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

Next Generation ACO Model

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Request for Applications – 2018 Model Starters

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I. Background and Introduction

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

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

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

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

II. Statutory Authority

A. General Authority to Test Model

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

the quality of beneficiaries' care.

B. Financial and Payment Model Authorities

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

C. Waiver Authority

The authority for the Next Generation Model is section 1115A of the Act. Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). Consistent with this standard, the Secretary issued certain waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act for this Model. No fraud or abuse waivers are being issued in this document; the fraud and abuse waivers issued for the Next Generation ACO Model can be found at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html. Thus, notwithstanding any other provision of this Request for Applications, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Next Generation Model.

III. Scope and General Approach

This Request for Applications (RFA) solicits a third round of applications for a new cohort of ACOs to begin participation in the Model on January 1, 2018. The Model is a five-year initiative that began on January 1, 2016. The first cohort of ACOs began participation on January 1, 2016; a second cohort of ACOs began participation on January 1, 2017. Information on current model participants can be found at https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/. CMS expects additional ACOs to participate in the Next Generation Model, starting in the third performance year of the Model (calendar year (CY) 2018). The number of ACOs selected will be based on the level of interest in the Model and available resources.

ACOs that began participation in 2016 have an initial agreement term that consists of three one-year performance years with a potential extension for two additional performance years. ACOs that began participation in 2017 have an initial agreement term of *two* one-year performance years, with a potential extension for two additional performance years. ACOs selected in the third round that elect to participate will sign a Next Generation ACO Model Participation Agreement ("Participation Agreement"), and have an initial agreement term of *one* one-year

performance year, with a potential extension for two additional performance years. The first performance period for the third cohort of ACOs will begin January 1, 2018.

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

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

While CMS is committed to improving care for beneficiaries, CMS reserves the right to modify or terminate the Model if it is determined that it is not achieving the goals and aims established for the Model.

IV. Application Process

As described in Section III above, there have been two previous application rounds for the Next Generation ACO Model and CMS is currently soliciting applications for a third. Each application round has its own respective Letter of Intent and Application processes. Organizations that completed the round one or two processes and were not selected for participation may apply for participation in round three, but application materials submitted during previous rounds will not be considered in round three. Therefore, an organization that applied during round one and/or two and was not selected for participation must submit a unique Letter of Intent and Application for consideration in round three.

A. Letter of Intent

For round three consideration, interested organizations must submit an LOI no later than 11:59 p.m. EDT May 4, 2017. Letters of Intent will be used only for planning purposes, and submitting an LOI will not bind an interested organization to moving forward under the Model. An LOI template is provided in Appendix A. To submit an LOI, interested organizations may access an electronic portal at: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

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

B. Application

The portal for round three applications will be made available in March 2017. The application will be submitted in two stages. The narrative portion of the application must be submitted

electronically no later than 5:00 p.m. EDT May 18, 2017, and the applicant's proposed Next Generation Participant Provider lists and list of Next Generation ACO Service Areas must be submitted electronically no later than 5:00 p.m. EDT June 9, 2017. An application template is provided in Appendix G so that applicants can begin preparing their responses. CMS reserves the right to request interviews, site visits, or additional information related to application responses from applicants in order to assess their applications. Applicants may access the application portal at: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

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

Of important note, and as described in the Legal Entity and State Licensure sections below, applicants to the Next Generation Model will not be expected to have their legal entity formed or requisite state licensure verified until after selection. However, these requirements must be satisfied prior to execution of the Participation Agreement. Before signing the Participation Agreement, selected applicants must submit a list identifying 100% of their proposed Next Generation Participants and Preferred Providers in order to allow for screening by CMS and its law enforcement partners and final approval by CMS. Prior to the start date of the Participation Agreement, applicants must have a written agreement that meets the criteria set forth in the Participation Agreement with each Next Generation Participant and Preferred Provider on its Next Generation Participant List and Next Generation Preferred Provider List.

C. Withdrawal of Application

Applicants seeking to withdraw completed applications must submit an electronic withdrawal request to CMS via the Next Generation Model mailbox: NextGenerationACOModel@cms.hhs.gov. The request must be submitted as a PDF on the organization's letterhead and signed by an authorized corporate official. It should include: the applicant organization's legal name; the organization's primary point of contact; the full and correct address of the organization; and a description of the nature of the withdrawal.

V. Applicant Eligibility and Participation Requirements

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

A. Eligible Providers/Suppliers

Next Generation ACOs may be formed by Next Generation Participants (defined in the Glossary at Appendix B) structured as:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Partnerships or joint venture arrangements between hospitals and physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)

- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

Any other Medicare-enrolled providers or suppliers may participate in an ACO formed by one or more of the entities listed above, provided that they satisfy the definition of a Next Generation Participant (defined in the Glossary at Appendix B), and other requirements of the Model. In addition, Medicare-enrolled providers or suppliers may also enter into an agreement with the ACO to act as Preferred Providers, provided that they satisfy the definition of Preferred Providers (defined in the Glossary at Appendix B), and other requirements of the Model. See Program Overlap at Section V.H below for an explanation of how ACOs, Next Generation Participants, and Preferred Providers may or may not participate in multiple Medicare initiatives.

B. Screening

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

C. Legal Entity, Governance Structure, and Leadership

1. Legal Entity

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

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

An ACO formed by two or more Next Generation Participants, each of which is identified by a unique TIN, must be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers.

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

ACOs that in the year prior to entry into the Next Generation Model have participated (without

termination for cause) in the Shared Savings Program as a Shared Savings Program ACO pursuant to a participation agreement (as defined at 42 C.F.R. § 425.20) will be deemed to have met the Next Generation legal entity requirement.

The applicant must comply with all applicable laws and regulations, as well as the terms of the Participation Agreement.

2. Structure of the Governing Body

Next Generation ACOs must have 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 governing body must be separate and unique to the ACO and must not be the same as the governing body of any other entity participating in the ACO (unless the ACO is formed by a single Next Generation Participant, in which case the ACO's governing body may be the same as that of the Next Generation Participant).

