specifically, the NGACO Model used the set of HCC risk models used for MA Plan payment for CY2014 for the base year and the set of HCC risk models used for MA Plan payment for CY2016 for the Performance Year. For Performance Years 2017 and 2018, the set of HCC risk models for 2017 will be used to calculate both the base year and the Performance Year HCC risk scores. For purposes of these calculations, CMS will use the methodology and weighting from the HCC risk score models, but will remove the MA-specific payment factors used for plan payment.

## 6.2 “Re-normalization” of Risk Scores

For Performance Year 2016 and Performance Year 2017 (if the NGACO is not subject to risk adjustment using the coding factor adjustment described in section 6.3 of this Appendix B for Performance Year 2017), risk adjustment will use re-normalized HCC risk scores used for purposes of MA Plan payment. Specifically, HCC risk scores will be re-normalized to the average HCC risk score for all reference beneficiaries in an entitlement category (i.e., A/D or ESRD) for each base year and for each Performance Year. As a result, for each base year and each Performance Year, the average re-normalized HCC risk score for an entitlement category for all reference beneficiaries will have a value of one (1.000). The re-normalized HCC risk score for an ACO for the base year or Performance Year will be the average HCC risk score for an entitlement category divided by the average HCC risk score of all reference beneficiaries who contribute experience to the entitlement category during the base year or Performance-Year.

The re-normalized risk score is calculated on a person-month weighted basis. An ACO’s re-normalized risk score measures the extent to which the beneficiaries aligned with the ACO who contribute experience to an entitlement category have a higher or lower expected cost in a base year or a Performance-Year relative to the average beneficiary contributing experience to that entitlement category in that year.

Using Aged/Disabled beneficiaries as an example,

1. If the average risk score of the BY/CY2014 Next Generation Beneficiaries for a given NGACO is 1.052; and,
2. The average risk score of all BY/CY2014 reference beneficiaries is 1.038;
3. Then the re-normalized risk score of the Next Generation Beneficiaries is 1.013 ( $= 1.052 \div 1.038$ ).

The re-normalized risk score can be interpreted as an estimate of the amount by which the expected cost of NGACO’s aligned Aged/Disabled beneficiaries in a given entitlement category differs from the expected cost of all NGACO alignment-eligible beneficiaries in that entitlement category. In the above example, the expected cost of the NGACO’s Next Generation Beneficiaries is 1.3% higher than the expected cost of all NGACO alignment-eligible (reference) beneficiaries.

For Performance Year 2 (CY2017), NGACOs will have the option to select risk-adjustment based on either the re-normalization of risk scores described in this section 6.2 or the coding factor adjustment described in section 6.3 of this Appendix B. All risk adjustment will be conducted using the coding factor adjustment described in section 6.3 of this Appendix B beginning in Performance Year 3 (CY2018).

The minimum re-normalized HCC risk score for a Performance Year is equal to 97% of the ACO's base year re-normalized HCC risk score. This imposes a floor of -3% HCC risk score growth in the Performance Year relative to the ACO's base year re-normalized HCC risk score. The maximum re-normalized HCC risk score for a Performance Year is equal to 103% of the ACO's base year re-normalized HCC risk score. This imposes a ceiling of 3% HCC risk score growth in the Performance Year relative to the ACO's base year re-normalized HCC risk score.

### **6.3 Coding Factor Adjustment**

For Performance Year 2017 (if the NGACO is not subject to risk adjustment using the re-normalization of risk scores described in section 6.2 of this Appendix B) and for Performance Year 2018, a projected coding factor will be used to adjust the ACO's Performance-Year HCC risk score, which is in turn used for risk adjustment when calculating the Performance Year Benchmark. In applying this coding factor adjustment, the minimum HCC risk score that an ACO may receive for a Performance-Year is equal to the ACO's base year HCC risk score. This imposes a floor of 0% downward growth in the Performance Year HCC risk score relative to the ACO's base year HCC risk score, following the application of the coding factor adjustment. For example, if, after the application of the coding factor adjustment, an ACO's Performance Year HCC risk score decreased below the ACO's base year HCC risk score, the final Performance Year HCC risk score would equal the ACO's base year HCC risk score. As is the case with the renormalization of HCC risk scores described in section 6.2 of this Appendix B, the maximum Performance Year HCC risk score growth that an ACO may receive in a Performance Year is 3%. This imposes a ceiling of 3% in upward growth in the ACO's Performance Year HCC risk score relative to the ACO's base year HCC risk score, following the application of the coding factor adjustment.

For Performance Year 2017, CMS will project a Performance Year 2017 coding factor based on the observed trend in the average HCC risk scores and demographic risk scores for months accruing to the Aged/Disabled reference beneficiary population from the base year to Performance Year 2017. The demographic risk scores are used to modify the coding factor by the ratio of age/sex risk in the Performance Year compared to the base year. Following Performance Year 2017, CMS will determine the percentage growth in the final Performance Year HCC risk score relative to the base year HCC risk score for months accruing to the Aged/Disabled reference beneficiary population (referred to as the "Final Observed Risk Trend") for Performance Year 2017.

For Performance Year 2018, in advance of the Performance Year, CMS will project a Performance Year 2018 coding factor based on the projected trend in the average HCC risk scores and demographic risk scores for months accruing to the Aged/Disabled reference beneficiary population from the base year to Performance Year 2018. Following Performance Year 2018, CMS will determine the percentage growth in the final Performance Year HCC risk score relative to the base year HCC risk score for months accruing to the Aged/Disabled reference beneficiary population (i.e., the Final Observed Risk Trend) for Performance Year 2018.

CMS may, at CMS' sole discretion, retroactively modify the projected coding factor, if the Final Observed Risk Trend for the applicable Performance Year is found to be greater than 3.0 percentage points higher or lower than that of the projected coding factor. For example, if following a Performance Year, CMS determines that the Final Observed Risk Trend is 8.0% and the projected coding factor for the Performance Year is 4.99%, CMS may, at its sole discretion, retroactively modify the coding factor to align the coding factor with the Final Observed Risk Trend. In the event that CMS retroactively modifies an ACO's coding factor, CMS will also make conforming retroactive modifications to the ACO's Performance Year HCC risk score and Performance Year Benchmark.

### 6.3.1 Calculation of the Coding Factor

For a given Performance Year, the coding factor will equal the ratio of:

1. The Aged/Disabled reference beneficiary HCC risk ratio (described below); to
2. The Aged/Disabled reference beneficiary demographic HCC risk ratio (described below).

The Aged/Disabled reference beneficiary HCC risk ratio will equal the ratio of:

1. The average HCC risk score of the Aged/Disabled reference beneficiaries in the Performance Year; to
2. The average HCC risk score of the Aged/Disabled reference beneficiaries in the base year.

The Aged/Disabled reference beneficiary demographic risk ratio will equal the ratio of:

1. The average age/sex demographic HCC risk score of the Aged/Disabled reference beneficiaries in the Performance Year; to
2. The average age/sex demographic HCC risk score of the Aged/Disabled reference beneficiaries in the in the base year.

### 6.3.2 Application of the Coding Factor Adjustment

The coding factor adjustment described in Section 6.3 will be applied to the ACO's HCC risk score for each entitlement category using the following procedures:

1. Calculate the ACO's HCC risk score for a given Performance Year and for a given entitlement category.
2. DIVIDE BY: the coding factor adjustment to determine the Coding Factor-Adjusted HCC Risk Score.
3. DIVIDE BY: the Aged/Disabled reference beneficiary demographic risk ratio to determine the Coding Factor and Demographic Adjusted HCC Risk Score.
4. Determine whether to apply either:
  - a. The minimum Performance Year HCC risk score (described in section 6.3 of this Appendix B) if the ACO's HCC risk score growth is below 0%, relative to the ACO's base year HCC risk score; or

b. The maximum Performance Year HCC risk score (described in section 6.3 of this Appendix B) if the ACO's HCC risk score growth is above 3%, relative to the ACO's base year HCC risk score.

5. EQUALS: Final ACO Performance Year HCC Risk Score for the entitlement category.

As described in the procedures above, in applying the coding factor, CMS will divide the Coding Factor-Adjusted HCC Risk Score by the Aged/Disabled reference beneficiary demographic risk ratio (step 3), in order to ensure that the trend in the CMS-HCC risk score is equal to the trend in expenditure PBPM that would be expected based on the changing age and sex structure of the reference beneficiary population.

This calculation will be re-run if CMS modifies the coding factor pursuant to Section XIII.C of the Agreement, as described in section 6.3 of this Appendix B.

Tables 6.3.2.1 - 6.3.2.3 illustrate the application of the coding factor adjustment for hypothetical ACOs in a Performance Year.

**Table 6.3.2.1.: Coding Factor Adjustment for Hypothetical ACO for PY2017 (No Application of Maximum/Minimum Performance Year HCC Risk Score)**

		<b>CY 2014</b>	<b>CY 2017</b>
<b>1.</b>	ACO HCC risk score for a given Performance Year and for a given entitlement category	1.1368	1.1960
<b>2.</b>	<b>DIVIDED BY:</b> Coding Factor Adjustment	1.0000	1.0482
	<b>EQUALS:</b> Coding Factor-Adjusted HCC Risk Score	1.1368	1.1410
<b>3.</b>	<b>DIVIDED BY:</b> Aged/Disabled reference beneficiary demographic risk ratio	1.0000	0.9924
	<b>EQUALS:</b> Coding Factor and Demographic-Adjusted HCC Risk Score	1.1368	1.1497
<b>4a.</b>	Minimum Performance Year HCC Risk Score (0% increase from base year HCC Risk Score), if applicable		1.1368 (not applied)
<b>4b.</b>	Maximum Performance Year HCC Risk Score (3% increase from base year HCC Risk Score), if applicable		1.1709 (not applied)
<b>5.</b>	<b>EQUALS:</b> Final ACO Performance Year HCC Risk Score	1.1368	1.1497

**Table 6.3.2.2.: Coding Factor Adjustment for Hypothetical ACO for PY2017 (Application of Maximum Performance Year HCC Risk Score)**

		<b>CY 2014</b>	<b>CY 2017</b>
<b>1.</b>	ACO HCC risk score for a given Performance Year and for a given entitlement category	1.1720	1.2619
<b>2.</b>	<b>DIVIDED BY:</b> Coding Factor Adjustment	1.0000	1.0482
	<b>EQUALS:</b> Coding Factor-Adjusted HCC Risk Score	1.1720	1.2038
<b>3.</b>	<b>DIVIDED BY:</b> Aged/Disabled reference beneficiary demographic risk ratio	1.0000	0.9924

	<b>EQUALS:</b> Coding Factor and Demographic-Adjusted HCC Risk Score	1.1720	1.2131
<b>4a.</b>	Minimum Performance Year HCC Risk Score (0% increase from base year HCC Risk Score), if applicable		1.1720 (not applied)
<b>4b.</b>	Maximum Performance Year HCC Risk Score (3% increase from base year HCC Risk Score), if applicable		1.2072 (applied)
<b>5.</b>	<b>EQUALS:</b> Final ACO Performance Year HCC Risk Score	1.1720	1.2072

**Table 6.3.2.3.: Coding Factor Adjustment for Hypothetical ACO for PY2017 (Application of Minimum Performance Year HCC Risk Score)**

		<b>CY 2014</b>	<b>CY 2017</b>
<b>1.</b>	ACO HCC risk score for a given Performance Year and for a given entitlement category	1.4230	1.4368
<b>2.</b>	<b>DIVIDED BY:</b> Coding Factor Adjustment	1.0000	1.0482
	<b>EQUALS:</b> Coding Factor-Adjusted HCC Risk Score	1.4230	1.3707
<b>3.</b>	<b>DIVIDED BY:</b> Aged/Disabled reference beneficiary demographic risk ratio	1.0000	0.9924
	<b>EQUALS:</b> Coding Factor and Demographic-Adjusted HCC Risk Score	1.4230	1.3812
<b>4a.</b>	Minimum Performance Year HCC Risk Score (0% increase from base year HCC Risk Score), if applicable		1.4230 (applied)
<b>4b.</b>	Maximum Performance Year HCC Risk Score (3% increase from base year HCC Risk Score), if applicable		1.4657 (not applied)
<b>5.</b>	<b>EQUALS:</b> Final ACO Performance Year HCC Risk Score	1.4230	1.4230

#### 6.4 Risk-adjusted trended baseline

For a given performance year, the trended, risk adjusted baseline for each entitlement category is equal to:

1. The trended baseline.
2. MULTIPLIED BY the performance year HCC risk score as calculated in §§6.2 or 6.3 (as applicable).
3. DIVIDED BY the base year HCC risk score as calculated in §§6.2 or 6.3 (as applicable).

The risk-adjusted trended baseline will be retrospectively adjusted for final reconciliation based on the final risk scores for the Performance Year. 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.

To the extent that preliminary or mid-year risk scores for the Performance Year are available during the Performance Year, CMMI may update the prospective Benchmark in the quarterly financial reports.

## 7.0 Quality- and efficiency-adjusted discount

The NGACO Benchmark will be calculated by applying to the trended, risk-adjusted baseline an efficiency- and quality-adjusted discount. The adjusted discount is:

1. A standard discount of 2.25%.
2. MINUS: A regional efficiency adjustment of  $\pm 1.0\%$
3. MINUS: A national efficiency adjustment of  $\pm 0.5\%$
4. MINUS: A quality adjustment to the standard discount of up to  $+1.0\%$

The adjusted discount for an NGACO can, therefore, vary from 0.0% to 3.75% as shown in table 7.0.

**Table 7.0. Minimum and maximum quality- and efficiency-adjusted discount**

	High efficiency / high quality ACO	Low efficiency / low quality ACO
The standard discount	2.25%	2.25%
MINUS: Regional efficiency adjustment <sup>1</sup>	1.0%	-1.0%
MINUS: National efficiency adjustment <sup>2</sup>	0.5%	-0.5%
MINUS: Quality adjustment	1.0%	0.0%
EQUALS: Quality- and efficiency-adjusted discount	0.0%	3.75%

<sup>1</sup> The regional efficiency adjustment may be a positive or negative value between  $+1.0\%$  and  $-1.0\%$ . An “efficient” (low cost) ACO has a positive efficiency adjustment which is subtracted from the standard discount. The regional efficiency adjustment therefore reduces the standard discount for a low cost ACO. An “inefficient” (high cost) ACO has a negative efficiency adjustment that is subtracted from the standard discount. The regional efficiency adjustment therefore increases the standard discount for a high cost ACO.

<sup>2</sup> The national efficiency adjustment may be a positive or negative value between  $+0.5\%$  and  $-0.5\%$ . An “efficient” (low cost) ACO has a positive efficiency adjustment which is subtracted from the standard discount. The national efficiency adjustment therefore reduces the standard discount for a low cost ACO. An “inefficient” (high cost) ACO has a negative efficiency adjustment that is subtracted from the standard discount. The national efficiency adjustment therefore increases the standard discount for a high cost ACO.

Separate quality- and efficiency-adjusted discounts will be calculated for Aged/Disabled and ESRD benchmarks. The efficiency adjustments will be calculated separately for Aged/Disabled and ESRD beneficiaries and may differ. However, the same quality adjustment will apply to both Aged/Disabled and ESRD components.

### 7.1 Quality adjustment to the standard discount

The quality adjustment to the standard Medicare savings requirement may be up to 1 percentage point. In other words, the standard discount of 2.25% may be reduced by as much as 1 percentage point based on the ACO’s quality performance. A higher quality score reduces the standard discount by more than a lower quality score.

For each performance year, the ACO’s quality score will range from 0% (0.000) to 100% (1.000). The quality adjustment to the standard discount will be the product of the quality score and 1%. Table 7.1 illustrates the relationship between the quality score and the quality adjustment to the standard discount.



**Table 7.2.2 Quality adjustment to the standard discount for selected quality scores**

Quality score	Adjustment
100	+1.00%
90	+0.90%
80	+0.80%
70	+0.70%
60	+0.60%
50	+0.50%
40	+0.40%
30	+0.30%
20	+0.20%
10	+0.10%
0	+0.00%

**7.1.1 Use of prior year quality score for the initial benchmark calculation**

In PY1/CY2016, for NGACOs with agreements effective January 1, 2016, the initial prospective Benchmark will be based on a quality score of 100 (or 100%) for all ACOs. In the event an ACO fails to successfully report for PY1/CY2016, CMS will retrospectively adjust the quality score to zero.

In PY2/CY2017, the initial prospective Benchmark will be based on a quality score of 100% as PY1/CY2016 quality scores will not be available at the time that the Benchmark is calculated. For NGACOs with an agreement start date of January 1, 2017, the initial quality score during PY2/CY2017 will be 100%.

For PY3/CY2018, the initial prospective Benchmark will be based on a quality score of 100% PY2 quality scores will be calculated in mid-2018 (if the ACO joined the Model in PY1/CY2016). When PY2 quality scores become available, CMS may update the Performance Year Benchmark to reflect the PY2 quality score (if the ACO joined the Model in PY1/CY2016). For NGACOs with an agreement start date after January 1, 2017, the initial quality score during PY3/CY2018 will be 100%.

**7.1.2 Use of performance-year quality score for purposes of financial settlement**

The Performance Year Benchmark that is used in financial settlement will be based on an adjusted discount that reflects the actual performance-year quality score attained by the NGACO. In PY1/CY2016 the quality score used to calculate the final adjusted discount will be 100% if all quality data reporting requirements have been satisfied. In subsequent performance years, the quality score will be calculated as described in the Participation Agreement.

For NGACOs with agreements effective January 1, 2017, the PY2/CY2017 quality score used to calculate the final adjusted discount will be 100% unless the quality data reporting and other requirements described in the Participation Agreement have not been met.

For NGACOs with agreements effective January 1, 2018, the PY3/CY2018 quality score used to calculate the final adjusted discount will be 100% unless the quality data reporting and other requirements described in the Participation Agreement have not been met.

### 7.1.3 Minimum Quality Requirement

Each NGACO must meet certain minimum quality requirements, including the submission of all data required to calculate quality scores. In the event an NGACO does not satisfy the minimum quality requirement, it will not be allowed to share in savings, but will be required to pay losses. The quality score for an NGACO that does not meet the quality measurement requirements of the Next Generation ACO Model will be zero. Details on the quality data reporting requirements are provided in Appendix F of the NGACO's Participation Agreement.

## 7.2 Regional Baseline Efficiency Adjustment to the standard discount

The ratio of an ACO's historic expenditures to regional FFS expenditures (regional efficiency), or the "regional efficiency ratio," will be used to calculate a "regional efficiency" adjustment to the standard discount. The regional efficiency adjustment is intended to recognize the baseline expenditure "operating efficiency" of the NGACO when measured against a regional norm.

In this context, "operating efficiency" indicates whether the ACO's baseline expenditure PBPM is higher or lower than the "average" baseline expenditure PBPM in the ACO's region.<sup>8</sup> 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). The regional efficiency adjustment to the standard discount will be set prospectively. The regional baseline efficiency ratio will be calculated using capped expenditures for all NGACOs.

The regional baseline efficiency adjustment to the standard discount ranges from -1.0% to +1.0%. An NGACO with a base-year expenditure PBPM that is below the prevailing regional average base-year expenditure PBPM will therefore have a smaller adjusted discount than an NGACO with baseline expenditures that are above average in its region.

### 7.2.1 Regional baseline efficiency ratio

A regional baseline efficiency ratio will be calculated for each entitlement category. The regional efficiency ratio is a measure of the ACO's efficiency relative to its region. The regional efficiency ratio will be the ratio of.

