Next Generation ACO Model Benchmarking Methods

December 15, 2015

Revision: 1.00.04

Document Number: RTI.NGACO.METHODS.BNMRK.01.00.04
Contact Number: HHSM-500-2014-0037I/HHSM-500-T0001

Prepared for:
Centers for Medicare & Medicaid Services (CMS)
Center for Medicare & Medicaid Innovation
Seamless Care Models Group
7500 Security Boulevard, N2-13-16
Baltimore, MD 21244-1850

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.
1.00.04	December 29, 2015	Corrected typographical error in footnotes to Table 7.0

Table of Contents

Next Generation ACO Model Benchmarking Methods

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.[1]

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.

[1] 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.[2]

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.

[2] 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 to the ACO's trended baseline will limited to a maximum of ±3%. Financial settlement will be based on the Performance-Year risk scores of the Next Generation Beneficiaries aligned to the ACO during the Performance Year.[3]

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 0.5% to 4.5%. The adjusted discount is:

1. A standard discount of 3.0%.
2. MINUS: A regional efficiency adjustment of ±1.0%
3. MINUS: A national efficiency adjustment of ±0.5%
4. MINUS: A quality adjustment to the standard discount of up to +1.0%

The minimum adjusted discount is, therefore, 0.5% and the maximum is 4.5% as shown in section 7.0.2.4.1.

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 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.

[3] 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.

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 ±1%.
2. The national efficiency adjustment to the standard discount will be ±0.5%.

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

2.5 Illustrative Example of Benchmark Calculation

Table 2.5 illustrates the benchmark calculation.

Table 2.5. Calculation of Performance Year Benchmark for Aged/Disabled beneficiaries

	Baseline (CY2014)		Benchmark
ACO baseline (CY2014) expenditure:	**$876.54**		$876.54
Projected PY1/CY2016 regional trend adjustment:			**$30.36**
Projected PY1/CY2016 national trend:	3.00%		
CY2016 GAF trend adjustment	0.45%		
Projected PY1/CY2016 regional trend:	3.46%		
Trended baseline[1]			**$906.90**
PY1 baseline risk adjustment factor[2]			**1.010**
Risk-adjusted trended baseline[3]			**$915.97**
Adjusted NGACO discount			
Standard discount	3.00%		**3.00%**
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			**1.84%**
LESS: NGACO discount[4]			**$16.85**
Benchmark[5]			**$899.12**

[1] The ACO baseline plus the regional trend adjustment (906.90 = 876.54 + 30.36 = 876.54 x (1 + 0.0346).

[2] The ratio of the PY1 risk score to the base-year risk score (subject to a ±3% limit). The example assumes the PY1 risk score is 1% higher than the base-year risk score, therefore a risk adjustment factor of 1.010.

[3] The product of the trended baseline and the risk adjustment factor (915.97 = 906.90 x 1.010).

[4] 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).

[5] 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).[4]

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.

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,

[4] 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.

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.[5] 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.
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

[5] Alignment methods are described in Appendix A.

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.[6]

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.

3.8 Capped expenditure

The capped expenditure for a base-year or Performance-Year that accrues to the entitlement category by the beneficiary is the lesser of:

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

[6] IME and DSH payments are excluded from the expenditure used to calculate the efficiency ratios because they are unrelated to an ACO's efficiency.

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 year;

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 will be based on national experience.

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

3.9 Provider payments made outside of standard claims systems

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.

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 expenditure 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.[7] Adjustments to the projected 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.

[7] 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 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.

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:

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 Performance Year of a beneficiary that is based on the clinical conditions for which a beneficiary was treated in the prior year. CMS maintains HCC prospective risk adjustment 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, diagnoses from claims for services provided in CY2013 are used to calculate the CY2014 risk score, which represents the beneficiary's expected CY2014 expenditures. HCC risk scores are calculated for all Medicare beneficiaries, including FFS beneficiaries. Thirteen separate models are used to predict the cost of different beneficiary subpopulations including:

1. Community-residing Aged/Disabled beneficiaries;
2. Aged/Disabled beneficiaries residing in long-term institutional settings;
3. New Aged/Disabled Medicare enrollees;
4. Aged/Disabled beneficiaries with functioning graft (post-kidney-transplant);
5. ESRD beneficiaries receiving dialysis;
6. ESRD beneficiaries during the three months following a kidney transplant.

One or more of the risk scores calculated using these models may be applicable to a beneficiary during a given calendar month. 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 risk score from the community-residing model will be used for months in which the beneficiary was living in the community, while the long-term institutional risk score will be used for months in which the beneficiary is a long-term resident of a nursing facility.

The MA risk adjustment model(s) that are used for each Benchmark and Performance Year will be used for risk adjustment in the NGACO Model. For example, the BY (CY2014) risk score(s) for a beneficiary will be the risk score(s) that were developed for the beneficiary using the MA risk adjustment models for CY2014. Risk scores without the MA coding intensity adjustment will be used for ACO risk adjustment.