3. Responsibilities of the Governing Body

- The governing body must have responsibility for oversight and strategic direction of the ACO and will be responsible for holding ACO management accountable for the ACO's activities.
- The governing body must have a transparent governing process.
- When acting as a member of the governing body of the ACO, each governing body member has a fiduciary duty to the ACO, including the duty of loyalty, and shall act consistent with that fiduciary duty.
- The governing body must receive regular reports from the designated compliance official of the ACO, who is not legal counsel to the ACO, and who must report directly to the governing body.

4. Composition and Control of the Governing Body

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

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

- The ACO Governing body shall not include a Prohibited Participant (defined in the Glossary at Appendix B), or an owner, employee or agent of a Prohibited Participant.
- In cases where beneficiary and/or consumer advocate representation on the ACO governing body is prohibited by state law, the Next Generation ACO, with CMS approval, shall provide for an alternative mechanism to ensure that its policies and procedures reflective consumer and patient perspectives.
- The governing body members may serve in similar or complementary roles or positions for Next Generation Participants or Preferred Providers to the roles of positions in which they serve for the ACO.

5. Conflict of Interest

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

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

6. ACO Leadership and Management

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

- The ACO's operations must be managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.
- Clinical management and oversight must be managed by a senior-level medical director who is: (1) a Next Generation Participant; (2) physically present on a regular basis at any clinic, office, or other location participating in the ACO; and (3) a board-certified physician and licensed in a state in which the ACO operates.

D. Next Generation Participants and Preferred Providers

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

Table 1: Types of Providers/Suppliers and Associated Functions[1]

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

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

[2] More information on the benefit enhancement may be found in Section VI.C.

E. State Licensure

Each state has unique regulatory systems for health care delivery, the practice of medicine, fraud and abuse, and insurance, but CMS understands that most states do not have laws that specifically address provider organizations bearing substantial financial risk, distributing savings, or, in the case of certain Next Generation payment mechanisms, paying claims. Therefore, depending on the particular state laws and the discretion of state authorities, Next Generation ACOs may be subject to insurer or third-party administrator (TPA) licensure requirements. It is a Next Generation ACO's responsibility to determine and meet all applicable licensure requirements. The Next Generation Model does not alter state law requirements, but CMS makes effort to engage relevant state agencies to promote understanding of the Model's features and requirements.

To participate in the Next Generation ACO Model, an ACO must demonstrate compliance with all applicable state licensure requirements in each state in which it operates regarding risk-bearing entities unless it provides a written attestation and certification to CMS that it is exempt from such state laws in accordance with the Participation Agreement.

F. Outcomes-Based Contracts with Other Purchasers

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

G. Use of Certified EHR Technology

Beginning in 2017, the ACO and its Next Generation Participants shall use certified EHR technology (as defined in section 1848(o)(4) of the Act) in a manner sufficient to meet the requirements for an "eligible alternative payment entity" under section 1833(z)(3)(D)(i)(I) of the Act (added by section 101(e)(2) of the Medicare Access and CHIP Reauthorization Act of 2015)

as prescribed through the final rule implementing the Quality Payment Program, 81 Fed. Reg. 77,008 (Nov. 4, 2016).

H. Program Overlap

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

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

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

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

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

VI. Model Design Elements

A. Financial Benchmark, Payment Mechanisms, and Shared Savings

The Next Generation Model tests ACO capacity to take on near-complete financial risk in combination with a stable, predictable benchmark and payment mechanisms that encourage ACO investments in care improvement infrastructure. Below are explanations of the Next Generation Model benchmark methodology (including risk adjustment), risk arrangement options, payment mechanism options, and shared savings/losses calculation methodology. A detailed financial methodology paper is available at https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

1. Benchmark

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

Unlike the Shared Savings Program and the Pioneer ACO Model, in which a final updated benchmark is determined at the end of each performance year, CMS establishes the Next Generation Model prospective Benchmark prior to the start of each performance year. The prospective Benchmark is set using the most accurate expenditure, quality, and risk score data available at the time of benchmark setting, with minimal updates to arrive at the final Benchmark after the performance year ends.[1]

In the first three performance years of the Model (CY 2016 – CY 2018), for each Next Generation ACO, this prospective Benchmark will be established through the following steps: (1) determine the ACO's historic baseline expenditures; (2) apply the regional projected trend; (3) risk adjust using the CMS Hierarchical Condition Category (HCC) model; and (4) apply the discount, which is derived from one quality adjustment and two efficiency adjustments. The benchmark will be calculated separately for two entitlement categories: 1) Aged/Disabled/Dual Eligible and 2) End Stage Renal Disease (ESRD).

i. Baseline (Benchmark Step 1)

CMS will employ a hybrid approach to developing the benchmark that incorporates both historical and regional costs. First, baseline ACO expenditures are determined by using an ACO's historic spending in a single baseline year: CY 2014. The same baseline year, CY 2014, will be used for performance year 1 of the Model (CY 2016) through performance year 3 of the Model (CY 2018). However, the baseline will be updated each year to reflect the ACO's Next Generation Participant list for the given performance year. The baseline year is CY 2014 for performance years 1 through 3 of the Model (CY 2016 – CY 2018) regardless of cohort and/or Model participation start date. Second, CMS calculates a regional FFS expenditure baseline for alignment-eligible beneficiaries in order to determine an ACO's relative efficiency in relation to its region. The ratio of an ACO's historic expenditures to regional FFS expenditures (regional efficiency) is used in calculating the discount, described in Benchmark Step 4 below. Under this approach, ACOs achieve savings through year-to-year improvement over historic expenditures (improvement), but the magnitude by which they must improve varies based on relative efficiency (attainment).