1. The NGACO's risk- and GAF-standardized baseline expenditure PBPM; and,
2. The NGACO's regional risk- and GAF-standardized baseline expenditure PBPM.

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<sup>8</sup> Risk adjustment and geographic pricing adjustment are applied to the regional efficiency adjustment. See below for details.

As noted in section 3.7.2, IME and DSH will be excluded from all expenditures when calculating the regional efficiency ratio. IME and DSH are not related to an ACO's regional efficiency, and inclusion of IME and DSH in the regional expenditure ratio could create bias in the NGACO Model.

The NGACO's risk- and GAF-standardized baseline expenditure PBPM for an entitlement category is:

1. The NGACO's baseline expenditure (excluding IME and DSH) PBPM; divided by
2. The product of:
  - a. The NGACO's re-normalized risk score; and
  - b. The NGACO's baseline GAF standardization factor.

The NGACO's regional risk- and GAF-standardized baseline expenditure PBPM is the weighted average of the risk- and GAF-standardized expenditure of the counties in which the NGACO's base-year aligned beneficiaries reside. The weights used are the months accrued by the base-year aligned beneficiaries residing in each county.

### 7.2.2 GAF baseline standardization factors

A GAF baseline adjustment factor will be calculated for each county that reflects the impact on base-year payments to providers and suppliers for services provided to reference beneficiaries residing in the county of the base-year Medicare GAFs. The resulting GAF-standardized payment is an estimate of the payment that would have been made if no GAF adjustments had been applied when calculating payments to providers and suppliers.

The GAF baseline adjustment factor for a county will be the ratio of:

1. The incurred PBPM expenditure (reflecting the geographic pricing factors that Medicare used in the base-year to calculate payments to providers and suppliers); to
2. The county PBPM expenditure calculated after adjusting base year claims to remove the impact on payments to providers and suppliers of the geographic pricing factors that Medicare used in the base-year.<sup>9</sup>

The GAF baseline adjustment factor will be calculated prospectively for alignment-eligible beneficiaries in each county in the base year and will have no impact on the national FFS trend.

The GAF baseline adjustment for an ACO will be the person-month weighted average of county GAF baseline adjustment factors, where the weights are the ACO aligned beneficiary person months residing in each county.

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<sup>9</sup> The calculation of the baseline GAF adjustment will be normalized such that the adjustment neither increases nor decreases the total expenditure of the reference population. That is the adjusted claim amount for the reference population will equal the incurred claim amount.

### 7.2.3 GAF-adjusted baseline claims

The GAF baseline adjustment removes the impact on payments to providers and suppliers of the GAFs that Medicare applied when calculating payments in the base-year. Baseline claims will be adjusted using appropriately weighted base-year geographic pricing factors. For example:

- The geographic price adjustment under the Inpatient Prospective Payment System (IPPS), the Area Wage Index (AWI), is weighted by the proportion of cost that is attributable to labor.
- Under the Physician Fee Schedule, the three Geographic Practice Cost Indexes (GPCIs) are weighted by the corresponding relative value units.

Adjusted payment amounts using performance-year geographic pricing factors will be calculated for each the following types of claims:

1. Inpatient claims paid under Prospective Payment Systems.
2. Outpatient claims paid under the Hospital Outpatient Prospective Payment System (HOPPS).
3. Skilled Nursing Facility claims paid under the SNF Prospective Payment System.
4. Home Health claims paid under the HHA Prospective Payment System.
5. Hospice claims.
6. Physician claims paid under the Physician Fee Schedule.
7. Claims paid under the Renal Dialysis Prospective Payment System.

For all other claims, the adjusted payment amount will be equal to the amount actually paid.

### 7.2.4 Risk- and GAF-adjusted expenditure PBPM for each county

The risk- and GAF-adjusted baseline expenditure PBPM for each county is:

1. The baseline expenditure (excluding IME and DSH) PBPM incurred by reference beneficiaries residing in the county; divided by
2. The product of:
  - a. The weighted average re-normalized risk score of reference beneficiaries residing in the county; and
  - b. The baseline GAF standardization factor of the county.

Separate ESRD and Aged/Disabled risk- and GAF-adjusted baseline expenditure PBPM will be calculated for each county.

### 7.2.5 Regional Efficiency Adjustment

For each entitlement category, the regional efficiency adjustment to the Medicare savings requirement ranges from -1.0% to +1.0%. If the regional efficiency ratio is:

- Less than 0.9, then the regional efficiency adjustment is +1.0%;
- Between 0.9 and 1.0, then the regional efficiency adjustment is between 0.0% and +1.0%;

- Between 1.0 and 1.1, then the regional efficiency adjustment is between 0.0% and -1.0%; and,
- Greater than 1.1, then the regional efficiency adjustment is -1.0%.

The floor (and ceiling) for the risk adjusted, geographically price adjusted regional efficiency ratio that an ACO must attain to receive the “maximum” (or “minimum”) regional efficiency adjustment is thus 10% below or above average, respectively.

Table 7.2.5 shows the regional efficiency adjustment that will be applied at selected regional efficiency ratios. Between the minimum and maximum efficiency ratios, the adjustment is a simple linear interpolation based on the regional efficiency ratio.

**Table 7.2.5 Regional efficiency adjustment for selected regional efficiency ratios**

Regional efficiency ratio	Adjustment <sup>1</sup>	Regional efficiency ratio	Adjustment <sup>1</sup>
0.90 or less	+1.00%	1.00	-0.00%
0.91	+0.90%	1.01	-0.10%
0.92	+0.80%	1.02	-0.20%
0.93	+0.70%	1.03	-0.30%
0.94	+0.60%	1.04	-0.40%
0.95	+0.50%	1.05	-0.50%
0.96	+0.40%	1.06	-0.60%
0.97	+0.30%	1.07	-0.70%
0.98	+0.20%	1.08	-0.80%
0.99	+0.10%	1.09	-0.90%
1.00	+0.00%	1.10 or higher	-1.00%

<sup>1</sup> The efficiency adjustment is subtracted from the standard discount. A positive adjustment therefore reduces the standard discount, and a negative adjustment increases it.

### 7.3 National Baseline Efficiency Adjustment to the Savings Requirement

The ratio of an ACO’s historic expenditures to national FFS expenditures (national efficiency), or the “national efficiency ratio”, will be used to calculate a “national efficiency” adjustment to the standard discount. The national efficiency adjustment is intended to recognize the baseline expenditure “operating efficiency” of the NGACO when measured against a national norm.

In this context, “operating efficiency” simply means whether the ACO’s baseline expenditure PBPM is higher or lower than the “average” baseline expenditure PBPM in the nation as a whole. 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). The national efficiency adjustment to the standard discount will be set prospectively.

The national baseline efficiency adjustment to the standard discount ranges from -0.5% to +0.5%. An NGACO with a base-year expenditure PBPM that is below the national average base-year expenditure PBPM will therefore have a smaller adjusted discount applied to its risk-adjusted trended baseline than an NGACO with baseline expenditures that are above average nationally.

The national baseline efficiency ratio will be calculated using capped expenditures for all NGACOs.

### 7.3.1 National Efficiency Ratio

A national baseline efficiency ratio will be calculated for each entitlement category. The national efficiency ratio is a measure of the ACO's efficiency relative to the entire reference population. The national efficiency ratio will be the ratio of.

1. The NGACO's risk- and GAF-adjusted baseline expenditure PBPM; and,
2. The national risk- and GAF-adjusted baseline expenditure PBPM.<sup>10</sup>

As noted in section 3.7.2, IME and DSH will be excluded from all expenditures when calculating the national efficiency ratio. IME and DSH are not related to an ACO's national efficiency, and inclusion of IME and DSH in the national expenditure ratio could create bias in the NGACO Model.

The NGACO's risk- and GAF-adjusted baseline expenditure PBPM for an entitlement category is discussed in section 7.2.1.

### 7.3.2 National Efficiency Adjustment

The national efficiency adjustment to the Medicare savings requirement ranges from -0.5% to 0.5%. If the national efficiency ratio is:

- Less than 0.9, then the national efficiency adjustment is +0.5%;
- Between 0.9 and 1.0, then the national efficiency adjustment is between 0.0% and +0.5%;
- Between 1.0 and 1.1, then the national efficiency adjustment is between 0.0% and -0.5%;
- Greater than 1.1, then the national efficiency adjustment is -0.5%.

The floor (and ceiling) for the risk adjusted, geographically price adjusted national efficiency ratio that an ACO must attain to receive the "maximum" (or "minimum") national efficiency adjustment is thus 10% below or above average, respectively. Between the minimum and maximum efficiency ratios, the adjustment is a simple linear interpolation based on the national efficiency ratio.

Table 8.3.2 shows the national efficiency adjustment that will be applied at selected national efficiency ratios.

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<sup>10</sup> The national risk- and GAF-adjusted baseline expenditure PBPM will, because of the steps taken to ensure that the standardization process neither increases nor decreases total expenditures, will equal the incurred expenditure PBPM of the reference population.

**Table 7.3.2. National efficiency adjustment for selected national efficiency ratios**

National efficiency ratio	Adjustment <sup>1</sup>	National efficiency ratio	Adjustment <sup>1</sup>
0.90 or less	+0.50%	1.00	-0.00%
0.91	+0.45%	1.01	-0.05%
0.92	+0.40%	1.02	-0.10%
0.93	+0.35%	1.03	-0.15%
0.94	+0.30%	1.04	-0.20%
0.95	+0.25%	1.05	-0.25%
0.96	+0.20%	1.06	-0.30%
0.97	+0.15%	1.07	-0.35%
0.98	+0.10%	1.08	-0.40%
0.99	+0.05%	1.09	-0.45%
1.00	+0.00%	1.10 or higher	-0.50%

<sup>1</sup> The efficiency adjustment is subtracted from the standard discount. A positive adjustment therefore reduces the standard discount, and a negative adjustment increases it.

## 8.0 NGACO Financial Settlement

As discussed in section 4, the NGACO Benchmark PBPM for each entitlement category is the product of:

1. The trended, risk adjusted ACO baseline; and,
2. The quality- and efficiency-adjusted discount.<sup>11</sup>

The overall NGACO Benchmark expenditure for a Performance-Year is the sum of two amounts:

1. The Benchmark for Aged/Disabled beneficiaries multiplied by the person-months accrued by to the Aged/Disabled entitlement category by Next Generation Beneficiaries during the Performance-Year; and,
2. The Benchmark for ESRD beneficiaries multiplied by the person-months accrued by to the ESRD entitlement category by Next Generation Beneficiaries during the Performance-Year.

This can be expressed as a PBPM Benchmark by dividing the Benchmark expenditure by the number of person-months accrued during the Performance-Year by aligned beneficiaries.<sup>12</sup>

<sup>11</sup> Technically, the PBPM benchmark is equal to the trended risk-adjusted baseline multiplied by 1 minus the quality- and efficiency adjusted discount.

<sup>12</sup> The combined benchmark is, therefore, simply the person-month weighted average of the Aged/Disabled and ESRD PBPM benchmarks.

### 8.1 Savings/Losses Amount

An NGACO's aggregate gross savings or losses will be determined by subtracting the expenditure incurred by Performance-Year aligned beneficiaries in the Performance-Year from the NGACO's Benchmark expenditure.

The risk arrangement selected by the NGACO will determine the portion of the aggregate gross savings that will be paid to (or the portion of the gross loss that will be recovered from) the NGACO. The NGACO Model offers two risk arrangements:

1. Arrangement A: 80% shared savings/losses, ACO selects a savings/losses cap between 5-15%.
2. Arrangement B: 100% shared savings/losses, ACO selects a savings/losses cap between 5-15%.

The shared savings (loss) for an NGACO that elects Arrangement A will be 80% of the difference between the Benchmark expenditure for the Performance Year and the expenditure incurred during the Performance-Year.

The shared savings (loss) for an NGACO that elects Arrangement B will be 100% of the difference between the Benchmark expenditure for the Performance Year and the expenditure incurred during the Performance-Year.

Budget sequestration will apply to shared savings payments, but will not apply to recover of shared losses. For example, if the budget sequestration rate is 2%, the shared savings payment to the NGACO will be 98% of the shared savings amount, but 100% of the shared loss amount will be recovered from the NGACO.

### 8.2 Alternative payment arrangements

Under the Next Generation ACO Model, an NGACO may participate in alternative payment arrangements, including an infrastructure payment arrangement, population-based payment (PBP), and (starting in Performance Year 2) all-inclusive population-based payment (AIPBP).

The payment made over the course of the performance-year to an NGACO that receives infrastructure payments will be deducted from any savings (or added to any loss) during financial settlement and will be considered Other Monies Owed in accordance with Appendix G of the Participation Agreement.

The payments that are made to an NGACO that participates in population-based payment will be reconciled with the reduction in FFS payments in accordance with Appendix H of the Participation Agreement. If the FFS reduction is less than the PBP payment, the difference will be deducted from the savings payment or added to the loss and be considered Other Monies Owed. If the FFS reduction is greater than the PBP payment, the difference will be added to the savings payment or added to the loss and be considered Other Monies Owed.



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## Appendix A. Next Generation ACO Model Alignment Procedures

### A.1 Alignment Years

Each Performance Year or base-year is associated with two alignment-years. The first alignment-year for a Performance Year or base-year is the 12-month period ending 18 months prior to the start of the Performance Year or base-year. The second-alignment year is the 12-month period ending 6 months prior to the start of the Performance Year or base-year. In this document, an Alignment Year is identified by the calendar year in which the alignment-year ends. For example, Alignment Year 2014 (AY2014) is the 12-month period ending in June 2014.

Table A.1 specifies the period covered by each base year and Performance Year, and their corresponding alignment years.

### A.2 Definitions used in alignment procedures

#### A.2.1 Alignment-eligible beneficiary

A beneficiary is alignment-eligible for a base- or Performance-Year if:

1. *During the related 2-year alignment period*, the beneficiary had at least one paid claim for a QEM (Qualified Evaluation and Management) service; and,
2. *During the base- or Performance Year*, the beneficiary:
  - a. Was covered under Part A in January;
  - b. Has no months of coverage under only Part A;
  - c. Has no months of coverage under only Part B;
  - d. Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
  - e. Has no months in which Medicare was the secondary payer;
  - f. Was a resident of the United States;

A beneficiary may be alignment-eligible in a base-year but not a Performance Year and may be alignment-eligible in a Performance Year but not a base-year.

#### A.2.2 “Alignable” beneficiary

To be aligned, a beneficiary necessarily must have at least one paid claim for a QEM service during the 2-year alignment period, but the beneficiary is not required to be alignment-eligible in either of the two alignment years. Consequently, the beneficiaries who are aligned for a base year or a Performance Year, *prior to the application of the requirements for alignment-eligibility*, include all beneficiaries who have at least one QEM service that was paid by fee-for-service Medicare during the 2-year alignment period. These beneficiaries may be referred to as “alignable” beneficiaries.

### **A.2.3 NGACO Service Area**

The NGACO's Service Area consists of all counties in which Next Generation Professionals who are primary care specialists have office locations and the adjacent counties. The counties in which Next Generation Participants have office locations will be referred to as the "core" service area. The counties adjacent to the "core" service area may be referred to as the "extended" service area. The NGACO is responsible for identifying the counties in which their Next Generation Professionals have office locations, i.e., the "core" service area.

### **A.2.4 Qualified Evaluation & Management services**

Qualified Evaluation & Management (QEM) services are identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Addendum A, Table A-1, and physician specialty. Specifically, a QEM service is a claim for a primary care service provided by a primary care specialist or, for purposes of the 2<sup>nd</sup> stage of the 2-stage alignment algorithm discussed in section A.6, one of the selected non-primary care specialist.

In the case of claims submitted by physician practices, the specialty of the practitioner providing a primary care service will be determined by the CMS specialty code appearing on the claim. The specialty codes that identify primary care and selected non-primary care specialties are listed in Addendum A, Tables A-2 or A-3.

In the case of claims submitted by institutional practices, the specialty of the practitioner providing a primary care service will generally be determined based on the physician's primary specialty as recorded in NPPES or PECOS.

### **A.2.5 Primary care services**

In the case of claims submitted by physician practices, a primary care service is identified by the HCPCS code appearing on the claim line. HCPCS codes identifying primary care services are listed in Addendum A, Table A-1.

In the case of claims submitted by an FQHC (type of bill = 77x) a primary care service is identified by HCPCS code appearing on the line item claim for the service.

In the case of claims submitted by an RHC (type of bill = 71x) a primary care service is identified by HCPCS code appearing on the line item claim for the service.

In the case of claims submitted by a CAH2 (type of bill = 85x) a primary care service is identified by HCPCS code appearing on the line item claim (for revenue centers 096x, 097x, or 098x) for the service.

### **A.2.6 Primary care specialists**

A primary care specialist is a physician or non-physician practitioner (NPP) whose principal specialty is included in Addendum A, Table A-2.

For purposes of applying the provider exclusivity requirements, the physician or NPP's specialty will be determined based on the physician or NPP's current information in the National Plan & Provider Enumeration System (NPPES) at the time the participating provider data is submitted to the Center for Medicare and Medicaid Innovation (CMMI).

For purposes of applying the 2-stage alignment algorithm described in section A.6, the physician or NPP's specialty will be determined based on the CMS Specialty Code recorded on the claim for a qualified E&M service. In the case of QEM services obtained from FQHC, RHC, or CAH Method 2 (CAH2) providers the specialty code may be determined based on the physician's primary specialty as recorded in NPPES or PECOS.

### **A.2.7 Next Generation Participant**

A Next Generation Participant is a physician or non-physician practitioner (NPP) as defined in the Participation Agreement.

Next Generation Participants are identified by either:

1. In the case of physician practices, a combination of Taxpayer Identification Number (TIN) and the practitioner's individual National Provider Identifier (NPI).
2. In the case of institutional practices (including FQHCs, RHCs, and CAH2s), a combination of a CMS Certification Number (CCN) and the practitioner's individual NPI.

A Next Generation Participant who is a primary care specialist may be identified as a Next Generation Participant by one and only one NGACO.

### **A.2.8 Participating practice**

A participating practice is:

1. A physician practice;
2. A Federally Qualified Health Center (FQHC);
3. A Rural Health Clinic (RHC); or,
4. A Critical Access Hospital that elects payment under Method 2 (CAH2) that has an agreement with an NGACO.

A participating physician practice is identified by TIN.

An FQHC, RHC, or CAH2 practice is identified by TIN, CCN, and an organizational NPI.

### **A.2.9 Participating practitioner (professional)**

A participating practitioner (professional) is a physician or non-physician practitioner (NPP) identified by an individual National Provider Identifier (NPI) who is a member of a participating practice. A practitioner may be a member of more than one practice and may participate in more than one NGACO.

### A.2.10 Legacy practice identifiers

A legacy practice identifier is a TIN or CCN that was used by a Next Generation Participant or Professional to bill for services provided to Medicare beneficiaries in an alignment-year for any of the base- or Performance-Years but that will *not* be used by that Next Generation Participant or Professional during the Performance Year.

A sunsetted legacy practice identifier means that the TIN or CCN is no longer used by any Medicare providers and/or suppliers. NGACOs may include sunsetted legacy practice identifiers on their Next Generation Participant list.

An active legacy practice identifier is a TIN or CCN that is no longer used by a Next Generation Participant, but is still in use by some Medicare providers and/or suppliers that are not Next Generation Participants. Active legacy practice identifiers may only be included on the NGACO Participant List with written agreement from the practice. Next Generation ACOs will submit legacy practice identifier acknowledgement forms annually for each active legacy practice.