6.2 "Re-normalization" of Risk Scores

Risk scores will be "re-normalized" to the average risk score of all alignment-eligible beneficiaries contributing experience to an entitlement category (e.g., A/D or ESRD) in each base- or Performance-Year. As a result, in each base- or Performance-Year the average re-normalized risk score for an entitlement category has a value of one (1.000). In other words, the risk scores are re-normalized to the reference population. A beneficiary's "re-normalized" risk score for months in which a beneficiary contributes experience to an entitlement category is:

1. The beneficiary's average risk score for months in which the beneficiary contributed experience to the entitlement category during the base- or Performance-Year; divided by,
2. The average risk score of all beneficiaries who contribute experience to the category during the base- 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- 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 ÷ 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.

6.3 Risk ratio

For a given Performance Year and entitlement category, the risk ratio will equal the ratio of:

1. The average HCC risk score of Next Generation Beneficiaries aligned in the Performance Year; to
2. The average HCC risk score for aligned beneficiaries in the base year.

For example, in PY1 (CY2016), the risk ratio for an entitlement category is equal to:

1. The average PY1 (CY2016) HCC risk score of all CY2016 Next Generation Beneficiaries belonging to the entitlement category in CY2016; divided by
2. The average BY (CY2014) HCC risk score of all CY2014-aligned beneficiaries belonging to the entitlement category in CY2014.

The risk ratio for the ACO aligned beneficiaries between the baseline and the performance year will be capped at 0.97 and 1.03 (a percentage change of ±3% from base-year to performance-year).

6.4 Risk-adjusted trended baseline

For a given performance year, the trended, risk adjusted baseline for each entitlement category is the product of the trended baseline and the risk ratio.

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 3.0%.
2. MINUS: A regional efficiency adjustment of ±1.0%
3. MINUS: A national efficiency adjustment of ±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 0.5% to 4.5% 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	3.0%	3.0%
MINUS: Regional efficiency adjustment[1]	1.0%	−1.0%
MINUS: National efficiency adjustment[2]	0.5%	−0.5%
MINUS: Quality adjustment	1.0%	0.0%
EQUALS: Quality- and efficiency-adjusted discount	0.5%	4.5%

[1] 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 adjusted discount for a high cost ACO.

[2] 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 adjusted 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 3% 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 7.1. 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, 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 quality scores will not be available at the time that the Benchmark is calculated. When PY1 quality scores are calculated at mid-year PY2, CMS will update the Performance Year Benchmark.[8] For NGACOs with agreements effective January 1, 2017, the initial and mid-year update to the quality score will be 100%.

For PY3, the prospectively-set quality score component will be based on the quality score from PY1. PY2 quality scores will be calculated in mid-2018. When PY2 quality scores become available, CMS will update the Performance Year Benchmark to reflect the PY2 quality score.

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.

[8] The PY1 quality score for purposes of calculation of the PY1 quality adjustment to the standard discount will be 100% assuming the NGACO reports all quality measures. However, a PY1 "baseline" quality score based on the NGACO's performance on each quality measure will also be calculated. This PY1 "baseline" quality score will be used to calculate the mid-year quality adjustment to the standard discount in PY2.

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.

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.[9] 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.

[9] 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.[10]

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.

[10] 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[1]	Regional efficiency ratio	Adjustment[1]
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%

[1] 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.[11]

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

[11] 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[1]	National efficiency ratio	Adjustment[1]
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%

[1] 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.[12]

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.[13]

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.

[12] Technically, the PBPM benchmark is equal to the trended risk-adjusted baseline multiplied by 1 minus the quality- and efficiency adjusted discount.

[13] The combined benchmark is, therefore, simply the person-month weighted average of the Aged/Disabled and ESRD PBPM benchmarks.

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, 15% savings/losses cap
2. Arrangement B: 100% shared savings/losses, 15% savings/losses cap.

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.

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-2, 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 2nd 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-3 or A-4.

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-2.

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-3.

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 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 1st (earlier) alignment-year will be weighted by a factor of ⅓.
2. The allowable charge for QEM services provided during the 2nd (later or more recent) alignment-year will be weighted by a factor of ⅔.

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 2nd 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-3, 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-4.

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

Period	Period covered[1]	Corresponding alignment years (AY)
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 – 06/30/2006 (AY2016)
		PY3/AY2: 07/01/2016 – 06/30/2017 (AY2017)

[1] 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

Office or Other Outpatient Services	
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
Nursing Facility Care	
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
Domiciliary, Rest Home, or Custodial Care Services	
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
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
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

Table A-1. Evaluation & Management Services (cont.)

Wellness Visits	
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

Code[1]	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
38	Geriatric Medicine
50	Nurse Practitioner
97	Physician Assistant

[1] 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

Code[1]	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

[1] 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