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

ii. Trend (Benchmark Step 2)

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

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

iii. Risk Adjustment (Benchmark Step 3)

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

CMS applies prospective CMS Hierarchical Condition Category (HCC) risk scores to the populations aligned in both the baseline year and the performance years. The full HCC risk score (both demographic and diagnostic components of the score) will be used for all aligned beneficiaries. The ACO's full HCC risk score will be allowed to grow with a 3% annual maximum cap (performance year compared to the baseline). For example, if an ACO experiences a 4% risk score growth, the adjustment will be reduced to 3%. If the ACO has 1% risk score growth, the adjustment will remain at 1% because it is below the cap. If the risk scores for aligned beneficiaries decrease, CMS will adjust downward correspondingly with a 3% downside cap. A Next Generation ACO's risk score for the performance year will not be available until after the completion of the performance year, and thus cannot be incorporated into the prospective Benchmark. The prospective Benchmark will use the most recent available final HCC risk score as a placeholder. For example, the Model PY3/CY2018 final risk scores are expected to be released in April 2019. The PY3/CY2018 final Benchmark will be updated to reflect the final PY3/CY2018 risk scores.

iv. Discount (Benchmark Step 4)

Unlike the Shared Savings Program and the Pioneer ACO Model, the Next Generation Model does *not* utilize a minimum savings rate (MSR). Instead, CMS applies a discount to the Benchmark once the baseline has been calculated, trended, and risk adjusted. The standard discount is 2.25% and then ranges from 0% to 3.75% based on ACO-specific adjustments reflecting three factors: (1) ACO quality score; (2) ACO baseline expenditures compared to regional FFS expenditures (regional efficiency); and (3) ACO baseline expenditures compared to

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

national FFS expenditures (national efficiency).

Below is a description of each factor of the discount.

- **Quality**: The standard discount will be reduced by up to 1% depending on the quality score attained by the ACO in the Performance-Year. Therefore, an ACO with a 100% quality score would have the standard discount reduced from 2.25% to 1.25%, and an ACO with a 0% quality score would receive no reduction to the 2.25% standard discount. ACOs that sign Participation Agreements with a start date of January 1, 2018, will have a quality score of 100% for 2018 so long as the ACO completely, timely, and accurately reports quality measures for 2018. More information on the use of quality scores in calculating the benchmark can be found in Section VII.C.
- **Regional Efficiency**: The regional efficiency component of the discount will range from -1% to 1% (i.e., the standard discount will be decreased or increased +/- 1.0%). This compares the ACO's risk-adjusted historical per capita baseline (described in Benchmark Steps 1 and 3) to a risk-adjusted regional FFS per capita baseline (determined by ACO beneficiaries' counties of residence). This ratio will determine the regional efficiency component of the discount.
- **National Efficiency**: The national efficiency component of the discount will range from -0.5% to 0.5% (i.e., the standard discount will be decreased or increased +/- 0.5%). This compares the ACO's risk-adjusted historical per capita baseline to a risk-adjusted national FFS per capita baseline to determine the national efficiency component of the discount.
- When these three components are added together, the discount range is 0% to 3.75%. Note that the discount may not be less than 0%. For an example discount calculation, see Appendix C.

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

- Eliminate or further de-emphasize the role of recent ACO cost experience when updating the baseline;
- Take into account public comments received in response to the Shared Savings Program Notice of Proposed Rulemaking (NPRM) from January 2016 on alternative benchmark approaches;
- Shift to valuing attainment more heavily than improvement;
- Consider the use of a normative trend;
- Continue to refine risk adjustment for beneficiary characteristics that balances changes in disease burden against diagnostic upcoding;
- Consider adjustments reflecting geographic differences in utilization or price changes.

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

2. Risk Arrangements

The Next Generation Model offers a choice of two risk arrangements that determine the portion of the savings or losses that accrue to the Next Generation ACO. The risk arrangement applies to

the difference between actual expenditures and the prospective benchmark. In both arrangements: (1) individual beneficiary expenditures will be capped at the 99th percentile of expenditures to prevent substantial impacts by outliers (the Next Generation ACO is not accountable for expenditures beyond the 99th percentile); and (2) aggregate savings or losses will be capped at up to 15% of the benchmark.

Table 2: Risk Arrangements in the Next Generation Model

Arrangement A: Increased Shared Risk	**Arrangement B: Full Performance Risk**
Parts A and B Shared Risk • 80% sharing rate (PY1-3 of the Model) • 85% sharing rate (PY4-5 of the Model) • 5-15% savings/losses cap (elected annually by each ACO)	100% Risk for Part A and B • 5-15% savings/losses cap (elected annually by each ACO)

3. Payment Mechanisms

The Next Generation Model tests the effectiveness of alternative payment mechanisms in facilitating investments in infrastructure and care coordination to improve health outcomes. None of the payment mechanisms offered in the Next Generation Model affect beneficiary out-of-pocket expenses. The payment mechanism options are summarized below, with mechanisms 2, 3, and 4 representing alternative payment mechanisms from which an ACO may only select one to participate in for a given performance year, and example calculations of each payment mechanism are included in Appendix D.