A legacy practice identifier (a TIN or CCN) cannot be used to identify a Next Generation Participant if the practice it identifies is participating in or intends to participate in a Medicare Shared Savings Program ACO during the Performance Year.

### A.3 Quarterly exclusion of beneficiaries during the Performance Year

Alignment-eligibility requirements 2.a through 2.f (see section A.2.1) will be applied during the Performance Year in the first month of each calendar quarter.

A beneficiary who is determined not to be alignment-eligible in one quarter will be continue to be considered ineligible even if subsequent updates to eligibility data indicate that the beneficiary was eligible in a subsequent quarter. Once a beneficiary is excluded in a Performance Year, the beneficiary is removed from all financial calculations for that year. All alignment-eligible Next Generation Beneficiaries except those who die during the Performance Year will, therefore, contribute 12 months of experience to the Performance Year expenditures.

### A.4 Alignment of beneficiaries

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.

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 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.

Only claims that are identified as being provided by the primary care specialists listed in Addendum A, Table A-2 and the non-primary care specialists listed in table A-3 will be used in alignment calculations.

#### A.5 Use of weighted allowable charges in alignment

The allowable charge on paid claims for services received during the two alignment-years associated with each base- or Performance Year will be used to determine the Next Generation ACO or physician practice from which the beneficiary received the most QEM services.

1. The allowable charge for QEM services provided during the 1<sup>st</sup> (earlier) alignment-year will be weighted by a factor of  $\frac{1}{3}$ .
2. The allowable charge for QEM services provided during the 2<sup>nd</sup> (later or more recent) alignment-year will be weighted by a factor of  $\frac{2}{3}$ .

The allowable charge that is used in alignment will be obtained from claims for QEM services that are:

1. Incurred in each alignment-year as determined by the date-of-service on the claim line-item; and,
2. Paid within 3 month following the end of the 2<sup>nd</sup> alignment-year as determined by the effective date of the claim.

#### A.6 The 2-stage alignment algorithm

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 as defined in Addendum A, Table A-2, 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 as defined in Addendum A, Table A-3.

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 CAH2 claims.

#### A.7 Tie-breaker rule

In the case of a tie in the dollar amount of the weighted allowed charges for QEM services, the beneficiary will be aligned with the provider from whom the beneficiary most recently obtained a QEM service.

#### A.8 Voluntary alignment

A beneficiary who has agreed to voluntary alignment for a Performance-Year with an NGACO will be aligned to that NGACO for that Performance-Year (and related base-year) regardless of the NGACO with which the beneficiary would be aligned based on the 2-stage alignment algorithm.

Beneficiaries who have voluntarily aligned with an NGACO will also be excluded from the base- or Performance-Year alignment if they do not meet the alignment-eligibility requirements described in section A.2 during the base- or Performance-Year.

**Table 2.1: Definition of base years and Performance Years**

<b>Period</b>	<b>Period covered<sup>1</sup></b>	<b>Corresponding alignment years (AY)</b>
Base Year (BY)	01/01/2014 – 12/31/2014	BY/AY1: 07/01/2011 – 06/30/2012 (AY2012)
		BY/AY2: 07/01/2012 – 06/30/2013 (AY2013)
Calendar Year 2015 (CY2015)	01/01/2015 – 12/31/2015	CY2015/AY1: 07/01/2012 – 06/30/2013 (AY2013)
		CY2015/AY2: 07/01/2013 – 06/30/2014 (AY2014)
Performance Year 1 (PY1)	01/01/2016 – 12/31/2016	PY1/AY1: 07/01/2013 – 06/30/2014 (AY2014)
		PY1/AY2: 07/01/2014 – 06/30/2015 (AY2015)
Performance Year 2 (PY2)	01/01/2017 – 12/31/2017	PY2/AY1: 07/01/2014 – 06/30/2015 (AY2015)
		PY2/AY2: 07/01/2015 – 06/30/2016 (AY2016)
Performance Year 3 (PY3)	01/01/2018 – 12/31/2018	PY3/AY1: 07/01/2015 – 06/30/2016 (AY2016)
		PY3/AY2: 07/01/2016 – 06/30/2017 (AY2017)

<sup>1</sup> The period covered is the calendar year for which the expenditures of aligned beneficiaries will be calculated for purposes of setting the NGACO baseline or determining performance period savings.

**Table A-1. Evaluation & Management Services – PY1/2016**

<b>Office or Other Outpatient Services</b>	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
<b>Nursing Facility Care</b>	
99304	Initial Nursing Facility Care, brief
99305	Initial Nursing Facility Care, moderate
99306	Initial Nursing Facility Care, comprehensive
99307	Subsequent Nursing Facility Care, brief
99308	Subsequent Nursing Facility Care, limited
99309	Subsequent Nursing Facility Care, comprehensive
99310	Subsequent Nursing Facility Care, extensive
99315	Nursing Facility Discharge Services, brief
99316	Nursing Facility Discharge Services, comprehensive
99318	Other Nursing Facility Services
<b>Domiciliary, Rest Home, or Custodial Care Services</b>	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
<b>Domiciliary, Rest Home, or Home Care Plan Oversight Services</b>	
99339	Brief
99340	Comprehensive
<b>Home Services</b>	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive



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<b>Office or Other Outpatient Services</b>	
99350	Established Patient, extensive
<b>Wellness Visits</b>	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

**Table A-1. Evaluation & Management Services – PY2/2017 and PY3/2018**

<b>Office or Other Outpatient Services</b>	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
<b>Domiciliary, Rest Home, or Custodial Care Services</b>	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
<b>Domiciliary, Rest Home, or Home Care Plan Oversight Services</b>	
99339	Brief
99340	Comprehensive
<b>Home Services</b>	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
<b>Transitional Care Management Services</b>	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
<b>Chronic Care Management Services</b>	
99490	Comprehensive care plan establishment/implementations/revision/monitoring
<b>Wellness Visits</b>	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

**Table A-2. Specialty codes used for alignment based on primary care specialists – PY1/2016**

<b>Code<sup>1</sup></b>	<b>Specialty</b>
1	General Practice
8	Family Medicine
11	Internal Medicine
38	Geriatric Medicine
50	Nurse Practitioner
97	Physician Assistant

<sup>1</sup> The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

**Table A-2. Specialty codes used for alignment based on primary care specialists – PY2/2017 and PY3/2018**

Code <sup>1</sup>	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical nurse specialist
97	Physician Assistant

<sup>1</sup> The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

**Table A-3. Specialty codes used for alignment based on other selected specialists – PY1/2016**

Code <sup>1</sup>	Specialty
6	Cardiology
13	Neurology
29	Pulmonology
39	Nephrology
46	Endocrinology
66	Rheumatology
83	Hematology/oncology
90	Medical oncology
91	Surgical oncology
92	Radiation oncology
98	Gynecological/oncology
86	Neuropsychiatry

**Table A-3. Specialty codes used for alignment based on other selected specialists – PY2/2017 and PY3/2018**

Code <sup>1</sup>	Specialty
6	Cardiology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonology
39	Nephrology
46	Endocrinology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology

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83	Hematology/oncology
84	Preventative medicine
90	Medical oncology
98	Gynecological/oncology
86	Neuropsychiatry

<sup>1</sup> The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

**Appendix B. Formal statement of Next Generation ACO Model benchmarking methods**

RESERVED

**Appendix C. Technical description of the GAF trend adjustment**

RESERVED

**Appendix D. Technical description of the GAF baseline-adjustment**

RESERVED



## Next Generation ACO Model Participation Agreement

### Appendix C

#### Voluntary Alignment

#### I. General

- A. This Appendix C will apply only if the ACO selects participation in Voluntary Alignment pursuant to Section X of the Agreement. For purposes of this Appendix C, an ACO's selection to participate in Voluntary Alignment for a given Performance Year refers to the ACO's decision to participate in targeted outreach as defined under Section II.A of this Appendix C and the other Voluntary Alignment activities described in this Appendix C during that Performance Year.
- B. If the ACO selects participation in Voluntary Alignment, CMS shall conduct Beneficiary alignment in accordance with Appendix B, except that CMS shall also align to the ACO any Beneficiary eligible for Voluntary Alignment under Section VI of this Appendix C.

#### II. Voluntary Alignment Outreach

- A. During a period starting on or after a date determined by CMS, the ACO shall conduct targeted outreach to all Beneficiaries who are eligible for targeted outreach under Section V.A of this Appendix C and to all Beneficiaries who are prior approved by CMS for targeted outreach under Section II.G of this Appendix C. Targeted outreach is defined as sending a form (the “**Voluntary Alignment Form**”) and a cover letter including instructions on how to complete the Voluntary Alignment Form (the “**Letter**”) electronically or by mail to a Beneficiary.
- B. CMS shall determine the content of the Voluntary Alignment Form. CMS shall provide templates to the ACO for both the Voluntary Alignment Form and the Letter.
- C. The ACO shall make no changes to the template Voluntary Alignment Form provided by CMS, with the exception of changes made solely for the insertion of the following information where indicated:
  - 1. The name of the Next Generation Participant that the ACO believes may be the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care;
  - 2. The logo of the ACO or Next Generation Participant;
  - 3. Instructions for how the Beneficiary can submit the Voluntary Alignment Form to the ACO.
- D. The ACO shall make no changes to the template Letter where CMS has indicated content that the ACO cannot amend or remove. The ACO may otherwise make changes, subject to the ACO obtaining CMS approval of the final Letter content pursuant to Section V.E. of the Agreement, including:

1. Formatting for electronic distribution;
  2. The name of the Next Generation Participant that the ACO believes may be the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary received care;
  3. The logo of the ACO or Next Generation Participant;
  4. Instructions for how the Beneficiary can submit the Voluntary Alignment Form to the ACO;
  5. The insertion of information about unique care coordination and preventative services offered by the ACO; and
  6. The ACO's contact information for answering Beneficiaries' questions.
- E. The ACO shall submit to CMS, by a time and in a manner specified by CMS, a document describing how the ACO will conduct its Voluntary Alignment activities during the Performance Year in which the ACO has selected to participate in Voluntary Alignment, including targeted outreach as that term is defined under Section II.A of this Appendix C.
- F. The ACO shall conduct targeted outreach to all Beneficiaries who satisfy the targeted outreach eligibility criteria under Section V.A. of this Appendix C, and may do so without prior approval from CMS.
- G. Before the ACO may conduct targeted outreach to any Beneficiary who does not satisfy the targeted outreach eligibility criteria under Section V.A. of this Appendix C, the ACO shall submit to CMS, for CMS's approval, a preliminary list identifying all Beneficiaries, other than those who satisfy the eligibility criteria under Section V.A. of this Appendix C, for whom the ACO intends to conduct targeted outreach ("**Proposed Voluntary Alignment Targeted Outreach List**").
- H. CMS will verify that the Beneficiaries on the Proposed Voluntary Alignment Targeted Outreach List satisfy the targeted outreach eligibility criteria under Section V.B. of this Appendix C for the Performance Year in which the ACO has selected to participate in Voluntary Alignment. CMS will return to the ACO a list identifying the Beneficiaries that CMS has verified are eligible for targeted outreach under Section V.B. of this Appendix C ("**Approved Voluntary Alignment Targeted Outreach List**").
- I. The ACO may provide the Voluntary Alignment Form at the point of care only in the offices of Next Generation Participants. The ACO shall notify CMS by a date specified by CMS if the ACO elects to provide the Voluntary Alignment Form at the point of care.
- J. Form Requests
1. The ACO shall permit any Beneficiary who receives care from a Next Generation Participant to receive a Voluntary Alignment Form, upon request. The ACO shall permit the Beneficiary to request a Voluntary Alignment Form in person at the office of the Next Generation Participant or by calling the ACO.
  2. The ACO shall permit any Beneficiary who has received a Voluntary Alignment Form to request another Voluntary Alignment Form that identifies

- a different Next Generation Participant as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care; or that identifies a physician or other individual or entity that is not a Next Generation Participant as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care; or otherwise reverses the Beneficiary's Voluntary Alignment. The ACO shall permit such requests to be made by calling the ACO.
3. The ACO shall permit any Beneficiary who has received a Voluntary Alignment Form to request another Voluntary Alignment Form that allows signature by an appointed representative. Instructions on how to make this request will be included on the Voluntary Alignment Form. The ACO shall permit such requests to be made by calling the ACO.

#### K. Maintenance of Records

The ACO shall maintain, in accordance with Section XVIII.B of the Agreement, copies of all Voluntary Alignment Forms sent to Beneficiaries (including copies of the Instructions sent with such forms), and, as applicable, original executed Voluntary Alignment Forms, envelopes in which Voluntary Alignment Forms were returned to the ACO, written documentation of any oral communications with a Beneficiary or his or her appointed representative regarding the potential or actual reversal of a Voluntary Alignment Form, all electronic data and files associated with the distribution and submission of Voluntary Alignment Forms, and all other documents and records regarding Voluntary Alignment, including documents and records pertaining to Beneficiary communications.

### III. Beneficiary-Next Generation Participant Communications

- A. The ACO, Next Generation Participants, and other individuals or entities performing functions or services related to ACO Activities may directly communicate orally with Beneficiaries regarding Voluntary Alignment and the Voluntary Alignment Forms.
- B. The ACO may instruct Next Generation Participants to answer questions from Beneficiaries regarding the Voluntary Alignment Form, but must prohibit Next Generation Participants from completing the form on behalf of any Beneficiary.
- C. The ACO shall require Next Generation Participants to instruct Beneficiaries to call the ACO for questions about how to make changes to a Voluntary Alignment Form.

### IV. Voluntary Alignment Process

- A. By a date specified by CMS, the ACO shall submit to CMS a list ("**Voluntary Alignment List**"). The Voluntary Alignment List must contain the following:
  1. The name, Health Insurance Claim Number (HICN), and, to the extent required by CMS, any other identifying information of each Beneficiary who

- returned a valid Voluntary Alignment Form to the ACO identifying a Next Generation Participant as the Beneficiary's main doctor, main provider, and/or the main place the Beneficiary receives care. For purposes of this Appendix C, a Voluntary Alignment Form is valid only if it has been signed and dated by the Beneficiary or his or her appointed representative, was returned to the ACO on or before the date on which the ACO submits its Voluntary Alignment List to CMS. A form submitted to a Next Generation Participant is considered to have been returned to the ACO;
2. For each Beneficiary identified pursuant to Section IV.A.1. of this Appendix C, the date on which the Beneficiary executed the Voluntary Alignment Form, and the identity of the Next Generation Participant that the Beneficiary has identified as his or her main doctor, main provider, and/or main place the Beneficiary receives care. If a Beneficiary returns more than one valid Voluntary Alignment Form to the ACO identifying a Next Generation Participant as his or main doctor, main provider, and/or main place the Beneficiary receives care, the ACO should include only the information from the latest submitted Voluntary Alignment Form on the Voluntary Alignment List; and
  3. A certification by an executive of the ACO issued in accordance with Section XXI.J of the Agreement that, to the best of his or her knowledge, information, and belief, the information contained on the Voluntary Alignment List is true, accurate, and complete and identifies only those Beneficiaries who have submitted a valid Voluntary Alignment Form to the ACO.
- B. CMS will use the Voluntary Alignment List submitted by the ACO to conduct alignment of Beneficiaries for the Performance Year subsequent to the Performance Year for which the ACO selected to participate in Voluntary Alignment (“**Subsequent Performance Year**”).
1. CMS will align Beneficiaries who were included on the ACO's Voluntary Alignment List to the ACO in accordance with the eligibility criteria set forth in Section VI of this Appendix.
  2. If a Beneficiary returns valid Voluntary Alignment Forms to multiple ACOs, CMS will honor the Voluntary Alignment Form with the most recent execution date.
- C. CMS will audit the ACO's Voluntary Alignment List for accuracy in accordance with Section XVII.B of the Agreement. This audit, including any surveys of Next Generation Beneficiaries conducted pursuant to Section IV.D of this Appendix C, may take place during the Performance Year in which the ACO has selected to participate in Voluntary Alignment or at a later time, as determined by CMS.
- D. For each Performance Year in which the ACO selects to participate in Voluntary Alignment, CMS may survey Next Generation Beneficiaries as a part of the audit process described in Section IV.C of this Appendix C.

## **V. Voluntary Alignment Targeted Outreach Eligibility Criteria**

A Beneficiary is eligible for targeted outreach if either:

- A. The Beneficiary is aligned to the ACO in the Performance Year during which the ACO has selected to participate in Voluntary Alignment pursuant to Section X of the Agreement, or was aligned to the ACO in a previous Performance Year in which the ACO participated in the Next Generation ACO Model; or
- B. The Beneficiary does not satisfy the eligibility criteria under Section V.A of this Appendix C, but has had at least one paid claim for a Qualified Evaluation and Management service, as that term is defined in Appendix B of this Agreement, furnished on or after January 1, 2014, by a provider or supplier billing under the TIN of a Next Generation Participant that is included on the ACO's Participant List for the Performance Year during which the ACO has selected to participate in Voluntary Alignment.

## **VI. Voluntary Alignment Eligibility Criteria**

CMS shall use Voluntary Alignment to align a Beneficiary to the ACO for the Subsequent Performance Year if the following conditions are satisfied:

- A. The Beneficiary has had at least one paid claim for a Qualified Evaluation and Management service, as that term is defined in Appendix B of this Agreement, furnished on or after January 1, 2014 by a provider or supplier billing under the TIN of a Next Generation Participant that is included on the ACO's Participant List for that Subsequent Performance Year;
- B. On or before the date referenced in Section IV.A of this Appendix C, the ACO received a valid Voluntary Alignment Form from the Beneficiary identifying a Next Generation Participant that is included on the ACO's Participant List for that Subsequent Performance Year as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care;
- C. The Beneficiary has not, on or before the date referenced in Section IV.A, subsequently identified a physician or other individual or entity that is not a Next Generation Participant that is included on the ACO's Participant List for that Subsequent Performance Year as the Beneficiary's main doctor, main provider, or main place the Beneficiary receives care;
- D. At the time CMS conducts the ACO's alignment for the Subsequent Performance Year, the Beneficiary meets the criteria to be considered alignment-eligible, as set forth in Appendix B of this Agreement; and
- E. At the time CMS conducts the ACO's alignment for the Subsequent Performance Year, CMS has not aligned the Beneficiary to another model, demonstration, or program including, but not limited to, the Independence at Home Demonstration, the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP), the Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals, or the Medicare Shared Savings Program (MSSP).

## **VII. Voluntary Alignment Decisions from Other ACO Initiatives**

If an ACO participates in a voluntary alignment process in another ACO initiative during the year immediately preceding the ACO's first Performance Year in the Next Generation ACO Model, CMS will align Beneficiaries that were included on the ACO's Voluntary Alignment List (or equivalent record of beneficiary submissions used in the other initiative) for the performance year that corresponds with the ACO's first Performance Year in the Next Generation ACO Model to the ACO in accordance with the criteria set forth in Section VI. of this Appendix C (applying the terminology used for that ACO initiative).

# Next Generation ACO Model Participation Agreement

## Appendix D

### HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet

#### I. 2018 Performance Year HIPAA-Covered Disclosure Request Attestation

The ACO requests the CMS data listed in the Data Specification Worksheet below for the 2018 Performance Year and makes the following assertions regarding its ability to meet the HIPAA requirements for receiving such data:

*The ACO is (select one):*

- A HIPAA Covered Entity (CE) as defined in 45 CFR § 160.103.
- The business associate (BA) of a HIPAA CE as defined in 45 CFR § 160.103.
- Neither a HIPAA CE nor a BA of a HIPAA CE.

*The ACO is seeking protected health information (PHI), as defined in 45 CFR § 160.103 (select one):*

- For its own use.
- On behalf of a CE for which the ACO is a BA.
- Other: Please attach a description of the intended purpose (e.g., for “research” purposes, for “public health” purposes, etc.).

*The ACO requests (select one):*

- For the Medicare beneficiaries that have been aligned to the ACO under the Model using the methodology described in this Agreement: (i) three years [2015-2017] of historical data files consisting of the data elements identified in the Data Specification Worksheet for newly aligned Next Generation Beneficiaries; and (ii) monthly claims data files for all aligned Next Generation Beneficiaries for the data elements identified in the Data Specification Worksheet, from the following CMS data files:

File	System of Record
HIGLAS - Payment Data	N/A
NLR - Meaningful Use Data	NCH (71 FR 67137 / 11/20/2006)
RAS - Risk Adjustment Data	IDR (71 FR 74915 / 12/13/2006)
CAHPS - Beneficiary Survey Data	IDR (71 FR 74915 / 12/13/2006)
GPCO - Quality Measurement Data	NCH (71 FR 67137 / 11/20/2006)
NPICS - NPI Crosswalk	NPS (63 FR 40297 / 7/28/1998)
PECOS - Provider Enrollment Data	PECOS (71 FR 60536/ 10/13/2006)
CME - Beneficiary Enrollment Data	EDB (73 FR 10249 / 2/26/2008)
IDR - Parts A, B, and D Claims	IDR (71 FR 74915 / 12/13/2006)

- Other: Please attach a detailed description of the data requested.

*The ACO intends to use the requested data to carry out (select one):*

- “Health care operations” that fall within the first and second paragraphs of the definition of that phrase under the HIPAA Privacy Rule (45 CFR § 164.501).
- Other: Please attach a description of the intended purpose (e.g., for “research” purposes, for “public health” purposes, etc.).

*The data requested is (select one):*

- The "minimum necessary" (as defined at 45 CFR § 164.502) to carry out the health care operations activities described above.
- Other: Please attach a description of how (if applicable) the data requested exceeds what is needed to carry out the work described above.

*This HIPAA-Covered Disclosure Request Attestation supersedes all such prior attestations made by the ACO to CMS at any time during its participation in the Model.*

*The ACO’s data custodian for the requested data is:* \_\_\_\_\_  
 (name)  
 \_\_\_\_\_  
 (phone number)

By: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 Name of authorized signatory

\_\_\_\_\_  
 Title

## II. Data Specification Worksheet

Data Element Source	Data Element	Data Element Description
Part A Claims	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Provider OSCAR Number	A facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim



	40=Outpatient claim
	50=Hospice claim
	60=Inpatient claim
	61=Inpatient "Full-Encounter" claim
Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
Claim Bill Facility Type Code	<p>The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are:</p> <p>1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved</p>
Claim Bill Facility Type Code	<p>The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are:</p> <p>1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved</p>
Claim Bill Classification Code	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital).
Principal Diagnosis Code	The International Classification of Diseases (ICD)-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
Admitting Diagnosis Code	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted.
Claim Medicare Non Payment Reason Code	Indicates the reason payment on an institutional claim is denied.
Claim Payment Amount	Amount that Medicare paid on the claim.
Claim NCH Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer.
Federal Information Processing Standards FIPS State Code	Identifies the state where the facility providing services is located.
Beneficiary Patient Status Code	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death).
Diagnosis Related Group Code	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
Claim Outpatient Service Type Code	<p>Indicates the type and priority of outpatient service. Claim Outpatient Service Type Codes are:</p> <p>0=Blank 1=Emergency</p>

		2=Urgent
		3=Elective
		5-8=Reserved
		9=Unknown
Facility Provider NPI Number		Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
Operating Provider NPI Number		Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
Attending Provider NPI Number		Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.
Other Provider NPI Number		Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
Claim Adjustment Type Code		Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
Claim Effective Date		Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
Claim IDR Load Date		When the claim was loaded into the IDR.
Beneficiary Equitable BIC HICN Number		This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
Claim Admission Type Code		Indicates the type and priority of inpatient services.
		Claim Admission Type Codes are:
		0=Blank
		1=Emergency
		2=Urgent
		3=Elective
		4=Newborn
		5=Trauma Center
		6-8=Reserved
	9=Unknown	
Claim Admission Source Code		Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Find Admission Source Codes here: <a href="http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code">http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code</a>
Claim Bill Frequency Code		The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Find Claim Frequency Codes here: <a href="http://www.resdac.org/cms-data/variables/Claim-Frequency-Code">http://www.resdac.org/cms-data/variables/Claim-Frequency-Code</a> .
Claim Query Code		Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator).
		Claim Query Codes are:
		0=Credit adjustment
		1=Interim bill
		2=HHA benefits exhausted
		3=Final bill
	4=Discharge notice	
	5=Debit adjustment	
Beneficiary Surrogate Key		A IDR assigned surrogate key used to uniquely identify a beneficiary
ACO Identifier		The unique identifier of an ACO
Calendar Century Year Month Number		The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
Meta Process Date		The date the CCLF process loaded the historical record in the table
Part A Claims Revenue Center Details	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line

	Beneficiary HIC Number	A beneficiary identifier.	
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim	
		Claim Line From Date	The date the service associated with the line item began.
		Claim Line Thru Date	The date the service associated with the line item ended.
		Product Revenue Center Code	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).
		Claim Line Institutional Revenue Center Date	The date that applies to the service associated with the Revenue Center code.
		HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
		Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.	
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.	
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.	
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.	
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.	
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.	
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.	
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.	
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.	
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
	ACO Identifier	The unique identifier of an ACO	
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.	
	Meta Process Date	The date the CCLF process loaded the historical record in the table	
Part A Procedure Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.	
	Beneficiary HIC Number	A beneficiary identifier.	
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim	

		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim
	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Procedure Code	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
	Procedure Performed Date	The date the indicated procedure was performed.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Diagnosis Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Claim Product Type Code	Codes classifying the diagnosis category:
		E=Accident diagnosis code
		1=First diagnosis E code
		D=Other diagnosis codes
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
50=Hospice claim		
60=Inpatient claim		
	61=Inpatient "Full-Encounter" claim	
Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability.	
Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key.	
Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.	
Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
	Also known as "Statement Covers From Date."	
Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.	
Claim Present on Admission Indicator	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-Admission values here:	

	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
	ACO Identifier	The unique identifier of an ACO	
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.	
	Meta Process Date	The date the CCLF process loaded the historical record in the table	
Part B Physicians	Current Claim Unique Identifier	A unique identification number assigned to the claim.	
	Claim Line Number	A sequential number that identifies a specific claim line	
	Beneficiary HIC Number	A beneficiary identifier.	
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.	
		Claim type codes are:	
		10=HHA claim	
		20=Non swing bed SNF claim	
		30=Swing bed SNF claim	
		40=Outpatient claim	
		61=Inpatient "Full-Encounter" claim	
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
	Provider Type Code	Identifies the type of Provider Identifier.	
	Rendering Provider FIPS State Code	Identifies the state that the provider providing the service is located in.	
	Claim Rendering Federal Provider Specialty Code	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item.	
	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.	
	Claim Line From Date	The date the service associated with the line item began.	
	Claim Line Thru Date	The date the service associated with the line item ended.	
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.	
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.	
	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code.	
Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.		
Claim Provider Tax Number	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.		
Rendering Provider NPI Number	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.		
Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.		
Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.		
Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)		
Claim Effective Date	Date the claim was processed and added to the NCH.		

	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Control Number	A unique number assigned to a claim by the Medicare carrier.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Claim Disposition Code	Information regarding payment actions on the claim.
		Claim Disposition Codes are:
		01=Debit accepted
		02=Debit accepted (automatic adjustment)
		03=Cancel accepted
	Claim Diagnosis First Code	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Second Code	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Third Code	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Fourth Code	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Fifth Code	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Sixth Code	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Seventh Code	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Eighth Code	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part B DMEs	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
10=HHA claim		
20=Non swing bed SNF claim		
	30=Swing bed SNF claim	
	40=Outpatient claim	

	50=Hospice claim	
	60=Inpatient claim	
	61=Inpatient "Full-Encounter" claim	
Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.	
Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.	
Claim Place of Service Code	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual.	
Claim Line From Date	The date the service associated with the line item began.	
Claim Line Thru Date	The date the service associated with the line item ended.	
HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.	
Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.	
Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer.	
Pay to Provider NPI Number	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.	
Ordering Provider NPI Number	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.	
Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied. Find Carrier Payment Denial Codes here:	
Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.	
Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)	
Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.	
Claim IDR Load Date	When the claim was loaded into the IDR.	
Claim Control Number	A unique number assigned to a claim by the Medicare carrier.	
Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.	
Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.	
Claim Disposition Code	Information regarding payment actions on the claim.	
	Claim Disposition Codes are:	
	01=Debit accepted	
	02=Debit accepted (automatic adjustment)	
	03=Cancel accepted	
Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
ACO Identifier	The unique identifier of an ACO	
Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'.	
Meta Process Date	The date the CCLF process loaded the historical record in the table	
Part D	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	NDC Code	A universal unique product identifier for human drugs.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.

	<p>Claim type codes are:</p> <p>10=HHA claim</p> <p>20=Non swing bed SNF claim</p> <p>30=Swing bed SNF claim</p> <p>40=Outpatient claim</p> <p>50=Hospice claim</p> <p>60=Inpatient claim</p> <p>61=Inpatient "Full-Encounter" claim</p>
Claim Line From Date	The date the service associated with the line item began.
Provider Service Identifier Qualifier Code	<p>Indicates the type of number used to identify the pharmacy providing the services:</p> <p>01= NPI Number</p> <p>06=Unique Physician Identification Number (UPIN)</p> <p>07=National Council for Prescription Drug Programs (NCPDP) Number</p> <p>08=State License Number</p> <p>11=TIN</p> <p>99=Other mandatory for Standard Data Format</p>
Claim Service Provider Generic ID Number	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
Claim Dispensing Status Code	<p>Indicates the status of prescription fulfillment.</p> <p>Dispensing Codes are:</p> <p>P=Partially filled</p> <p>C=Completely filled</p>
Claim Dispense as Written DAW Product Selection Code	<p>Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed.</p> <p>DAW Product Selection Codes are:</p> <p>0=No product selection indicated</p> <p>1=Substitution not allowed by prescriber</p> <p>2=Substitution allowed – Patient requested that brand be dispensed</p> <p>3=Substitution allowed – Pharmacist selected product dispensed</p> <p>4=Substitution allowed – Generic not in stock</p> <p>5=Substitution allowed – Brand drug dispensed as generic</p> <p>6=Override</p> <p>7=Substitution not allowed – Brand drug mandated by law</p> <p>8=Substitution allowed – Generic drug not available in marketplace</p> <p>9=Other</p>
Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
Claim Line Days' Supply Quantity	The number of days the supply of medication dispensed by the pharmacy will cover.
Provider Prescribing ID Qualifier Code	<p>The number of days the supply of medication dispensed by the pharmacy will cover.</p> <p>Indicates the type of number used to identify the prescribing provider:</p> <p>01= NPI Number</p> <p>06= UPIN</p> <p>07= NCPDP Number</p> <p>08=State License Number</p> <p>11=TIN</p> <p>99=Other mandatory for Standard Data Format</p>
Claim Prescribing Provider Generic ID Number	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.
Claim Line Beneficiary Payment Amount	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)



	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.	
	Claim IDR Load Date	When the claim was loaded into the IDR.	
	Claim Line Prescription Service Reference Number	Identifies a prescription dispensed by a particular service provider on a particular service date.	
	Claim Line Prescription Fill Number	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.	
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
	ACO Identifier	The unique identifier of an ACO	
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.	
	Meta Process Date	The date the CCLF process loaded the historical record in the table	
Beneficiary Demographics	Beneficiary HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.	
	Beneficiary FIPS State Code	Identifies the state where the beneficiary receiving services resides.	
	Beneficiary FIPS County Code	Identifies the county where the beneficiary receiving services resides.	
	Beneficiary ZIP Code	The beneficiary’s ZIP code as indicated in their Medicare enrollment record.	
	Beneficiary Date of Birth	The month, day, and year of the beneficiary’s birth.	
	Beneficiary Sex Code	The beneficiary’s sex:	
		1=Male	
		2=Female	
	Beneficiary Race Code	0=Unknown	
		The beneficiary's race:	
		1=White	
		2=Black	
		3=Other	
		4=Asian	
	Beneficiary Age	5=Hispanic	
6=North American Native			
The beneficiary’s current age, as calculated by subtracting the beneficiary’s date of birth from the current date.			
Beneficiary Medicare Status Code		Indicates the reason for a beneficiary’s entitlement to Medicare benefits as of a particular date, broken down by the following categories: Old Age & Survivors Insurance (OASI), Disabled, and End Stage Renal Disease (ESRD), and by appropriate combinations of these categories:	
		10=Aged without ESRD	
	11=Aged with ESRD		
	20=Disabled without ESRD		
	21=Disabled with ESRD		
31=ESRD only			
Beneficiary Dual Status Code	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid).		
Beneficiary Death Date	The month, day, and year of a beneficiary’s death.		
Date beneficiary enrolled in Hospice	The date the beneficiary enrolled in Hospice.		
Date beneficiary ended Hospice	The date the beneficiary is-enrolled in hospice.		
Beneficiary First Name	The first name of the beneficiary.		

	Beneficiary Middle Name	The middle name of the beneficiary.
	Beneficiary Last Name	The last name of the beneficiary.
	Beneficiary Original Entitlement Reason Code	Original Reason for the beneficiary's entitlement to Medicare Benefits.
		Values are:
		0 Beneficiary insured due to age (OASI);
		1 Beneficiary insured due to disability;
		2 Beneficiary insured due to End Stage; Renal Disease (ESRD);
		3 Beneficiary insured due to disability and current ESRD.
		4. None of the above
	Beneficiary Entitlement Buy In Indicator	Indicates for each month of the Denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Beneficiary XREF	Current HIC Number	A beneficiary identifier.
	Previous HIC Number	The HICN that appears in this field is the beneficiary's previous HICN.
	Previous HICN Effective Date	The date the previous HICN became active.
	Previous HICN Obsolete Date	The date the previous HICN ceased to be active.
	Beneficiary Railroad Board Number	The external (to Medicare) HICN for beneficiaries that are RRB members.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Summary Statistics	ACO Identifier	The unique identifier of an ACO
	File Type	The CCLF File Type
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
	File Description	The description of the CCLF File
	Total Records Count	The total number of records in the file
	Record Length	The length of the record for the file
	File Name	The name the CCLF extract file that was sent to be swept by the EFT process

## Next Generation ACO Model Participation Agreement

### Appendix F

#### Quality Measures

#### I. CY2018 Quality Measures

The following quality measures are the measures for use in establishing quality performance standards in the third Performance Year of the Model (CY2018).

The column “2018 Starters” indicates that all measures are pay-for-reporting (“R”) for ACOs for which the start date in the Model is January 1, 2018; the column “2017 Starters” indicates whether each measure is pay-for-reporting (“R”) or pay-for-performance (“P”) for ACOs for which the start date in the Model is January 1, 2017; the column “2016 Starters” indicates whether each measure is pay-for-reporting (“R”) or pay-for-performance (“P”) for ACOs for which the start date in the Model is January 1, 2016.

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In		
				2018 Starters	2017 Starters	2016 Starters
<b>AIM: Better Care for Individuals</b>						
Patient / Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	R	P	P
	ACO - 2	CAHPS: How Well Your Providers Communicate	Survey	R	P	P
	ACO - 3	CAHPS: Patients' Rating of Provider	Survey	R	P	P
	ACO - 4	CAHPS: Access to Specialists	Survey	R	P	P
	ACO - 5	CAHPS: Health Promotion and Education	Survey	R	P	P
	ACO - 6	CAHPS: Shared Decision Making	Survey	R	P	P
	ACO - 7	CAHPS: Health Status/Functional Status	Survey	R	R	R
	ACO - 34	CAHPS: Stewardship of Patient Resources	Survey	R	P	P
Care Coordination / Patient Safety	ACO - 8	Risk-Standardized, All Condition Readmission	Claims	R	R	P
	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Claims	R	R	P
	ACO - 36	All-Cause Unplanned Admissions for Patients with Diabetes	Claims	R	R	P
	ACO - 37	All-Cause Unplanned Admissions for Patients with Heart Failure	Claims	R	R	P
	ACO - 38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	R	R	P
	ACO - 43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator [PQI] #91)	Claims	R	R*	R*

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In		
				2018 Starters	2017 Starters	2016 Starters
	ACO - 44	Use of Imaging Studies for Low Back Pain	Claims	R	R	R
	ACO - 12	Medication Reconciliation Post-Discharge	CMS Web Interface	R	R*	R*
	ACO - 13	Falls: Screening for Future Fall Risk	CMS Web Interface	R	P	P
<b>AIM: Better Care for Populations</b>						
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	R	P	P
	ACO - 15	Pneumonia Vaccination Status for Older Adults	CMS Web Interface	R	P	P
	ACO - 16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	CMS Web Interface	R	P	P
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	R	P	P
	ACO - 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	CMS Web Interface	R	P	P
	ACO - 19	Colorectal Cancer Screening	CMS Web Interface	R	R	P
	ACO - 20	Breast Cancer Screening	CMS Web Interface	R	R	P
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Depression	ACO - 40	Depression Remission at Twelve Months	CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Composite (All or Nothing Scoring): ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control	CMS Web Interface	R	P	P
	ACO - 41	ACO - 41: Diabetes: Eye Exam				
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure	CMS Web Interface	R	P	P
Clinical Care for At Risk Population - Ischemic Vascular Disease (IVD)	ACO - 30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	CMS Web Interface	R	P	P

\* Measure introduced in the 2017 Physician Fee Schedule final rule, and will remain Pay-for-Reporting in 2017 and 2018; after that, the phase-in schedule (<https://www.federalregister.gov/d/2016-26668/p-3291>) will apply. Measure will be Pay-for-Performance for all ACOs participating in the Model during any future Performance Year.

## II. CY2017 Quality Measures

The following quality measures are the measures for use in establishing quality performance standards in the second Performance Year of the Model (CY2017).

The column “2017 Starters” indicates that all measures are pay-for-reporting (“R”) for ACOs for which the start date in the Model is January 1, 2017, and the column “2016 Starters” indicates whether each measure is pay-for-reporting (“R”) or pay-for-performance (“P”) for ACOs for which the start date in the Model is January 1, 2016.