i. Payment Mechanism 1: Normal FFS Payment

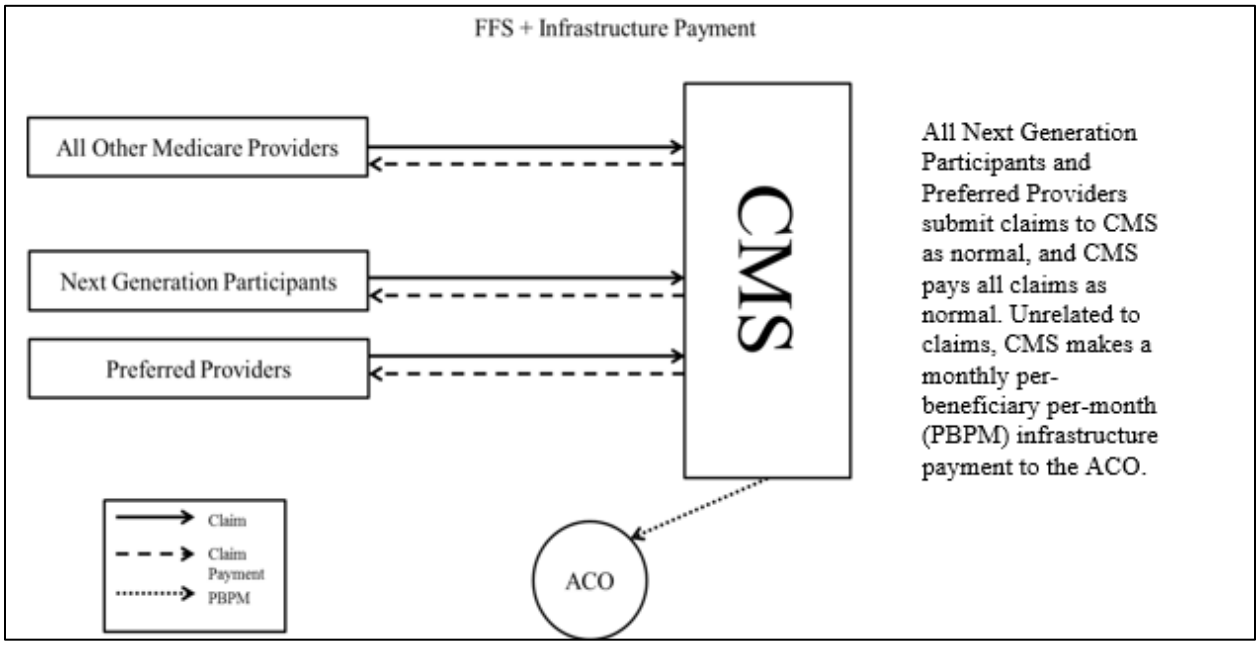
Next Generation Participants and Preferred Providers are paid by CMS for services performed through the normal FFS payment mechanisms at standard payment levels. This represents no change from Original Medicare.

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

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

CMS will make this infrastructure payment at a rate of no more than $6 PBPM. Infrastructure payments do not affect the calculation of Shared Savings/Losses, which will continue to be based on the total FFS expenditures during the Performance Year for aligned beneficiaries. Infrastructure payments will be recouped in full from the ACO during reconciliation regardless of savings or losses. The amount of the monthly infrastructure payment is the product of the number of beneficiaries aligned to the ACO for a performance year and the PBPM amount selected by the ACO. The aggregate monthly payment is calculated prior to the start of each performance year in which the ACO has elected to receive infrastructure payments and will not be updated during a performance year.

Figure 1: Infrastructure Payments Conceptual Diagram



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

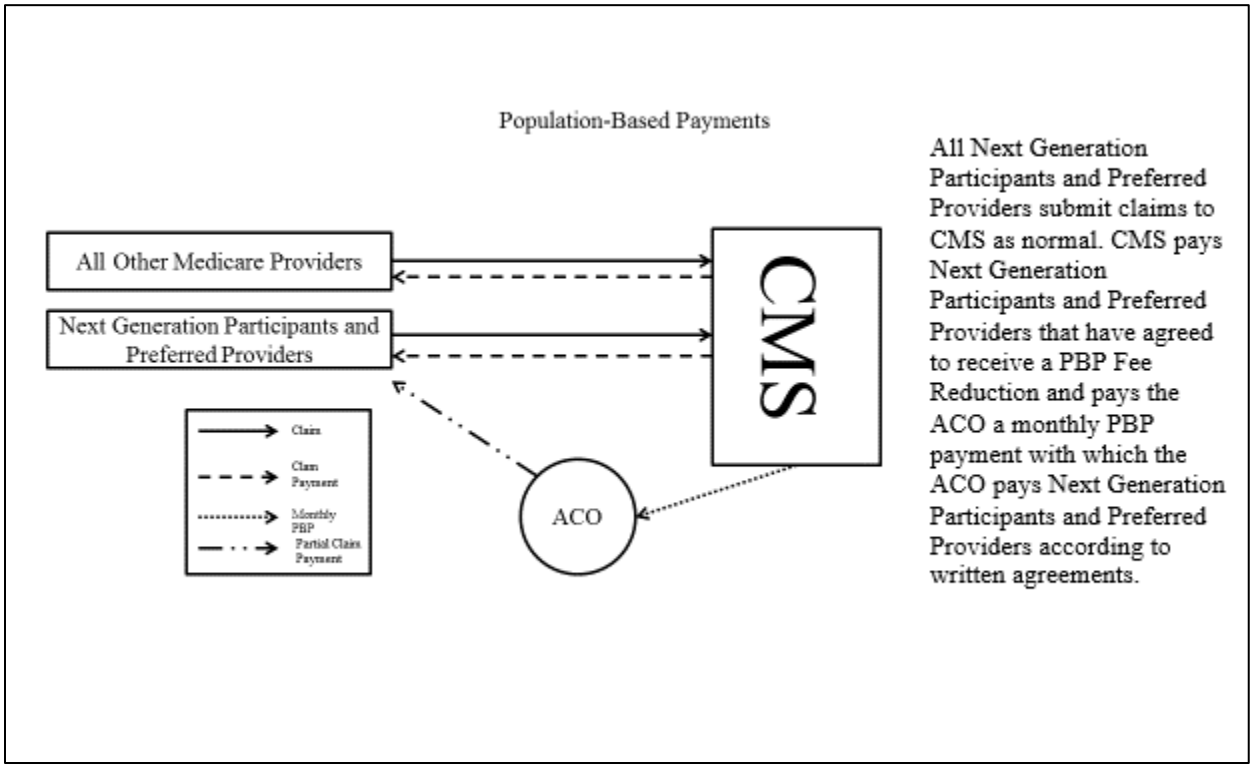
Population-Based Payments (PBP) provide Next Generation ACOs with a monthly payment to support ongoing ACO activities and allow flexibility in the types of arrangements the ACO enters into with its Next Generation Participants and Preferred Providers. If a Next Generation ACO elects to participate in PBP, the ACO will determine a percentage reduction to the FFS payments of its Next Generation Participants and Preferred Providers who have agreed to participate in PBP and with whom the ACO is not prohibited from having a PBP Payment Arrangement ("PBP Fee Reduction"). The ACO will then receive a monthly PBP payment that is an estimate of the total amount by which FFS payments will be reduced for Medicare FFS services rendered by PBP-participating Next Generation Participants and Preferred Providers who have agreed to accept reduced FFS payments when providing care to aligned beneficiaries during the applicable Performance Year. This estimate will be based on available data on payments to Next Generation Participants and Preferred Providers participating in PBP during the applicable performance year for services that were provided to beneficiaries who would have been aligned to the ACO during the calendar year immediately prior to the applicable performance year. When PBP-participating Next Generation Participants and Preferred Providers submit claims to CMS for Medicare FFS services rendered to aligned beneficiaries during the applicable performance year, the payment will be reduced by the agreed upon percentage.