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In	
				R—Reporting P—Performance	
				2017 Starters	2016 Starters
<b>AIM: Better Care for Individuals</b>					
Patient / Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	R	P
	ACO - 2	CAHPS: How Well Your Providers Communicate	Survey	R	P
	ACO - 3	CAHPS: Patients' Rating of Provider	Survey	R	P
	ACO - 4	CAHPS: Access to Specialists	Survey	R	P
	ACO - 5	CAHPS: Health Promotion and Education	Survey	R	P
	ACO - 6	CAHPS: Shared Decision Making	Survey	R	P
	ACO - 7	CAHPS: Health Status/Functional Status	Survey	R	R
	ACO - 34	CAHPS: Stewardship of Patient Resources	Survey	R	P
Care Coordination / Patient Safety	ACO - 8	Risk-Standardized, All Condition Readmission	Claims	R	R
	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Claims	R	R
	ACO - 36	All-Cause Unplanned Admissions for Patients with Diabetes	Claims	R	R
	ACO - 37	All-Cause Unplanned Admissions for Patients with Heart Failure	Claims	R	R
	ACO - 38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	R	R
	ACO - 43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator [PQI] #91)	Claims	R	R*
	ACO - 44	Use of Imaging Studies for Low Back Pain	Claims	R	R
	ACO - 12	Medication Reconciliation Post-Discharge	CMS Web Interface	R	R*
	ACO - 13	Falls: Screening for Future Fall Risk	CMS Web Interface	R	P
<b>AIM: Better Care for Populations</b>					
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	R	P
	ACO - 15	Pneumonia Vaccination Status for Older Adults	CMS Web Interface	R	P

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In	
				2017 Starters	2016 Starters
	ACO - 16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	CMS Web Interface	R	P
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	R	P
	ACO - 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	CMS Web Interface	R	P
	ACO - 19	Colorectal Cancer Screening	CMS Web Interface	R	R
	ACO - 20	Breast Cancer Screening	CMS Web Interface	R	R
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	R	R
Clinical Care for At Risk Population - Depression	ACO - 40	Depression Remission at Twelve Months	CMS Web Interface	R	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Composite (All or Nothing Scoring): ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control ACO - 41: Diabetes: Eye Exam	CMS Web Interface	R	P
	ACO - 41				
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure	CMS Web Interface	R	P
Clinical Care for At Risk Population - Ischemic Vascular Disease (IVD)	ACO - 30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	CMS Web Interface	R	P

\* Measure introduced in the 2017 Physician Fee Schedule, and will remain Pay-for-Reporting in 2017 and 2018; after that, the phase-in schedule will apply. Measure will be Pay-for-Performance for all NGACOs in the Model in 2019.

### III. CY2016 Quality Measures

The following quality measures are the measures for use in establishing quality performance standards in the first Performance Year of the Model (CY2016). As indicated in the right-hand column, all measures are pay-for-reporting (“R”) for ACOs for which the start date in the Model is January 1, 2016.

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance
<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 Providers Communicate	Survey	R
	ACO – 3	CAHPS: Patients' Rating of Provider	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 with Diabetes	Claims	R
	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 Index (BMI) Screening and Follow Up	CMS Web Interface	R
	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

<b>Domain</b>	<b>ACO Measure #</b>	<b>Measure Title</b>	<b>Method of Data Submission</b>	<b>Pay for Performance Phase In R—Reporting P—Performance</b>
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): ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control ACO - 41: Diabetes: Eye Exam	CMS Web Interface	R
	ACO – 41			
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



# Next Generation ACO Model Participation Agreement

## Appendix G

### Alternative Payment Mechanism - Infrastructure Payments

#### I. Infrastructure Payment Election

- A. CMS may reject the ACO's election to participate in Infrastructure Payments for a Performance Year if CMS has imposed any remedial actions pursuant to Section XIX of this Agreement, or similar remedial actions pursuant to participation in another Medicare ACO initiative during the two Performance Years prior to the applicable Performance Year.
- B. If CMS rejects the ACO's election to participate in Infrastructure Payments for a Performance Year (in accordance with Section X.C), the ACO will defer to traditional FFS, a non-Alternative Payment Mechanism, for the Performance Year. The ACO will not have the ability to choose another Alternative Payment Mechanism for the Performance Year.

#### II. Calculation

##### A. Determining Aligned Population

CMS will calculate the amount of the ACO's Infrastructure Payments using an estimation of the Performance Year aligned population and the number of person months per aligned Beneficiary, calculated as follows:

##### 1. Calibration Year Exclusions Used to Estimate Performance Year Aligned Beneficiary Population

CMS will use exclusions from a calibration year to estimate the proportion of initially aligned Beneficiaries that will be excluded because alignment-eligibility requirements and service area requirements are not met during the Performance Year. The calibration year is the most recent calendar year for which complete data needed to perform alignment-eligibility exclusions and service area exclusions are available.

##### 2. Estimation of Performance-Year Aligned Population Person-Months

CMS will use a set 11.70 months as the estimated number of person-months per aligned Beneficiary.

##### B. PBPM Payment

1. If the ACO selects to participate in Infrastructure Payments through the annual selections process under Section X of this Agreement, the ACO must select the dollar amount of the per-beneficiary per-month (“**PBPM**”) payment.
2. The PBPM amount may not exceed \$6.00 PBPM.

#### C. Monthly Payment

1. The amount of the monthly Infrastructure Payment:
  - (a) Is the mathematical product of the following, divided by twelve months:
    - i. The PBPM amount selected pursuant to Section II.B of this Appendix;
    - ii. The number estimated person-months accrued per aligned Beneficiary described in II.A.2 of this Appendix; and
    - iii. The estimated number of aligned Beneficiaries determined in accordance with Section II.A.1 of this Appendix.
  - (b) Will be calculated by CMS prior to the start of each Performance Year in which the ACO has selected to participate in Infrastructure Payments; and
  - (c) Will not be updated during the Performance Year.
2. CMS will make Infrastructure Payments as a monthly lump sum payment to the ACO.
3. Infrastructure Payments may be subject to budget sequestration.

#### D. Claims Payment

In a Performance Year in which the ACO has selected to receive Infrastructure Payments, CMS will continue to pay all claims for services furnished to Next Generation Beneficiaries as normal through the FFS claims system.

#### E. Reconciliation of Infrastructure Payments

1. The ACO shall repay CMS all Infrastructure Payments amounts received during a Performance Year as Other Monies Owed at the Performance Year settlement under Section XIV or through settlement reports issued at such other times as may be required under this Agreement under Section XIV.
2. Infrastructure Payments do not affect the calculation of Shared Savings/Losses, which will continue to be based on total FFS expenditures during the Performance Year for Next Generation Beneficiaries (see Appendix B for more detail).

3. The reconciliation of Infrastructure Payments does not affect and is not affected by the ACO's selected risk arrangement or savings/losses cap.
4. Infrastructure Payments will be reconciled as Other Monies Owed during the Performance Year financial settlement or through a settlement report at such other time as may be required under this Agreement.
5. To reduce the number of transactions between the ACO and CMS, the amount of Infrastructure Payments owed will be added to any Shared Losses to be paid to CMS or deducted from any Shared Savings to be paid to the ACO, such that the ACO may owe CMS a payment despite earning Shared Savings.
6. Settlement and repayment of Infrastructure Payments will occur in accordance with Section XIV of this Agreement.

### **III. Performance Year 2016 Alternative Payment Mechanism - Infrastructure Payments**

The Infrastructure Payments Benefit Enhancement for the 2016 Performance Year is governed by Appendix G of the Next Generation ACO Model Participation Agreement that was executed in December 2015, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

## Next Generation ACO Model

### Appendix H

#### Alternative Payment Mechanism - Population-Based Payments (PBP)

##### I. PBP Election

- A. If the ACO wishes to participate in PBP, it must -
1. Timely submit to CMS its selection of PBP as an Alternative Payment Mechanism for a Performance Year in accordance with Section X.A of this Agreement;
  2. Submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Next Generation Participants that have agreed to participate in PBP and a true, accurate, and complete list of Preferred Providers that have agreed to participate in PBP;
  3. Timely submit a fully executed “Next Generation ACO Model: Population-Based Payments Fee Reduction Agreement” (described in Section II.I of this Appendix) for each Next Generation Participant and Preferred Provider that is identified as participating in PBP, as set forth on the lists submitted in accordance with Section I.A.2 of this Appendix; and
  4. Submit by a date and in a manner specified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.A of this Appendix.
- B. CMS may reject the ACO’s selection to participate in PBP for a Performance Year if:
1. CMS has taken any remedial actions pursuant to Section XIX of this Agreement;
  2. CMS has taken any remedial actions against the ACO in connection with its participation in another Medicare ACO initiative during either of the ACO’s last two performance years in that initiative;
  3. CMS determines on the basis of a program integrity screening or other information that the ACO’s participation in PBP might compromise the integrity of the Model; or
  4. The ACO’s selection to participate in PBP is for its first Performance Year in the Model and the ACO has not participated in any Medicare ACO initiative prior to its participation in the Model.
- C. CMS may prohibit the ACO from having a PBP Payment Arrangement (as defined in Section III of this Appendix) with a Next Generation Participant or Preferred Provider if:
1. The conduct of the Next Generation Participant or Preferred Provider has caused CMS to impose remedial action pursuant to Section XIX of this Agreement or to impose a sanction under any CMS administrative authority; or
  2. CMS determines on the basis of a program integrity screening or other information that the Next Generation Participant’s or Preferred Provider’s participation in PBP might compromise the integrity of the Model.

- D. If CMS rejects or later terminates the ACO's selection to participate in PBP for a Performance Year (in accordance with Section X.C or XIX.A. of this Agreement, respectively), payments to the ACO's Next Generation Participants and Preferred Providers will default to traditional FFS for the remainder of the Performance Year. The ACO will not have the ability to choose a different Alternative Payment Mechanism for the Performance Year.

## **II. PBP Fee Reduction**

- A. If the ACO selects to participate in PBP for a Performance Year in accordance with Section I.A of this Appendix, the ACO shall, by a date specified by CMS, notify and educate all Next Generation Participants and Preferred Providers about the ACO's intended participation in PBP and the associated PBP Fee Reduction for those Next Generation Participants and Preferred Providers that agree to participate in PBP. Providing a copy of the Next Generation ACO Model Population-Based Payments Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in PBP for a Performance Year is rejected, the ACO shall notify all Next Generation Participants and Preferred Providers that it is not participating in PBP for that Performance Year.
- B. A Next Generation Participant or Preferred Provider may participate in PBP for a Performance Year only if the Next Generation Participant or Preferred Provider was included on the ACO's Participant List or Preferred Provider List, respectively, at the start of that Performance Year. Next Generation Participants and Preferred Providers who were added to the ACO's Participant List or Preferred Provider List during a Performance Year may participate in PBP in a subsequent Performance Year only if they are included on the ACO's Participant List or Preferred Provider List at the start of the subsequent Performance Year.
- C. Not all Next Generation Participants and Preferred Providers must agree to participate in PBP for the ACO to participate in PBP.
- D. Not all Next Generation Participants and Preferred Providers billing under a TIN must agree to participate in PBP for other Next Generation Participants and Preferred Providers billing under the same TIN to participate in PBP.
- E. All Next Generation Participants and Preferred Providers that bill under the same TIN and that have agreed to participate in PBP must agree to the same PBP Fee Reduction percentage, as documented on the Next Generation ACO Model Population-Based Fee Reduction Agreement completed by the TIN, as provided in Section II.I of this Appendix.
- F. CMS will reduce FFS payments on claims for services furnished to Next Generation Beneficiaries by the agreed PBP Fee Reduction percentage only for those Next Generation Participants and Preferred Providers that have consented to receive the PBP Fee Reduction pursuant to Section II.I of this Appendix and with whom the ACO is not prohibited under Section I.C of this Appendix from having a PBP Payment Arrangement.
- G. A hospital paid under the Inpatient Prospective Payment System that is a Next Generation Participant or Preferred Provider that has agreed to receive the PBP Fee

Reduction will continue to receive IME, DSH, inpatient outlier, and inpatient new technology add-on payments calculated in accordance with the applicable statutory and regulatory provisions.

H. For certain types of institutional providers, such as Method II CAHs and FQHCs, that are Next Generation Participants or Preferred Providers and are participating in PBP, CMS will reduce by the agreed PBP Fee Reduction percentage all FFS payments for services furnished to Next Generation Beneficiaries that are billed under that institution's CCN and organizational NPI regardless of whether the individual NPIs rendering the service are Next Generation Participants or Preferred Providers.

I. Written Confirmation of Consent

1. The ACO shall obtain written confirmation that each PBP-participating Next Generation Participant or Preferred Provider has consented to receive the PBP Fee Reduction and the amount of the PBP Fee Reduction percentage. Such written confirmation of consent must be in the form of a completed "Next Generation ACO Model: Population-Based Payments Fee Reduction Agreement" signed by an individual legally authorized to act for the entity through whose TIN the Next Generation Participant or Preferred Provider bills Medicare. Consistent with Section II.E of this Appendix, all Next Generation Participants and Preferred Providers that bill under the same TIN and that have agreed to participate in PBP must agree to the same PBP Fee Reduction percentage.
2. As part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN the Next Generation Participant or Preferred Provider bills Medicare must verify the accuracy of the list of Next Generation Participants and Preferred Providers that have affirmatively consented to receiving the PBP Fee Reduction.
3. A Next Generation Participant's or Preferred Provider's consent to receive the PBP Fee Reduction must apply for the full Performance Year and must be renewed annually in order for the Next Generation Participant or Preferred Provider to continue to participate in PBP.
4. Consent to participate in PBP by a Next Generation Participant or Preferred Provider must be voluntary and must not be contingent on or related to receipt of referrals from the ACO, its Next Generation Participants, or Preferred Providers.

### III. PBP Payment Arrangement

- A. The ACO shall have a written payment arrangement with each PBP-participating Next Generation Participant or Preferred Provider that establishes how the ACO will compensate the PBP-participating Next Generation Participant or Preferred Provider for Covered Services that are subject to the PBP Fee Reduction ("**PBP Payment Arrangement**").
- B. In establishing the terms of any PBP Payment Arrangement, neither party gives or receives remuneration in return for or to induce business other than business covered by the PBP Payment Arrangement.

- C. The compensation paid by the ACO under a PBP Payment Arrangement may not be made knowingly to induce the PBP-participating Next Generation Participant or Preferred Provider to reduce or limit Medically Necessary items or services to Beneficiaries.
- D. The compensation paid by the ACO under a PBP Payment Arrangement must be negotiated in good faith and may be monetary or nonmonetary, or both.
- E. The ACO shall maintain, in accordance with Section XVIII.B of the Agreement, records of all payments made pursuant to each PBP Payment Arrangement.
- F. The PBP Payment Arrangement must:
  - 1. Require the Next Generation Participant or Preferred Provider to make Medically Necessary Covered Services available to Next Generation Beneficiaries in accordance with all applicable laws and regulations.
  - 2. Prohibit the ACO from requiring prior authorization for services furnished to Next Generation Beneficiaries.
  - 3. Prohibit the ACO and Next Generation Participant or Preferred Provider from interfering with a Next Generation Beneficiary's freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in PBP or with the ACO.
  - 4. Require the Next Generation Participant or Preferred Provider to maintain records regarding the PBP Payment Arrangement (including records of any compensation paid under the arrangement) in accordance with Section XVIII.B of the Agreement.
  - 5. Require the Next Generation Participant or Preferred Provider to provide the Government with access to records regarding the PBP Payment Arrangement (including records of any payments made under the arrangement) in accordance with Section XVIII.A. of the Agreement.

#### **IV. Calculation of the Population-Based Payment**

##### **A. Overview**

- 1. CMS shall calculate the Monthly PBP Payment in accordance with Section IV.B of this Appendix.
- 2. CMS will make a Monthly PBP Payment to the ACO for each month that the ACO participates in PBP during the Performance Year.
- 3. CMS shall not make any Monthly PBP Payments to the ACO after the effective date of termination of this Agreement.
- 4. CMS shall not make any Monthly PBP Payments after the effective date of CMS's termination (in accordance with Section XIX.A. of this Agreement) of the ACO's selection to participate in PBP.

##### **B. PBP Payment Calculation**

## 1. Calibration Year Used to Estimate the Reduction in FFS Payments

CMS will use FFS payments from a calibration year to estimate the reduction in FFS payments to PBP-participating Next Generation Participants and Preferred Providers for Part A and Part B services furnished to Next Generation Beneficiaries during the applicable Performance Year. The calibration year is the calendar year prior to the Performance Year.

## 2. Population Used to Estimate the Reduction in FFS Payments

The population used to estimate the reduction in FFS Payments to PBP-participating Next Generation Participants and Preferred Providers for a Performance Year consists of those Beneficiaries who would have been aligned to the ACO for the calibration year on the basis of Performance Year Next Generation Participants. This population includes Beneficiaries who were alive on January 1 of the calibration year and not enrolled in a managed care plan in January of that year. This population also includes Beneficiaries who would later have been excluded from alignment to the ACO because they did not meet alignment-eligibility requirements during the calibration year or who would have been excluded based on service-area restrictions that are applied retrospectively.

## 3. Use of Completion Factors to Estimate PBP Monthly Payment

- i. CMS will use a partial year of claims experience, without run-out, to calculate the estimated reduction in FFS payments to PBP-participating Next Generation Participants and Preferred Providers because the total PBP payment amount is generally calculated prior to or at the start of the Performance Year.
- ii. To adjust for run-out and claims not yet incurred, a completion factor is applied based on the experience of the most recent calendar year for which complete experience is available (the “**Completion Factor Year**”). The most recent calendar year for which complete experience is available is typically the calendar year that is two years prior to the Performance Year. (For example, for PY2018, the completion factor would be based on claims from CY2016 and applied to the CY2017 calibration year.)
- iii. A completion factor will be calculated and applied for each claim type (e.g., inpatient hospital, skilled nursing facility, home health agency, hospice, physician, and outpatient hospital service, etc.).
- iv. The completion factor is calculated using the ratio of total expenditures for claims paid for the Completion Factor Year through December 1 of that year (e.g., December 1, 2016, for PY2018) to expenditures for claims paid for the Completion Factor Year through a three-month run-out period into the following calendar year. (If CY2016 is the Completion Factor Year, this would be March 31, 2017.)

## 4. Calculation of Total PBP Payment and Monthly PBP Payment

The total amount of PBP payments to the ACO for a Performance Year is calculated by determining the total estimated PBP Fee Reduction for each PBP-participating Next



Generation Participant and Preferred Provider (each TIN/NPI combination), which is equal to:

- i. The aggregate Part A and Part B payments made for services furnished by that PBP-participating Next Generation Participant or Preferred Provider to beneficiaries who would have been aligned to the ACO in the calibration year on the basis of Performance Year Next Generation Participants;
- ii. Multiplied by the PBP Fee Reduction for that PBP-participating Next Generation Participant or Preferred Provider;
- iii. The total from Section IV.D.4.ii of this Appendix H is then split out by each claim type;
- iv. The total for each claim type, as determined in Section IV.D.4.iii of this Appendix H is then multiplied by the completion factor for the relevant claim type; and
- v. The total from Section IV.D.4.iv of this Appendix H is then aggregated across all claim types and across all PBP-participating Next Generation Participants and Preferred Providers, and then multiplied by the ratio of the number of Next Generation Beneficiaries for the Performance Year to the number of aligned Beneficiaries for the calibration year.

The resulting amount is then multiplied by 0.98 (i.e., reduced by 2%) if budget sequestration is in effect for the Performance Year and then divided by 12 to determine the “**Monthly PBP Payment**” to the ACO.

#### C. PBP Payment Recalculation

1. CMS will not recalculate the total amount of the PBP payment for the Performance Year or the Monthly PBP Payment during the Performance Year, except as otherwise provided for in this Section IV.C of this Appendix.
2. CMS will review actual PBP Fee Reductions during the Performance Year. If Performance Year performance data shows, after two quarters, that the Monthly PBP Payments for the previous quarter are at least 25% greater than or 25% less than the total actual PBP Fee Reductions taken in the previous quarter, CMS may recalculate and revise the amount of the Monthly PBP Payment calculated under Section IV.B.4 of this Appendix based on Performance Year data and make Monthly PBP Payments in this revised amount for future months of the Performance Year. The revised Monthly PBP Payment shall be payable on a prospective basis only. CMS will provide a report of the recalculated amounts to the ACO.

### V. Reconciliation of Total Monthly PBP Payments

- A. CMS will reconcile total Monthly PBP Payments with total PBP Fee Reductions for each Performance Year the ACO participates in PBP, by calculating the difference between the total Monthly PBP payments CMS paid to the ACO during the Performance Year and the total PBP Fee Reductions taken during the Performance Year. Any difference will constitute Other Monies Owed and may be subject to recoupment during annual financial settlement as described in Section XIV.C of this Agreement and Section V.D of this Appendix.

- B. CMS will reconcile total Monthly PBP Payments separately from the annual financial settlement with the ACO's benchmark under Appendix B to determine the ACO's Shared Savings or Shared Losses. The PBP Fee Reductions do not affect the calculation of Shared Savings or Shared Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the PBP Fee Reduction. The reconciliation of total Monthly PBP Payments and total PBP Fee Reductions does not affect and is not affected by the ACO's selected Risk Arrangement, savings/loss cap, or expenditure cap.
- C. During the annual financial settlement, CMS will include any Other Monies Owed due to reconciliation of total Monthly PBP Payments, with the Shared Savings or Shared Losses on the settlement report issued under Section XIV.C.1. of this Agreement, such that the settlement report will show the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.
- D. If the total PBP Fee Reductions exceed the total Monthly PBP Payments paid to the ACO, CMS will:
  - 1. Add the difference to the amount paid to the ACO if the ACO has earned Shared Savings;
  - 2. Subtract the difference from the amount of the Shared Losses owed by the ACO if the ACO owes Shared Losses; or
  - 3. Pay the amount to the ACO as Other Monies Owed if no Shared Savings are earned and no Shared Losses are owed.
- E. If the total Monthly PBP Payments paid to the ACO exceed the total PBP Fee Reductions, CMS will:
  - 1. Subtract the difference from the amount paid to the ACO if the ACO has earned Shared Savings;
  - 2. Add the difference to the amount owed to CMS by the ACO if the ACO owes Shared Losses; or
  - 3. Recover the difference from the ACO as Other Monies Owed if no Shared Savings are earned and no Shared Losses are owed.
- F. In the event that a PBP-participating ACO elects to terminate this Agreement pursuant to Section XIX.C of the Agreement prior to the end of a Performance Year by providing notice to CMS on or before February 28 of that Performance Year with effect no later than 30 days from that notice, CMS will reconcile total Monthly PBP Payments within three (3) months after the effective date of the termination, and the ACO must pay any Other Monies Owed to CMS in accordance with XIV.C.5 of the Agreement.
- G. CMS will include in the reconciliation of total Monthly PBP Payments any PBP Fee Reductions for services furnished to Beneficiaries who were Next Generation Beneficiaries at the time the services were furnished but were later excluded from the aligned population during the Performance Year because they did not meet alignment-eligibility requirements.

- H. If, as a result of provider appeals or additional claims adjustments after the initial PBP reconciliation, CMS pays an amount in excess of the Reduced FFS Payment for any item or service furnished to a Next Generation Beneficiary by a Next Generation Participant or Preferred Provider participating in PBP, the ACO shall owe CMS the difference between the total amount CMS actually paid for such item or service and the total amount of the Reduced FFS Payment for such claim. Such difference would constitute Other Monies Owed and be subject to recoupment during settlement under Section XIV.C of this Agreement.
- I. Adjusted Settlement
1. For each Performance Year in which the ACO participates in PBP, CMS shall conduct a second PBP Reconciliation one year after the original PBP Reconciliation at the same time that CMS issues the settlement report for the subsequent Performance Year.
  2. If, as a result of the second PBP Reconciliation, CMS determines that:
    - a. The total PBP Fee Reductions exceed the total amount of PBP Payments made to the ACO as Monthly PBP Payments during the Performance Year, as reconciled during the initial PBP Reconciliation for the applicable Performance Year under Section V.A of this Appendix, the difference will be deemed Other Monies Owed and CMS will pay the amount to the ACO pursuant to Section XIV.C.5 of the Agreement;
    - b. The total amount of PBP payments made to the ACO as Monthly PBP Payments during the Performance Year, as reconciled during the initial PBP Reconciliation for the applicable Performance Year under Section V.A of this Appendix, exceeds the total PBP Fee Reductions during the Performance Year, the difference will be deemed Other Monies Owed and the ACO will pay the amount to CMS pursuant to Section XIV.C.5 of the Agreement;
  3. In the case of the final year of the Agreement Term or if the ACO voluntarily terminates the Agreement pursuant to Section XIX.C of the Agreement prior to the end of a Performance Year by providing notice to CMS on or before February 28 of that Performance Year with effect no later than 30 days from that notice:
    - a. CMS will make reasonable efforts to conduct the second PBP Reconciliation within 12 months after the issuance of the original settlement report for the applicable Performance Year;
    - b. CMS will issue an adjusted settlement report to the ACO setting forth the results of the second PBP Reconciliation and identifying any Other Monies Owed by the ACO to CMS, or by CMS to the ACO, as a result of this second PBP Reconciliation.
    - c. Any amounts owed by the ACO to CMS, or by CMS to the ACO, as a result of this second PBP Reconciliation will be payable in accordance with Section XIV.C.5 of the Agreement.

## **VI. Performance Year 2016 Alternative Payment Mechanism – Population-Based Payments**

The PBP Alternative Payment Mechanism for the 2016 Performance Year is governed by Appendix H of the Next Generation ACO Model Participation Agreement that was executed in December 2015, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

## Next Generation ACO Model Participation Agreement

### Appendix I

#### 3-Day SNF Rule Waiver Benefit Enhancement

##### I. Election of the 3-Day SNF Rule Waiver Benefit Enhancement

If the ACO wishes to offer the 3-Day SNF Rule Waiver Benefit Enhancement during a Performance Year it must –

- A. Timely submit to CMS its election of the 3-Day SNF Rule Waiver as a Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement; and
- B. Submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Next Generation Participants that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement.

##### II. Waiver

CMS waives the requirement in section 1861(i) of the Social Security Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services (“**SNF Services**”) furnished under the terms and conditions set forth in this Appendix (“**3-Day SNF Rule Waiver Benefit Enhancement**”).

##### III. Eligible SNFs

- A. For purposes of this waiver, an “**Eligible SNF**” is a skilled nursing facility (“**SNF**”) or a hospital or critical access hospital that has swing-bed approval for SNF services (“**Swing-Bed Hospital**”) that is a Next Generation Participant or Preferred Provider that has (i) entered into a written agreement with the ACO to provide SNF Services in accordance with the SNF 3-Day Rule Waiver under Section II of this Appendix; (ii) been identified by the ACO as having agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement in accordance with Section I.B of this Appendix; and (iii) been approved by CMS to participate under the 3-Day SNF Rule Waiver following a review of the qualifications of the SNF to accept admissions without a prior inpatient hospital stay (“**Direct SNF Admissions**”) and admissions after an inpatient stay of fewer than three days.
- B. CMS review and approval of a SNF to provide services in accordance with the 3-Day SNF Rule Waiver Benefit Enhancement includes consideration of the program integrity history of the SNF and any other factors that CMS determines may affect the qualifications of the SNF to provide SNF Services under the terms and conditions of the

3-Day SNF Rule Waiver Benefit Enhancement. Additionally, at the time of CMS review and approval of the SNF to participate under the 3-Day SNF Rule Waiver Benefit Enhancement, the SNF must have an overall rating of three or more stars under the CMS 5-Star Quality Rating System in seven of the previous twelve months, as reported on the Nursing Home Compare website.

- C. Eligibility of SNFs and swing bed hospitals to provide services under this 3-Day SNF Rule Waiver Benefit Enhancement will be reassessed by CMS annually, prior to the start of each Performance Year.
- D. The ACO shall maintain and provide to its Next Generation Participants and Preferred Providers an accurate and complete list of Eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF eligibility. The ACO shall also furnish these lists to a Next Generation Beneficiary, upon request.
- E. The ACO must provide written notification to CMS within 10 days of any changes its list of Eligible SNFs. Within 10 days following the removal of any Eligible SNF from the list of Eligible SNFs, the ACO must also provide written notification to the SNF or Swing-Bed Hospital that it has been removed from the list and that it no longer qualifies to use this 3-Day SNF Rule Waiver Benefit Enhancement.
- F. The ACO shall provide a copy of this Appendix I to each Eligible SNF to which Next Generation Beneficiaries are referred.

#### **IV. Beneficiary Eligibility Requirements**

- A. To be eligible to receive services covered under the terms of the 3-Day SNF Rule Waiver under Section II of this Appendix the Beneficiary must be:
  - 1. A Next Generation Beneficiary at the time of SNF admission under this waiver or within the grace period under Section VI of this Appendix; and
  - 2. Not residing in a SNF or long-term care facility at the time of SNF admission under this waiver. For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities.
- B. A Direct SNF Admission will be covered under the terms of the 3-Day SNF Rule Waiver under Section II of this Appendix only if, at the time of admission, the Eligible Next Generation Beneficiary:
  - 1. Is medically stable;
  - 2. Has confirmed diagnoses;
  - 3. Has been evaluated by a physician or other practitioner licensed to perform the evaluation within three days prior to SNF admission;
  - 4. Does not require inpatient hospital evaluation or treatment; and
  - 5. Has a skilled nursing or rehabilitation need that is identified by the evaluating physician and cannot be provided as an outpatient.
- C. A SNF admission will be covered under the terms of the 3-Day SNF Rule Waiver under Section II of this Appendix for a Beneficiary who is discharged to an Eligible

SNF after fewer than three days of inpatient hospitalization only if, at the time of admission, the Beneficiary:

1. Is medically stable;
2. Has confirmed diagnoses;
3. Does not require further inpatient hospital evaluation or treatment; and
4. Has a skilled nursing or rehabilitation need that has been identified by a physician during the inpatient hospitalization and that cannot be provided on an outpatient basis.

## **V. Grace Period for Excluded Beneficiaries**

In the case of a former Next Generation Beneficiary, that is, a Beneficiary who was aligned to the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO, CMS shall make payment for SNF Services furnished by an Eligible SNF to such Beneficiary without a prior 3 day inpatient hospitalization under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as if the Beneficiary were still a Next Generation Beneficiary aligned to the ACO, provided that admission to the Eligible SNF occurs within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

## **VI. SNF Services Provided to Non-Eligible Next Generation Beneficiaries**

If an Eligible SNF provides SNF Services under this 3-Day SNF Rule Waiver Benefit Enhancement to a Next Generation Beneficiary who does not meet the Beneficiary Eligibility Requirements in Section IV of this Appendix, the following rules shall apply:

- A. CMS shall make no payment to the Eligible SNF for such services;
- B. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Next Generation Beneficiary for the expenses incurred for such services;
- C. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Next Generation Beneficiary any monies collected from the Next Generation Beneficiary related to such services.

## **VII. Responsibility for Denied Claims**

- A. If a claim for any SNF Services furnished to a Beneficiary by an Eligible SNF is denied as a result of a CMS error and the Eligible SNF did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such SNF Services under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as though the coverage denial had not occurred.
- B. If a claim for any SNF Services furnished to a Beneficiary by an Eligible SNF is denied for any reason other than a CMS error and CMS determines that that the Eligible SNF did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. CMS shall, notwithstanding such determination, pay for such SNF Services under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
  2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred by such services; and
  3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for SNF Services furnished to a Beneficiary by an Eligible SNF is denied and the Eligible SNF knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall not make payment to the Eligible SNF for such services;
  2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred by such services; and
  3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- D. If a Next Generation Participant or Preferred Provider that is not an Eligible SNF submits a claim for SNF Services under this 3-Day SNF Rule Waiver Benefit Enhancement, furnishes services to a Beneficiary for which CMS only would have made payment if the Next Generation Participant or Preferred Provider was an Eligible SNF participating in the 3-Day SNF Rule Waiver Benefit Enhancement at the time of service:
1. CMS shall not make payment to the Next Generation Participant or Preferred Provider for such services;
  2. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the SNF Services does not charge the Beneficiary for the expenses incurred by such services; and
  3. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

## **VIII. Compliance and Enforcement**

- A. CMS may revoke its approval of a Next Generation Participant or Preferred Provider to participate as an Eligible SNF under the 3-Day SNF Rule Waiver Benefit Enhancement at any time if the Next Generation Participant or Preferred Provider's continued participation in this 3-Day SNF Rule Waiver Benefit Enhancement might compromise the integrity of the Next Generation ACO Model.



- B. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Next Generation Beneficiary alignment to the ACO.
- C. The ACO shall submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of the 3-Day SNF Rule Waiver Benefit Enhancement. The ACO shall provide CMS with supplemental information upon request regarding its use of the 3-Day SNF Rule Waiver Benefit Enhancement.
- D. CMS will monitor the ACO's use of the 3-Day SNF Rule Waiver Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.
- E. In accordance with Section XIX of the Agreement, CMS may terminate or suspend the 3-Day SNF Rule Waiver under Section II of this Appendix or take other remedial action, as appropriate, if the ACO or any of its Next Generation Participants or Preferred Providers fails to comply with the terms and conditions of the 3-Day SNF Rule Waiver Benefit Enhancement.

#### **IX. Performance Year 2016 3-Day SNF Rule Waiver Benefit Enhancement**

The 3-Day SNF Rule Waiver Benefit Enhancement for the 2016 Performance Year is governed by Appendix I of the Next Generation ACO Model Participation Agreement that was executed in December 2015, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

## **Next Generation ACO Model Participation Agreement**

### **Appendix J**

#### **Telehealth Expansion Benefit Enhancement**

##### **I. Election of the Telehealth Expansion Benefit Enhancement**

If the ACO wishes to offer the Telehealth Expansion Benefit Enhancement during a Performance Year it must –

- A. Timely submit to CMS its election of Telehealth Expansion as a Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement; and
- B. Submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Next Generation Participants that have agreed to participate in the Telehealth Expansion Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Telehealth Expansion Benefit Enhancement.

##### **II. Waiver**

- A. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to otherwise covered telehealth services furnished to a Next Generation Beneficiary by an Eligible Telehealth Provider, as that term is defined in Section III.A of this Appendix:
  1. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 CFR § 410.78(b)(3)–(4) with respect to telehealth services furnished in accordance with this Appendix.
  2. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be “furnished at an originating site” when the services are furnished in accordance with this Appendix.
  3. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 CFR § 414.65(b) with respect to telehealth services furnished to a Beneficiary at his/her home or place of residence when furnished in accordance with this Appendix.
- B. Waiver of Interactive Telecommunications System Requirement: Beginning in Performance Year 2018, CMS waives the following requirements with respect to otherwise covered teledermatology and teleophthalmology services furnished to a Next Generation Beneficiary by an Eligible Asynchronous Telehealth Provider, as that term is defined in Section III.B of this Appendix, using asynchronous store and forward technologies:
  1. Waiver of Originating Site Requirements: CMS waives the requirement in Section 1834(m)(4)(C)(i) of the Act regarding the location of the originating site

and the requirements of 42 CFR § 410.78(b)(4) with respect to covered tele dermatology and teleophthalmology furnished using asynchronous store and forward technologies in accordance with this Appendix.

2. Waiver of Interactive Telecommunications System Requirement: CMS waives the requirement under Section 1834(m)(1) of the Act and 42 CFR § 410.78(b) that telehealth services be furnished via an “interactive telecommunication system,” as that term is defined under 42 CFR § 410.78(a)(3), when such services are furnished in accordance with this Appendix.
- C. The waivers described in Section II.A and II.B of this Appendix are collectively referred to as the “**Telehealth Expansion Benefit Enhancement**”.

### III. Eligible Telehealth Providers and Eligible Asynchronous Telehealth Providers

- A. For purposes of this Telehealth Expansion Benefit Enhancement, an “**Eligible Telehealth Provider**” is a Next Generation Professional or Preferred Provider who meets the requirements under Section XI.C.2 of the Agreement.
- B. For the purposes of this Telehealth Expansion Benefit Enhancement, an “**Eligible Asynchronous Telehealth Provider**” is a Next Generation Professional or Preferred Provider who meets the requirements under Section XI.C.4 of the Agreement.
- C. CMS review and approval of a Next Generation Professional or a Preferred Provider to provide services in accordance with the Telehealth Expansion Benefit Enhancement under Section II of this Appendix includes consideration of the program integrity history of the Next Generation Professional or Preferred Provider and any other factors that CMS determines may affect the qualifications of the Next Generation Professional or Preferred Provider to provide telehealth services under the terms of the Telehealth Expansion Benefit Enhancement.

### IV. Eligibility Requirements

- A. In order for telehealth services to be eligible for reimbursement under the terms of the waivers under Section II.A of this Appendix:
  1. The Beneficiary must be a Next Generation Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
  2. The Beneficiary must be located at an originating site that is either:
    - a. One of the sites listed in section 1834(m)(4)(C)(ii) of the Social Security Act; or
    - b. The Beneficiary’s home or place of residence.
- B. In order for the telehealth services to be eligible for reimbursement under the terms of the waiver under Section II.B of this Appendix:

1. The Beneficiary must be a Next Generation Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
  2. The Beneficiary must be located at an originating site that is one of the sites listed in Section 1834(m)(4)(C)(ii) of the Act.
- C. Claims for telehealth services furnished under the terms of the waiver under Section II.A of this Appendix for which the originating site is a Beneficiary's home or place of residence will be denied unless submitted using one of the HCPCS codes G9481-G9489.
- D. Claims for asynchronous tele dermatology and teleophthalmology services furnished under the terms of the waiver under Section II.B of this Appendix will be denied unless submitted using one of the HCPCS codes G9868-G9870.
- E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider shall not submit a claim for such telehealth services.
- F. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining requirements of Section 1834(m) of the Act and 42 CFR §§ 410.78 and 414.65.
- G. An Eligible Telehealth Provider or an Eligible Asynchronous Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Next Generation Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knows or should know in person services are medically necessary.

## **V. Grace Period for Excluded Beneficiaries**

In the case of a former Next Generation Beneficiary, that is, a Beneficiary who had been aligned with the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO, CMS shall make payment for telehealth services furnished to such Beneficiary under the terms of the Telehealth Expansion Benefit Enhancement as if the Beneficiary were still a Next Generation Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

## **VI. Responsibility for Denied Claims**

- A. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider under the Telehealth Expansion Benefit Enhancement is denied as a result of a CMS error and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment

shall, notwithstanding such denial, be made by CMS for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred.

- B. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider is denied for any reason other than a CMS error and CMS determines that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
  - 1. CMS shall, notwithstanding such denial, pay for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
  - 2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
  - 3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
  - 1. CMS shall not make payment to the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider for such services;
  - 2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
  - 3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- D. If a Next Generation Participant or Preferred Provider that is not an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider submits claims for telehealth services for which CMS only would have made payment if the Next Generation Participant or Preferred Provider was an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider participating in the this Telehealth Expansion Benefit Enhancement at the time of service:
  - 1. CMS shall not make payment to the Next Generation Participant or Preferred Provider for such services;

2. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

## **VII. Compliance and Enforcement**

- A. CMS may reject the ACO's designation of a Next Generation Participant or Preferred Provider as an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider at any time if the Next Generation Participant or Preferred Provider's participation in this Telehealth Expansion Benefit Enhancement might compromise the integrity of the Model.
- B. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Next Generation Beneficiary alignment to the ACO.
- C. As a condition of this waiver, the ACO is required to submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of the Telehealth Expansion Benefit Enhancement and to provide CMS with supplemental information upon request regarding its use of the Benefit Enhancement.
- D. CMS will monitor the ACO's use of the Telehealth Expansion Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.
- E. In accordance with Section XIX of this Agreement, CMS may terminate or suspend one or more of the waivers under Section II of this Appendix or take other remedial action if the ACO or any of its Next Generation Participants or Preferred Providers fails to comply with the terms and conditions of the Telehealth Expansion Benefit Enhancement.