Not all Next Generation Participants and Preferred Providers must agree to participate in PBP for the ACO to participate in PBP and not all Next Generation Participants and Preferred Providers billing under a TIN must agree to participate in PBP for the TIN to participate in PBP. Next Generation Participants and Preferred Providers participating in PBP must agree to permit CMS to reduce their Medicare reimbursement for aligned beneficiaries by a specified percentage. An ACO may opt to apply a different percentage reduction to different subsets of its Next Generation Participants and Preferred Providers, but this differing amount is limited to TINs (Next Generation Participants or Preferred Providers that bill under the same TIN must agree to

the same PBP Fee Reduction).

The reductions to FFS payments do not affect the calculation of Shared Savings/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 Reductions. The reconciliation of PBP payments and reductions in FFS payments determines the net amount owed by either CMS or the Next Generation ACO as the difference between the total PBP payment amount paid during the Performance Year and the actual amount of the PBP Fee Reductions for PBP-participating Next Generation Participants and Preferred Providers.

Figure 2: Population-Based Payments Conceptual Diagram



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

All-Inclusive Population-Based Payments (AIPBP) are determined by estimating total annual expenditures for care furnished to aligned beneficiaries by Next Generation Participants and Preferred Providers who have agreed to participate in AIPBP and with whom the ACO is not prohibited from entering into an AIPBP Payment Arrangement. Not all Next Generation Participants and Preferred Providers must agree to participate in AIPBP for the ACO to participate in PBP and not all Next Generation Participants and Preferred Providers billing under the same TIN must agree to participate in PBP for the TIN to participate in AIPBP. Next Generation Participants and Preferred Providers participating in AIPBP must agree to permit CMS to reduce their Medicare reimbursement for aligned beneficiaries by 100%. CMS pays that projected amount to the ACO through monthly AIPBP payments and reduces Medicare FFS payments by 100% on claims submitted by AIBPB-participating Next Generation Participants and Preferred Providers for services furnished to Next Generation Beneficiaries ("AIPBP Fee Reduction"). A Next Generation ACO participating in AIPBP is responsible for paying its Next Generation Participants and Preferred Providers with which the ACO has written agreements

regarding participation in AIPBP for covered services furnished to aligned beneficiaries. ACOs are not required to pay 100% of Medicare FFS rates to Next Generation Participants and Preferred Providers participating in AIPBP; ACOs may have alternative compensation arrangements with these providers consistent with all applicable laws and the Participation Agreement. Next Generation Participants and Preferred Providers that have agreed to participate in AIPBP will continue to submit claims to CMS for processing, and CMS will continue to be responsible for assessing coverage for such services and any beneficiary liability for the covered services.

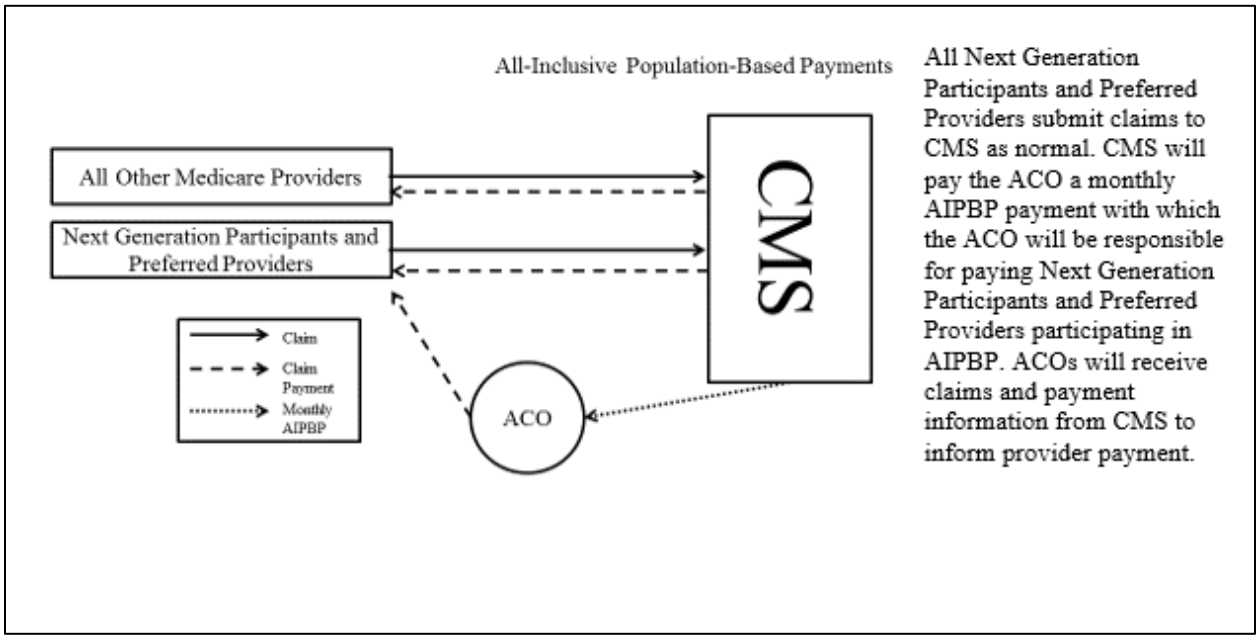
On an ongoing basis, CMS sends Next Generation ACOs participating in AIPBP claims information for those services for which the Next Generation ACO is responsible for making payment to AIPBP-participating Next Generation Participants and Preferred Providers. Please note that CMS will not reduce FFS Payments on claims for services furnished to Next Generation Beneficiaries who have elected to decline data sharing with the ACO or for claims related to the diagnosis and treatment of substance abuse furnished to Next Generation Beneficiaries. These reports are in addition to those described in Section IX below. Additional requirements for ACOs participating in AIPBP are described in the Participation Agreement.