## **VIII. Performance Year 2016 Telehealth Expansion Benefit Enhancement**

The Telehealth Expansion Benefit Enhancement for the 2016 Performance Year is governed by Appendix J of the Next Generation ACO Model Participation Agreement that was executed in December 2015, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

## **IX. Performance Year 2017 Telehealth Expansion Benefit Enhancement**

The Telehealth Expansion Benefit Enhancement for the 2017 Performance Year is governed by Appendix J of the First Amended and Restated Participation Agreement for 2016 Starters that was executed in January 2017, as if such appendix were included in this Second Amended and Restated Participation Agreement for 2016 Starters.

## Next Generation ACO Model Participation Agreement

### Appendix K

#### Post-Discharge Home Visits Benefit Enhancement

This Post-Discharge Home Visits Benefit Enhancement increases the availability to Beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility by altering the supervision level for “incident to” services to allow personnel under a physician’s general supervision (instead of direct supervision) to make home visits under certain conditions.

#### I. Post-Discharge Home Visits Benefit Enhancement Election

If the ACO wishes to offer the Post-Discharge Home Visits Benefit Enhancement during a Performance Year it must –

- A. Timely submit to CMS its election of Post-Discharge Home Visits as a Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement; and
- B. Submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Next Generation Participants that have agreed to participate in the Post-Discharge Home Visits Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Post-Discharge Home Visits Benefit Enhancement.

#### II. Waiver and Terms

CMS waives the requirement in 42 CFR § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) (“incident to” services) must be furnished under the direct supervision of the physician (or other practitioner)<sup>1</sup>, provided that such services are furnished as follows and in accordance with all other terms and conditions set forth in this Appendix (“**Post-Discharge Home Visits Benefit Enhancement**”):

- A. The services are furnished to a Next Generation Beneficiary who either does not qualify for Medicare coverage of home health services under 42 CFR § 409.42 or who qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 § 60.4; and
- B. The services are furnished in the Next Generation Beneficiary’s home after the beneficiary has been discharged from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility; and

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<sup>1</sup> For additional guidance on “incident to” billing, the ACO may refer to the Medicare Benefit Policy Manual, Chapter 15 § 60, found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>, excepting the references therein to direct supervision.



- C. The services are furnished by “auxiliary personnel,” as defined in 42 CFR § 410.26(a)(1), under the general supervision, as defined in 42 CFR § 410.32(b)(3)(i), of a Next Generation Professional or Preferred Provider identified on the ACO’s Participant List or Preferred Provider List submitted in accordance with Section IV of this Agreement as participating in the Post-Discharge Home Visits Benefit Enhancement under the terms of this Appendix who is a physician or other practitioner and meets the requirements under Section XI.D.2 of the Agreement; and
- D. The claims for such services are submitted by the supervising Next Generation Professional or Preferred Provider who satisfies the criteria outlined in Section XI.D.2 of the Agreement; and
- E. The services are furnished not more than nine times in the first ninety (90) days following discharge the provision of such services must be documented and records maintained by the ACO in accordance with Section XVIII.B of the Agreement; and.
- F. The nine services described in Section II.E of this Appendix cannot be accumulated across multiple discharges: if the Beneficiary is readmitted within ninety (90) days of the initial discharge, following the subsequent discharge the Beneficiary may receive only the nine services described in Section II.E above in connection with the most recent discharge; and
- G. The services are furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 CFR § 410.26(b).

CMS also waives the direct supervision requirement in 42 CFR § 410.26(b)(5) under such other circumstances as provided in this Appendix.

### **III. Grace Period for Excluded Beneficiaries**

In the case of a former Next Generation Beneficiary, that is, a Beneficiary who had been aligned with the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO, CMS shall make payment for the Post-Discharge Home Visits services furnished to such Beneficiary under the terms of the Post-Discharge Home Visits Benefit Enhancement as if the Beneficiary were still aligned to the ACO, provided that the Post-Discharge Home Visits services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section II of this Appendix are met.

### **IV. Responsibility for Denied Claims**

- A. If a claim for any Post-Discharge Home Visits services furnished by a Next Generation Professional or Preferred Provider who has been identified as participating in the Post-Discharge Home Visits Benefit Enhancement pursuant to Section IV of the Agreement is denied as a result of a CMS error and the Next Generation Professional or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such services under the terms of the Post-Discharge Home Visits Benefit Enhancement as though the coverage denial had not occurred.



- B. If a claim for any Post-Discharge Home Visits services furnished to a Beneficiary by a Next Generation Professional or Preferred Provider that has been identified as participating in the Post-Discharge Home Visits Benefit Enhancement pursuant to Section IV of the Agreement is denied for any reason other than a CMS error and the Next Generation Professional or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall, notwithstanding such denial, pay for such Post-Discharge Home Visits services under the terms of the Post-Discharge Home Visits Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
  2. The ACO shall ensure that the Next Generation Professional or Preferred Provider that furnished the Post-Discharge Home Visits services does not charge the Beneficiary for the expenses incurred for such services; and
  3. The ACO shall ensure that the Next Generation Professional or Preferred Provider that furnished the Post-Discharge Home Visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for any Post-Discharge Home Visits services furnished by a Next Generation Professional or Preferred Provider who has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Next Generation Professional or Preferred Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall not make payment to the Next Generation Professional or Preferred Provider for such services;
  2. The ACO shall ensure that the Next Generation Professional or Preferred Provider that furnished the Post-Discharge Home Visits services does not charge the Beneficiary for the expenses incurred for such services; and
  3. The ACO shall ensure that the Next Generation Professional or Preferred Provider that furnished the Post-Discharge Home Visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- D. If a Next Generation Participant or Preferred Provider who has not been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement furnishes Post-Discharge Home Visits services to a Beneficiary for which CMS only would have made payment if the Next Generation Participant or Preferred Provider had been identified as participating in this Benefit Enhancement at the time of service:

1. CMS shall make no payment to the Next Generation Participant or Preferred Provider for such services;
2. The ACO shall ensure that the Next Generation Participant or Preferred Provider that furnished the Post-Discharge Home Visits services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Next Generation Participant or Preferred Provider that furnished the Post-Discharge Home Visits services returns to the Beneficiary any monies collect from the Beneficiary related to such services.

## **V. Compliance and Enforcement**

- A. The ACO shall ensure, through its agreement with each Next Generation Professional and Preferred Provider that will be participating in the Post-Discharge Home Visits Benefit Enhancement, that the Next Generation Professional or Preferred Provider shall require all auxiliary personnel to comply with the terms of this Agreement and Appendix.
- B. CMS may remove a Next Generation Professional or Preferred Provider from the list of Next Generation Professionals or Preferred Providers that may participate in this Post-Discharge Home Visits Benefit Enhancement at any time if the Next Generation Professional or Preferred Provider's participation in this Post-Discharge Home Visits Benefits Enhancement might compromise the integrity of the Next Generation ACO Model.
- C. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Next Generation Beneficiary alignment to the ACO.
- D. As a condition of the Post-Discharge Home Visits Benefit Enhancement, the ACO is required to submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of this Benefit Enhancement and to provide CMS with supplemental information upon request regarding its use of the Benefit Enhancement.
- E. CMS will monitor the ACO's use of the Post-Discharge Home Visits Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

In accordance with Section XIX of this Agreement, CMS may terminate or suspend this Benefit Enhancement or take other remedial action if the ACO or any of its Next Generation Participants or Preferred Providers fails to comply with the terms and conditions of the Post-Discharge Home Visits Benefit Enhancement.

## **VI. Performance Year 2016 Post-Discharge Home Visits Benefit Enhancement**

The Post-Discharge Home Visits Benefit Enhancement for the 2016 Performance Year is governed by Appendix K of the Next Generation ACO Model Participation Agreement that

was executed in December 2015, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

## **VII. Performance Year 2017 Post-Discharge Home Visits Benefit Enhancement**

The Post-Discharge Home Visits Benefit Enhancement for the 2017 Performance Year is governed by Appendix K of the First Amended and Restated Participation Agreement for 2016 Starters that was executed in January 2017, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

# Next Generation ACO Model Participation Agreement

## Appendix L

### Financial Guarantee

This Appendix provides requirements regarding the ACO's financial guarantee for repayment of amounts owed to CMS as Shared Losses and/or Other Monies Owed, as required under Section XIV.D of this Agreement for Performance Year 2017 and subsequent Performance Years. Such financial guarantee for Performance Year 2016 is governed by the Appendix L of the Next Generation ACO Model Participation Agreement that was executed in December 2015, as if such appendix were included in this First Amended and Restated Participation Agreement for 2016 Starters.

#### 1. Form of Financial Guarantee

- 1.1. The financial guarantee must be in one or more of the following forms:
  - (a) Funds placed in escrow;
  - (b) A line of credit as evidenced by a letter of credit upon which CMS may draw;
  - (c) Surety bond.
- 1.2. CMS may reject any financial guarantee that does not comply with the terms of this Appendix L.
- 1.3. Consistent with Section XIV.D.3 of the Agreement, any changes made to a financial guarantee must be approved in advance by CMS.

#### 2. Amount of the Financial Guarantee

- 2.1. For each Performance Year during which the ACO participates in the Model, the ACO shall obtain a financial guarantee in an amount to be specified by CMS in the written notice furnished to the ACO under paragraph 2.2 of this Appendix L.
- 2.2. CMS shall provide written notice to the ACO of the amount that must be funded by the financial guarantee for the Performance Year, which will be equal to two percent of the ACO's total Medicare Parts A and B fee-for-service expenditures for Beneficiaries for that Performance Year. Such expenditures will be either capped or uncapped, depending on the ACO's expenditure cap selection for the Performance Year, made pursuant to Section X.A.6 of this Agreement. The amount will be calculated by CMS using a financial report. Such financial report will be provided to the ACO prior to the start of the Performance Year except as provided in paragraph 2.4 of this Appendix.
- 2.3. The ACO shall submit to CMS written documentation of the form and amount of its financial guarantee for the Performance Year for CMS review within 60 days of the date of the written notice furnished to the ACO under paragraph 2.2
- 2.4. If the ACO selects uncapped expenditures pursuant to Section X.A.6 of this Agreement for Performance Year 2017, CMS will update the written notice described in paragraph 2.2 to increase the amount that must be funded by the financial guarantee for Performance Year 2017. The ACO shall submit to CMS written documentation of the form and increased amount of its financial guarantee or financial guarantees for Performance Year 2017 for CMS review within 60 days of the date of the updated written notice.

### 3. Duration of the Financial Guarantee

- 3.1. Except as set forth in paragraph 3.2, the financial guarantee for each Performance Year must remain in effect (or the amount funded for a Performance Year in a financial guarantee that funds multiple Performance Years must remain available to CMS) until the earliest of the following:
  - (a) The ACO has fully repaid CMS any Shared Losses and/or Other Monies Owed for the Performance Year;
  - (b) CMS has exhausted the amount funded by the financial guarantee for the Performance Year and CMS determines that the ACO does not need to replenish the financial guarantee in accordance with paragraph 3.3; or
  - (c) CMS determines that the ACO does not owe any Shared Losses and/or Other Monies Owed under this Model for the Performance Year.
- 3.2. The ACO shall maintain its financial guarantee until the earlier of the following with respect to the final Performance Year:
  - (a) The date on which the settlement report for the final Performance Year, including any second AIPBP reconciliation or PBP reconciliation for the final Performance Year, is deemed final, if such settlement report indicates that the ACO does not owe any Shared Losses or Other Monies Owed for any Performance Year; or
  - (b) The date on which the ACO makes payment in full for all Shared Losses or Other Monies Owed for any Performance Year.
- 3.3. If any portion of the financial guarantee is used to repay Shared Losses or Other Monies Owed to CMS for a Performance Year and the financial guarantee for the Performance Year must remain in effect in accordance with paragraph 3.1 or the financial guarantee funds multiple Performance Years, the ACO must, within 90 days of the date that CMS draws on the financial guarantee: (1) replenish the amount of its financial guarantee or establish another financial guarantee to ensure it maintains coverage equal to the amount required under paragraph 2.1; and (2) submit to CMS documentation demonstrating that it has complied with this provision.

### 4. Other requirements

- 4.1. **Beneficiary/Obligee:** The ACO shall designate CMS as the sole beneficiary or obligee of the financial guarantee. CMS's address is 7500 Security Boulevard, Baltimore, MD 21244.
- 4.2. **Condition for calling funds:** The financial guarantee should indicate that the ACO is obligated to repay money it owes to CMS as a result of participation in the Next Generation ACO Model, citing the Next Generation ACO Model Participation Agreement.

Example:

The ACO is obligated to repay money it owes to CMS under the Next Generation ACO Model, as required by the Next Generation ACO Model Participation Agreement. The amount of Shared Losses and/or Other Monies Owed will be noted in a demand letter to the ACO from CMS.
- 4.3. **Demand letter:** The financial guarantee must allow for payment to CMS in response to a demand letter from CMS.

- 4.4. **Account fees:** Account fees or other fees associated with establishing, maintaining, or cancelling a financial guarantee are the responsibility of the ACO and must not be paid out of the principal for the financial guarantee.

## 5. Requirements for specific financial guarantee mechanisms

### 5.1. Funds placed in Escrow

CMS and U.S. Bank National Association (“U.S. Bank”) have a standard escrow account agreement available for use between U.S. Bank, CMS, and third parties, where CMS is the recipient of funds held in escrow if payment is due to CMS. The ACO should contact the Next Generation ACO Model (as specified below) to open a U.S. Bank escrow account.

If the ACO wants to establish an escrow account at a different institution, CMS must approve the escrow agreement and the instructions for disbursement of the assets. Generally, CMS will accept an escrow agreement with a different institution under the following conditions:

- (a) The funds are invested in Treasury-backed securities or a money market fund;
- (b) The instructions for disbursement of the assets are consistent with CMS’ standard escrow instructions (see Escrow Instructions of Depositor in Exhibit A);
- (c) The costs, fees, and expenses associated with the escrow account, including any legal expenses incurred by the escrow agent or the ACO, are not borne by CMS and such costs are not charged to principal;
- (d) The principal cannot be encumbered for any purpose other than repaying Shared Losses and/or Other Monies Owed by the ACO to CMS;
- (e) CMS is not required to indemnify any person or entity against any loss, claim, damages, liabilities, or expenses, including the costs of litigation arising from the escrow agreement or the subject of the agreement;
- (f) CMS will receive advance notice of early termination of the escrow account and any change in the amount of funds held in escrow.

### 5.2. Letter of Credit

- (a) CMS will generally accept a Letter of Credit under the following conditions:
  - i. The letter of credit is irrevocable;
  - ii. CMS is designated as the sole beneficiary;
  - iii. The appropriate credit amount is specified;
  - iv. The terms allow an authorized official of CMS to draw on the letter of credit upon submission to the issuing bank of the following items: (a) a certification that “The amount of the drawing under this credit represents funds due to CMS from [ACO Name] under the Next Generation ACO Model and which have remained unpaid for at least 30 days”; and (b) a copy of the appropriate written notice to the ACO of the amount owed; and
  - v. The letter must show that CMS will receive advance notice if there is any change in the amount of credit.
- (b) **Auto renewal clauses:** ACO must not use clauses providing for the automatic renewal of an irrevocable standby letter of credit to establish the required term. The ACO may, however, use these clauses to automatically renew the letter of credit for a period of time

beyond the required term. If the ACO uses an auto renewal clause, it should state that the lender will notify CMS and the ACO at least 90 days in advance if electing not to renew.

- (c) **Sanctioned entity clauses:** The bank issuing the letter of credit must omit these clauses entirely, or, if included, exclude entities sanctioned by a federal health care program or by any federal agency.

### 5.3. Surety Bond

- (a) **Surety Companies:** The surety bond should be issued from a company included on the U.S. Department of Treasury's Listing of Certified (Surety Bond) Companies ([https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570\\_a-z.htm](https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm)).
- (b) **Surety Bond Terms:** The bond must contain:
- i. A statement that the surety is liable for assessments that occur during the term of the bond;
  - ii. The surety's name, street address or post office box number, city, state, and zip code; and
  - iii. A statement naming the ACO as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety.

Exhibit A

Escrow Instructions of Depositor

- 1) Immediately upon deposit, all monies (“Assets”) held in the Account shall be invested by Agent in Treasury-backed securities. Upon deposit and at such other times as may be requested by Recipient, Agent shall notify Recipient of the date and amount of each deposit and other Account transaction.
- 2) Agent shall dispose of the Assets only upon written instruction from an authorized representative of Recipient. Such written instructions shall:
  - a) Identify the amount, if any, of Shared Losses and/or Other Monies Owed incurred by the Depositor for the relevant performance year, as determined by CMS and set forth in a final settlement report, as revised if applicable, issued by CMS pursuant to Section XIV.C of the Next Generation ACO Model Participation Agreement.
  - b) Identify the amount of such Shared Losses and/or Other Monies Owed that Depositor has failed to pay (the “Debt”) within 30 days of the date of the settlement report.
  - c) Instruct Agent to convert the Assets to cash and pay the amount of the Debt to Recipient. If the Assets will be zero after delivering the amount of the Debt to Recipient, Agent shall notify Recipient, and Recipient shall provide further instructions, in consultation with Depositor, for the replenishment of assets or closure of the Account.
  - d) In the event of the expiration or termination of the Depositor’s Next Generation ACO Model Participation Agreement or other circumstances requiring closure of the Account, the Depositor will notify the Agent and instruct Agent to convert the Assets to cash and dispose of them as follows:
    - i) If the Debt is zero, Agent shall return the full cash value of the Assets to Depositor, less Agent’s unpaid fees, costs and expenses.
    - ii) If the cash value of the Assets is less than or equal to the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the full cash value of the Assets.
    - iii) If the cash value of the Assets exceeds the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the Debt and shall return the remaining Assets to Depositor, less Agent’s unpaid fees, costs and expenses.
- 3) Upon disposition of the Assets as specified in paragraph 2(d), Agent shall close the Account and the Escrow Agreement shall terminate.
- 4) Unless otherwise specified by written notice of the Parties, the following persons are authorized to provide instructions from Depositor or Recipient, as the case may be, to Agent, consistent with the terms of this Agreement:

**Depositor**

Name: \_\_\_\_\_

\_\_\_\_\_

Specimen Signature

Title: \_\_\_\_\_

**Recipient**

Name: \_\_\_\_\_

\_\_\_\_\_

Specimen Signature

Title: \_\_\_\_\_



## **Next Generation ACO Model Participation Agreement**

### **Appendix M**

#### **ACO Proprietary and Confidential Information**

The following are specific examples, without limitation, of what the ACO considers proprietary and confidential information currently contained in its program that should not be publicly disclosed:

- 1)
- 2)
- 3)

In accordance with Section XV.D of the Agreement, this information shall remain the sole property of the ACO and, except as required by federal law, shall not be released by CMS without the express written consent of the ACO.

## Next Generation ACO Model

### Appendix N

#### Alternative Payment Mechanism – All-Inclusive Population-Based Payments (AIPBP)

##### I. AIPBP Election

- A. If the ACO wishes to participate in AIPBP, it must --
1. Timely submit to CMS its selection of AIPBP as an Alternative Payment Mechanism for a Performance Year in accordance with Section X.A of this Agreement;
  2. Submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Next Generation Participants that have agreed to participate in AIPBP and a true, accurate, and complete list of Preferred Providers that have agreed to participate in AIPBP;
  3. Timely submit a fully executed “Next Generation ACO Model: All-Inclusive Population-Based Payments Fee Reduction Agreement” (described in Section II.J of this Appendix) for each Next Generation Participant and Preferred Provider that is identified as participating in AIPBP, as set forth on the lists submitted in accordance with Section I.A.2 of this Appendix;
  4. Submit by a date and in a manner specified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.B of this Appendix; and
  5. Submit by a date and in a manner specified by CMS a certification that the ACO has the necessary infrastructure to be able to pay its AIPBP-participating Next Generation Participants and Preferred Providers promptly in accordance with Section III.G of this Appendix.
- B. CMS may reject the ACO’s selection to participate in AIPBP for a Performance Year if:
1. CMS has taken any remedial actions against the ACO pursuant to Section XIX of this Agreement;
  2. CMS has taken any remedial actions against the ACO in connection with its participation in another Medicare ACO initiative during either of the ACO’s last two performance years in that initiative;
  3. CMS determines on the basis of a program integrity screening or other information that the ACO’s participation in AIPBP might compromise the integrity of the Model; or
  4. The ACO’s selection to participate in AIPBP is for its first Performance Year in the Next Generation ACO Model and the ACO has not participated in any Medicare ACO initiative prior to its participation in the Model.
- C. CMS may prohibit the ACO from having an AIPBP Payment Arrangement (as defined in Section III of this Appendix) with a Next Generation Participant or Preferred Provider if:

1. The conduct of the Next Generation Participant or Preferred Provider has caused CMS to impose remedial action pursuant to Section XIX of this Agreement or to impose a sanction under any CMS administrative authority; or
  2. CMS determines on the basis of a program integrity screening or other information that the Next Generation Participant's or Preferred Provider's Participation in AIPBP might compromise the integrity of the Model.
- D. If CMS rejects or later terminates the ACO's selection to participate in AIPBP for a Performance Year (in accordance with Section X.C or XIX.A of this Agreement, respectively), payments to the ACO and its Next Generation Participants and Preferred Providers will default to traditional FFS for the Performance Year. The ACO will not have the ability to choose a different Alternative Payment Mechanism for the Performance Year.

## **II. AIPBP Fee Reduction**

- A. If the ACO elects to participate in AIPBP for the 2017 Performance Year, Monthly AIPBP Payments to the ACO and AIPBP Fee Reductions in payments to Next Generation Participants and Preferred Providers that have agreed to accept the AIPBP Fee Reduction (100% Reduced FFS Payments) in the Performance Year will be made only for the period from April 1 through December 31, 2017. For the period from January 1 through March 31, 2017, no Monthly AIPBP Payments will be made to the ACO and no AIPBP Fee Reductions will be made to payments to Next Generation Participants and Preferred Providers who have agreed to receive the AIPBP Fee Reduction for the 2017 Performance Year.
- B. If the ACO has elected to participate in AIPBP for a Performance Year in accordance with Section I.A, the ACO shall, by a date specified by CMS, notify and educate all Next Generation Participants and Preferred Providers about the ACO's intended participation in AIPBP and the associated AIPBP Fee Reduction. Providing a copy of the Next Generation ACO Model: All-Inclusive Population-Based Payments Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in AIPBP for a Performance Year is rejected, the ACO shall notify all Next Generation Participants and Preferred Providers that it is not participating in AIPBP for that Performance Year.
- C. A Next Generation Participant or Preferred Provider may participate in AIPBP for a Performance Year only if the Next Generation Participant or Preferred Provider was included on the ACO's Participant List or Preferred Provider List, respectively, at the start of that Performance Year. Next Generation Participants and Preferred Providers who were added to the ACO's Participant List or Preferred Provider List during a Performance Year may participate in AIPBP in a subsequent Performance Year only if they are included on the ACO's Participant List or Preferred Provider List at the start of the subsequent Performance Year.
- D. Not all Next Generation Participants and Preferred Providers must agree to participate in AIPBP for the ACO to participate in AIPBP.

- E. Not all Next Generation Participants and Preferred Providers billing under a TIN must agree to participate in AIPBP for other Next Generation Participants and Preferred Providers billing under the same TIN to participate in AIPBP.
- F. CMS will reduce FFS Payments on claims for services furnished to Next Generation Beneficiaries by 100% only for those Next Generation Participants and Preferred Providers that have consented to receive the AIPBP Fee Reduction pursuant to Section II.J of this Appendix and with whom the ACO is not prohibited under Section I.C of this Appendix from having an AIPBP Payment Arrangement.
- G. A hospital paid under the Inpatient Prospective Payment System that is a Next Generation Participant or Preferred Provider that has agreed to receive the AIPBP Fee Reduction will continue to receive IME, DSH, inpatient outlier, and inpatient new technology add-on payments calculated in accordance with the applicable statutory and regulatory provisions.
- H. For certain types of institutional providers, such as Method II CAHs and FQHCs, that are Next Generation Participants or Preferred Providers and are participating in AIPBP, CMS will reduce by 100% all FFS payments for services furnished to Next Generation Beneficiaries that are billed under that institution's CCN and organizational NPI regardless of whether the individual NPIs rendering the service are Next Generation Participants or Preferred Providers.
- I. CMS will not reduce FFS Payments on claims for services furnished to Next Generation Beneficiaries who elect to decline data sharing or for claims for services related to the diagnosis and treatment of substance use disorder furnished to Next Generation Beneficiaries.
- J. Written Confirmation of Consent
  1. The ACO shall obtain written confirmation that each AIPBP-participating Next Generation Participant and Preferred Provider has consented to receive the AIPBP Fee Reduction. Such written confirmation of consent must be in the form of a completed Next Generation ACO Model: All-Inclusive Population-Based Payments Fee Reduction Agreement signed by an individual legally authorized to act for the entity through whose TIN the Next Generation Participant or Preferred Provider bills Medicare.
  2. As part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN the Next Generation Participant or Preferred Provider bills Medicare must verify the accuracy of the list of Next Generation Participants and Preferred Providers billing under that TIN that have affirmatively consented to receiving AIPBP Fee Reduction.
  3. A Next Generation Participant's or Preferred Provider's consent to receive the AIPBP Fee Reduction must apply for the full Performance Year and must be renewed annually in order for the Next Generation Participant or Preferred Provider to continue to participate in AIPBP.
  4. Consent to participate in AIPBP by a Next Generation Participant or Preferred Provider must be voluntary and must not be contingent on or related to receipt of referrals from the ACO, its Next Generation Participants, or Preferred Providers.

### III. AIPBP Payment Arrangements

- A. The ACO shall have a written payment arrangement with each AIPBP-participating Next Generation Participant or Preferred Provider that establishes how the ACO will make payments to the AIPBP-participating Next Generation Participant or Preferred Provider for Covered Services that are subject to the AIPBP Fee Reduction (“**AIPBP Payment Arrangement**”).
- B. In establishing the terms of any AIPBP Payment Arrangement, neither party gives or receives remuneration in return for or to induce business other than business covered by the AIPBP Payment Arrangement.
- C. The payments made by the ACO under an AIPBP Payment Arrangement may not be made knowingly to induce AIPBP-participating Next Generation Participants and Preferred Providers to reduce or limit Medically Necessary items or services to Beneficiaries.
- D. All payments made by the ACO for Covered Services under an AIPBP Payment Arrangement must be monetary payments that have been negotiated in good faith and are consistent with fair market value (which may be more or less than the Medicare Payment amount for a given Medicare-reimbursable service).
- E. The ACO shall maintain, in accordance with Section XVIII.B of the Agreement, records of all payments made pursuant to each AIPBP Payment Arrangement.
- F. The AIPBP Payment Arrangement must:
  - 1. Require the ACO to reimburse Next Generation Participants and Preferred Providers for all Covered Services that Medicare would have otherwise paid for, but for the AIPBP Fee Reduction.
  - 2. Require the ACO to pay for Covered Services furnished by AIPBP-participating Next Generation Participants and Preferred Providers no later than 30 days after receiving notice of the processed claim, as indicated on a weekly report from CMS to the ACO.
  - 3. Require the Next Generation Participant or Preferred Provider to make Medically Necessary Covered Services available to Next Generation Beneficiaries in accordance with all applicable laws and regulations.
  - 4. Prohibit the ACO from requiring prior authorization for services furnished to Next Generation Beneficiaries.
  - 5. Prohibit the ACO and the Next Generation Participant or Preferred Provider from interfering with a Next Generation Beneficiary’s freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in AIPBP or with the ACO.
  - 6. Require the Next Generation Participant or Preferred Provider to maintain records regarding the AIPBP Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section XVIII.B of the Agreement.

7. Require the Next Generation Participant or Preferred Provider to provide the Government with access to records regarding the AIPBP Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section XVIII.A of the Agreement.
- G. The ACO shall ensure that it has and will maintain the capability and funds to reimburse AIPBP-participating Next Generation Participants and Preferred Providers for all Covered Services that they furnish, and that it will promptly make such payments in accordance with Section III.F.2 of this Appendix.

#### **IV. Beneficiary Disputes**

- A. CMS will process all claims submitted by AIPBP-participating Next Generation Participants and Preferred Providers, and assess coverage for such services and any Beneficiary liability using the same standards that apply under traditional Medicare fee-for-service.
- B. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claims appeals process at 42 C.F.R. Part 405, subpart I.

#### **V. Provider Payment Dispute Resolution**

The ACO must establish procedures under which AIPBP-participating Next Generation Participants and Preferred Providers may request reconsideration by the ACO of a payment determination. The procedures for requesting reconsideration must be included in the written AIPBP Payment Arrangement between the ACO and the AIPBP-participating Next Generation Participant or Preferred Provider required under Section III.A of this Appendix.

#### **VI. Calculation of the All-Inclusive Population-Based Payment**

##### **A. Overview**

1. CMS shall calculate the Monthly AIPBP Payment in accordance with Section VI.B of this Appendix.
2. CMS will make a Monthly AIPBP Payment to the ACO for each month that the ACO participates in AIPBP during the Performance Year.
3. CMS shall not make any Monthly AIPBP Payments to the ACO after the effective date of the termination of this Agreement.
4. CMS shall not make any Monthly AIPBP Payments after the effective date of CMS' termination (in accordance with Section XIX.A of this Agreement) of the ACO's selection to participate in AIPBP.

##### **B. AIPBP Payment Calculation**

###### **1. Calibration Year Used to Estimate the Reduction in FFS Payments**

CMS will use FFS payments from a calibration year to estimate the reduction in FFS payments to AIPBP-participating Next Generation Participants and Preferred Providers for Part A and Part B services furnished to Next Generation Beneficiaries during the applicable Performance Year. The calibration year is the calendar year prior to the Performance Year.

## 2. Population Used to Estimate the Reduction in FFS Payments

The population used to estimate the reduction in FFS Payments to AIPBP-participating Next Generation Participants and Preferred Providers for a Performance Year consists of those Beneficiaries who would have been aligned with the ACO during the calibration year on the basis of Performance Year Next Generation Participants. This population includes Beneficiaries who were alive on January 1 of the calibration year and not enrolled in a managed care plan in January of that year. This population includes Beneficiaries who would later have been excluded from alignment to the ACO because they did not meet alignment-eligibility requirements during the calibration year or who would have been excluded based on service-area restrictions that are applied retrospectively.

## 3. Use of Completion Factors to Estimate the Reduction in FFS Payments

- i. CMS will use a partial year of claims experience, without run-out, to calculate the estimated reduction in FFS payments to AIPBP-participating Next Generation Participants and Preferred Providers because the AIPBP payment amount is generally calculated prior to or at the start of the Performance Year.
- ii. To adjust for run-out and claims not yet incurred, a completion factor is applied based on the experience of the most recent calendar year for which complete experience is available (the “**Completion Factor Year**”). The most recent calendar year for which complete experience is available is typically the calendar year that is two years prior to the Performance Year. (For example, for PY2018, the completion factor would be based on claims from CY2016 and applied to the CY2017 calibration year).
- iii. A completion factor will be calculated and applied for each claim type (e.g., inpatient hospital, skilled nursing facility, home health agency, hospice, physician, outpatient hospital service, etc.).
- iv. The completion factor is calculated using the ratio of total expenditures for claims paid for the Completion Factor Year through December 1 of that year (e.g., December 1, 2016, for PY2018) to expenditures for claims paid for the Completion Factor Year through a three-month run-out period into the following calendar year. (If CY2015 is the Completion Factor Year, this would be March 31, 2016.)

## 4. Calculation of Total AIPBP Payment and Monthly AIPBP Payment

The total amount of AIPBP payments to the ACO for a Performance Year is calculated by determining the total estimated AIPBP Fee Reduction for each AIPBP-participating Next Generation Participant and Preferred Provider, which is equal to:

- i. The aggregate Part A and Part B payments made for services furnished by all AIPBP-participating Next Generation Participants and Preferred Providers in the calibration year;
- ii. Multiplied by the completion factor for the relevant claim type;

- iii. Multiplied by the ratio of the number of Next Generation Beneficiaries for the Performance Year to the number of aligned Beneficiaries for the calibration year; and
- iv. Multiplied by 0.98 (i.e. reduced by 2%) if budget sequestration is in effect for the Performance Year.

The resulting amount is then divided by 12 to determine the “**Monthly AIPBP Payment.**”

#### C. AIPBP Payment Recalculation

1. CMS will not recalculate the total amount of the AIPBP payment for the Performance Year or the Monthly AIPBP Payment during the Performance Year, except as provided for in this Section VI.C of this Appendix.
2. CMS will review actual AIPBP Fee Reductions during the Performance Year. If Performance Year performance data shows, after one quarter, that the Monthly AIPBP Payments for the previous quarter are at least 10% greater or 10% less than total actual AIPBP Fee Reductions taken in the previous quarter, CMS may recalculate and revise the total amount of the AIPBP payment for the Performance Year and the amount of the Monthly AIPBP Payment calculated under Section IV.B.4 based on Performance Year data. The revised Monthly AIPBP Payment shall be payable on a prospective basis only. CMS will provide a report of the recalculated amounts to the ACO.

## VII. Reconciliation of the Total Monthly AIPBP Payments

- A. CMS will reconcile total Monthly AIPBP Payments with total AIPBP Fee Reductions for each Performance Year the ACO participates in AIPBP, by calculating the difference between the total Monthly AIPBP Payments CMS paid to the ACO during the Performance Year and the total AIPBP Fee Reductions taken during the Performance Year. Any difference will constitute Other Monies Owed and may be subject to recoupment during annual financial settlement as described in Section XIV.C of this Agreement and Section VII.E of this Appendix.
- B. CMS will reconcile total Monthly AIPBP Payments separately from the annual financial settlement with the ACO’s Performance Year Benchmark under Appendix B to determine the ACO’s Shared Savings or Shared Losses. The AIPBP Fee Reductions do not affect the calculation of Shared Savings or Shared Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the AIPBP Fee Reduction. The reconciliation of total Monthly AIPBP Payments and the total AIPBP Fee Reductions does not affect and is not affected by the ACO’s selected Risk Arrangement, Savings/Losses cap, or expenditure cap.
- C. During the annual financial settlement, CMS will include any Other Monies Owed due to reconciliation of the total Monthly AIPBP Payments, with the Shared Savings or Shared Losses on the settlement report issued under Section XIV.C.1. of this Agreement, such that the settlement report will show the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.



- D. If the total AIPBP Fee Reductions exceed the total Monthly AIPBP Payments paid to the ACO, CMS will:
1. Add the difference to the amount paid to the ACO if the ACO has earned Shared Savings;
  2. Subtract the difference from the amount of the Shared Losses owed by the ACO if the ACO owes Shared Losses; or
  3. Pay the amount to the ACO as Other Monies Owed if no Shared Savings are earned and no Shared Losses are owed.
- E. If the total Monthly AIPBP Payments paid to the ACO exceed the total AIPBP Fee Reductions, CMS will:
1. Subtract the difference from the amount paid to the ACO if the ACO has earned Shared Savings;
  2. Add the difference to the amount owed to CMS by the ACO if the ACO owes Shared Losses; or
  3. Recover the difference from the ACO as Other Monies Owed if no Shared Savings are earned and no Shared Losses are owed.
- F. In the event that an AIPBP-participating ACO elects to terminate its Agreement prior to the end of a Performance Year by providing notice to CMS on or before February 28 of that Performance Year with effect no later than 30 days from that notice, CMS will reconcile total Monthly AIPBP Payments within three (3) months after the effective date of termination, and the ACO must pay any Other Monies Owed to CMS in accordance with Section XIV.C.5 of the Agreement.
- G. CMS will include in the reconciliation of total Monthly AIPBP Payments any AIPBP Fee Reductions for services furnished to Beneficiaries who were Next Generation Beneficiaries at the time the services were furnished but were later excluded from the aligned population during the Performance Year because they did not meet alignment-eligibility requirements.
- H. Adjusted Settlement
1. For each Performance Year in which the ACO participates in AIPBP, CMS shall conduct a second AIPBP reconciliation one year after the original AIPBP reconciliation at the same time that CMS issues the settlement report for the subsequent Performance Year.
  2. If, as a result of the second AIPBP reconciliation, CMS determines that:
    - a. The total AIPBP Fee Reductions exceed the total amount of AIPBP Payments made to the ACO as Monthly AIPBP Payments during the Performance Year, as reconciled during the initial AIPBP reconciliation for the applicable Performance Year under Section VII.A of this Appendix, the difference will be deemed Other Monies Owed and CMS will pay the amount to the ACO pursuant to Section XIV.C.5 of the Agreement;

- b. The total amount of AIPBP payments made to the ACO as Monthly AIPBP Payments during the Performance Year, as reconciled during the initial AIPBP reconciliation for the applicable Performance Year under Section VII.A of this Appendix, exceeds the total AIPBP Fee Reductions during the Performance Year, the difference will be deemed Other Monies Owed and the ACO will pay the amount to CMS pursuant to Section XIV.C.5 of the Agreement;
- 3. In the case of the final year of the Agreement Term or if the ACO voluntarily terminates the Agreement pursuant to Section XIX.C of the Agreement prior to the end of a Performance Year by providing notice to CMS on or before February 28 of that Performance Year with effect no later than 30 days from that notice:
  - a. CMS will make reasonable efforts to conduct the second AIPBP reconciliation within 12 months after the issuance of the original settlement report for the applicable Performance Year;
  - b. CMS will issue an adjusted settlement report to the ACO setting forth the results of the second AIPBP reconciliation and identifying any Other Monies Owed by the ACO to CMS, or by CMS to the ACO, as a result of this second AIPBP reconciliation.
  - c. Any amounts owed by the ACO to CMS, or by CMS to the ACO, as a result of this second AIPBP reconciliation will be payable in accordance with Section XIV.C.5 of the Agreement.

#### **VIII. Performance Year 2017 Alternative Payment Mechanism - All-Inclusive Population-Based Payments**

The AIPBP Alternative Payment Mechanism for the 2017 Performance Year is governed by the Appendix N of the First Amended and Restated Participation Agreement for 2016 Starters that was executed in January 2017, as if such appendix were included in this Second Amended and Restated Participation Agreement for 2016 Starters.