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

AIPBP is an alternative payment mechanism and does not affect the Next Generation ACO's benchmark. As with all of the Next Generation alternative payment mechanisms, Next Generation ACOs participating in AIPBP have a separately calculated benchmark, which determines the savings in which the ACO may share or the losses for which the ACO is accountable. While CMS will not be actually making payment to providers/suppliers on that subset of FFS claims subject to the 100% AIPBP Fee Reduction, CMS will use the FFS amount that would have been paid for those claims in conducting financial reconciliation. CMS will separately reconcile the monthly AIPBP payments with the actual AIPBP Fee Reductions during the performance year.

Specifically, monthly AIPBP amounts are calculated prior to the start of the performance year. At the end of year, CMS will reconcile the total Monthly AIPBP Payment versus the Medicare FFS claims that were actually reduced by the 100% AIPBP Fee Reduction during the performance year. This reconciliation may result in monies owed from the ACO to CMS, or vice versa. This accounting is separate from the savings and losses calculation (similar to the PBP payment mechanism).

Figure 3: All-Inclusive Population-Based Payments Conceptual Diagram



4. Savings/Losses Calculations

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

Next Generation ACOs are required to have in place a financial guarantee sufficient to cover potential losses and other monies for which the ACO may be liable under the terms of the Participation Agreement. The specific form and methodology for calculating the amount of the financial guarantee is set forth in the Participation Agreement.

B. Beneficiary Eligibility and Alignment to Next Generation ACOs

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

1. Minimum Aligned Population

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

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

2. Alignment-Eligible Beneficiaries

A beneficiary is alignment-eligible during the base- or performance-year, if the beneficiary:

- Had at least one paid claim for a Qualified Evaluation and Management (QEM) service during the alignment period for the given base- or performance-year; and,
- 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;
- Has no months of coverage under only Part A;
- Has no months of coverage under only Part B;
- Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
- Has no months in which Medicare was the secondary payer; and,
- Was a resident of the United States.

QEM services are identified by a set of Healthcare Common Procedure Coding System (HCPCS) codes and physician specialty. The list of QEM codes is described in the Participation Agreement, as well as the financial methodology paper available on the Next Generation Model website. 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 (described below), one of the selected non-primary care specialist.

Each performance- or base-year is associated with two alignment-years. The first alignment-year for a performance- or base-year is the 12-month period ending 18 months prior to the start of the performance- or base-year. The second-alignment year is the 12-month period ending 6 months prior to the start of the performance- or base-year. Alignment is performed prior to the start of each performance-year, and alignment eligibility is determined on a quarterly basis throughout the performance-year. A beneficiary may be alignment-eligible in the base-year but not a performance-year and may be alignment-eligible in a performance-year but not the base-year.

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. In addition to the criteria listed above, beneficiaries are also not eligible for inclusion in financial settlement (i.e., will be excluded from the aligned population) if:

1. The Next Generation Beneficiary was a resident of a county that was part of the ACO's service area in the last month of the 2-year alignment period (described above) 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 QEM services used by the Next Generation Beneficiary were from providers practicing outside the ACO's service area.

Where a beneficiary may meet eligibility criteria and be aligned/assigned/attributed to more than one Medicare shared savings initiative, CMS applies a hierarchical set of rules to determine which initiative will include that beneficiary. CMS currently employs a formal (cross-agency)

governance structure to execute hierarchical decision-making and determine how best to integrate new initiatives.

3. Claims-Based Alignment

Next Generation Beneficiaries are identified prospectively, *prior to the start of the Performance Year* on the basis of each beneficiary's receipt of QEM services in the 2-year alignment period ending 6 months *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 receipt of QEM services in the 2-year alignment period ending 6 months *prior* to the start of the base-year. For the 2018 performance year, the 2-year alignment period is July 1, 2015 through June 30, 2017.

Alignment of a beneficiary is determined by comparing:

1. The weighted allowable charge for all QEM services that the beneficiary received from each Next Generation ACOs' 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 a Next Generation ACO.

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

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

1. **Alignment based on primary care services provided by primary care specialists.** If 10% or more of the allowable charges incurred for 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 the Participation Agreement, then alignment is based on the allowable charges incurred for 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 the Participation Agreement.

Provider specialty is determined by the specialty code that is assigned to the claim during claims 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 claims from Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Critical Access Hospitals (CAHs) billing under Method II.

Details of the Next Generation Model alignment methodology are described in the financial methodology paper, available at:https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

4. Voluntary Alignment

In addition to claims-based alignment, CMS offers beneficiaries an opportunity to become aligned to Next Generation ACOs voluntarily. Each performance year, Next Generation ACOs may seek approval by CMS to offer certain Medicare beneficiaries the option to confirm or deny their care relationships with specific Next Generation Participants. Alignment for beneficiaries who voluntarily align to a Next Generation ACO is effective the subsequent performance year. A beneficiary who completes the Voluntary Alignment Form has the option to reverse that decision or change the identified care relationship.

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

If an ACO joins the Next Generation Model after participating in another Medicare ACO initiative with voluntary alignment during the year prior to the Next Generation ACO's first performance year, the ACO may be allowed to retain beneficiaries who voluntarily aligned through the other ACO initiative when transitioning into the Next Generation Model.

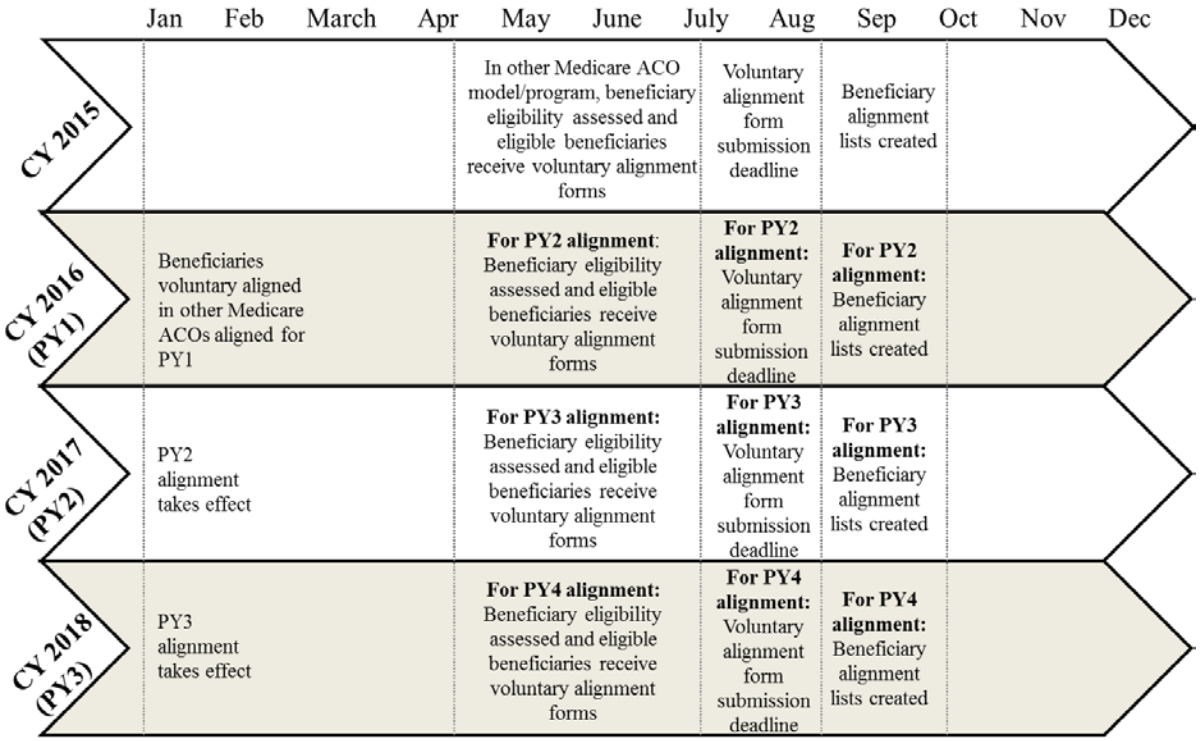
Prior to the start of the performance-year, during a period determined by CMS, Next Generation ACOs that have elected to participate in Voluntary Alignment shall provide a CMS-approved Voluntary Alignment Form ——which includes instructions and information regarding voluntary alignment and the potential benefit enhancements associated with alignment to Next Generation ACOs (described in Section VI.C below)— to all Medicare beneficiaries that are included on the ACO's Voluntary Alignment Beneficiary List. Next Generation ACOs may also choose to provide the Voluntary Alignment Form at the point of care only in the offices of Next Generation Participants. However, the ACOs must permit any Medicare beneficiary who is a patient of a Next Generation Participant to receive a Voluntary Alignment Form, upon request. In addition, ACOs, Next Generation Participants, and other individuals or entities performing ACO-related functions or services may communicate orally to beneficiaries regarding voluntary alignment and the Voluntary Alignment Forms, provided that such discussions comply with requirements specified by CMS in the Participation Agreement. The specific guidelines and approval processes for voluntary alignment are described in the Participation Agreement.

Given the unique characteristics of each ACO, CMS may allow ACOs to use either hard-copy or electronic Voluntary Alignment Forms to best meet the needs of their respective beneficiary populations. The ACO must allow beneficiaries to select their preferred mode(s) of requesting a Voluntary Alignment Form (e.g., by phone or in person at the office of a Next Generation Participant). CMS regional offices, State Health Insurance Assistance Programs (SHIPs), and consumer coalitions may also be resources to educate beneficiaries about voluntary alignment. CMS has implemented certain program integrity safeguards and monitoring measures and requires Next Generation ACOs and/or Next Generation Participants to implement protections to ensure that voluntary alignment does not result in coercion or improper influence of beneficiaries or violations of the terms of the Participation Agreement.

In later years of the Model, CMS may refine voluntary alignment policies to: (1) make alignment accessible to a broader group of Medicare beneficiaries; (2) include affirmation of a general care relationship between beneficiaries and ACOs, instead of between beneficiaries and specific Next Generation Participants; and/or (3) allow beneficiaries to *opt out* of alignment to a particular

ACO in addition to *opting into* ACO alignment. Allowing voluntary *de-alignment* will require additional provisions to monitor ACO communications on this design element and to protect beneficiaries.

Figure 4: Voluntary Alignment Conceptual Timeline



C. Benefit Enhancements

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

Following acceptance into the Next Generation Model, each ACO is required to provide additional information to CMS, including a benefit enhancement election and an implementation plan, which CMS will review prior to approving the ACO's use of selected optional benefit enhancements. The "implementation plan" that ACOs must provide for each selected optional benefit enhancement will include, for example: (1) descriptions of the ACO's planned use of the benefit enhancement; (2) self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and (3) documented authorization by the governing body to participate in the benefit enhancement.

As part of the Next Generation Model monitoring and oversight strategy, CMS has incorporated a variety of program integrity safeguards (described in Section VIII) to ensure that these benefit

enhancements do not result in program or patient abuse.

In pursuit of policy goals based upon accountable care and driving beneficiary value, CMS may continue to explore the operational feasibility and potential effectiveness of additional benefit enhancements in future performance years. For instance, CMS is exploring the possibility of offering Next Generation ACO Model Participants additional flexibility under the telehealth and post-discharge home visit waivers, beginning in PY 2018. Similarly, for policy reasons akin to those stated in the discussion of the beneficiary coordinated care reward below, in later performance years CMS may consider reducing or waiving the Next Generation Beneficiary requirements to pay the Part B deductible and/or coinsurance when receiving care from Next Generation Participants or Preferred Providers.

1. 3-Day SNF Rule Waiver

CMS makes available to Next Generation ACOs a waiver of the otherwise applicable requirement for a three-day inpatient stay prior to admission to a skilled nursing facility (SNF) or acute-care hospital or CAH with swing-bed approval for SNF services (swing-bed hospital). For Next Generation ACOs that have been approved to offer this benefit enhancement, the waiver allows eligible Next Generation Beneficiaries to be admitted to eligible Next Generation Participant or Preferred Provider SNFs or swing bed hospitals either directly or with an inpatient stay of fewer than three days.

A Next Generation Beneficiary is eligible for SNF or swing-bed hospital admission in accordance with this waiver if (1) the beneficiary does not reside in a SNF or other long-term care setting at the time of the admission to a SNF or swing-bed hospital; and (2) the beneficiary meets all other CMS criteria for SNF or swing-bed hospital admission, including that the Next Generation Beneficiary:

- is medically stable;
- has confirmed diagnoses (e.g., does not have conditions that require further testing for proper diagnosis);
- does not require inpatient hospital evaluation or treatment;
- has a skilled nursing or rehabilitation need that is identified by the evaluating physician and cannot be provided on an outpatient basis or through home health services; and
- for a direct admission to a SNF or swing-bed hospital, without a prior inpatient hospitalization, the Next Generation Beneficiary must have been evaluated by a physician or other practitioner licensed to perform the evaluation within three days prior to admission.

Next Generation ACOs that elect to provide this benefit enhancement must identify the SNFs and swing-bed hospitals that have agreed to participate in the 3-day SNF Rule Waiver Benefit Enhancement. These SNFs and swing-bed hospitals must be either Next Generation Participants or Preferred Providers and must have, at the time of CMS review and approval of the SNF to participate under the 3-Day SNF Rule Waiver, a quality rating of 3 or more stars under the CMS 5-Star Quality Rating System as reported on the Nursing Home Compare website. 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 may affect the qualifications of the SNF to provide SNF Services under the terms of the 3-Day SNF Rule Waiver.

2. Telehealth Expansion

CMS makes available to Next Generation ACOs a waiver of the otherwise applicable requirements that beneficiaries be located, at the time of service, in a specified type of rural geographic area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement allows for payment of claims for telehealth services delivered by Next Generation Participants or Preferred Providers, who are physicians or certain other practitioner types, to aligned beneficiaries in specified facilities or at their residence regardless of the geographic area in which the beneficiary was located at the time of service.

Notwithstanding this waiver, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Act and its implementing regulations, with the exception that claims will ***not*** be allowed for the following telehealth services rendered to aligned beneficiaries located at their home or place of residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. HCPCS codes G0406 – G0408.
- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days. CPT codes 99231 – 99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days. CPT codes 99307 – 99310.

3. Post-Discharge Home Visits

CMS makes available to Next Generation ACOs a waiver of the otherwise applicable *direct* supervision requirements in order to allow for coverage of "incident to" claims for home visits to non-homebound Next Generation Beneficiaries by auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1) under the *general* supervision of a Next Generation Participant or Preferred Provider (who is a physician or other practitioners).

Claims for these visits are only allowed following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility and are limited to no more than one visit in the first 10 days following discharge and one additional time in the first 30 days following discharge. Payment of claims for these visits are allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 C.F.R. § 410.26.

D. Beneficiary Coordinated Care Reward

In order to support alternative payment and service delivery models and to reward beneficiary engagement with providers and suppliers accountable for the cost and quality of their care, CMS may make direct payments to each Next Generation Beneficiary who receives certain services from the ACO's Next Generation Participants and Preferred Providers. All Next Generation Beneficiaries are automatically eligible for this reward payment should they receive the applicable services. For example, for the 2017 performance year, this reward is structured as a $25 check payment to all beneficiaries who receive a Medicare Annual Wellness Visit (AWV) from a Next Generation Participant or Preferred Provider. Any coordinated care reward (CCR)

payments will be paid according to criteria specified by CMS, regardless of beneficiary supplemental coverage. CMS plans to make quarterly assessments to determine which beneficiaries qualified for the reward in the preceding quarter and subsequently make the reward payments.

Additional information on the beneficiary CCR, including information on communicating about the reward, will be made available by CMS in guidance. Beneficiaries will be responsible for paying all applicable state and federal taxes associated with the reward payment.

E. Part D Interaction

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

CMS believes it is important to find strategies for including Part D accountability into ACO initiatives and is exploring options for facilitating partnerships between Part D plans and ACOs participating in this Model. Any future inclusion of Part D in the Next Generation Model would be subject to appropriate safeguards and conditions to protect against fraud and abuse.

VII. Quality and Performance

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

A. Quality Measures

The Next Generation Model closely follows the Shared Savings Program quality measure set. The Next Generation Model does not use the electronic health record (EHR) measure (ACO-11: Use of Certified EHR Technology). Similar to the Shared Savings Program, under the Next Generation ACO Model the quality performance standard transitions from pay-for-reporting for all quality measures during an ACO's first performance year participating in the Model, to pay-for-performance for certain measures in subsequent performance years. For purposes of illustration, the Next Generation Model Quality Measures that are included in the quality measure set for the second Performance Year of the Model (CY2017) can be found in Appendix E.

B. Quality Monitoring

To ensure quality measures are reported accurately and completely, CMS will conduct quality measure validation (QMV) of ACO quality data. QMV may involve ad hoc or scheduled desk reviews, focused audits, or full audits. These efforts will be in addition to the overall program monitoring and oversight strategy described in Section VIII. Starting in the ACO's second Performance Year in the Model, the ACO's quality score may be adjusted downward based on

QMV findings. Prior to the start of the ACO's second Performance Year and each subsequent Performance Year, CMS will provide additional information regarding how the quality score will be adjusted based on the QMV findings.

C. Quality in Calculating the Benchmark

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

An ACO's first performance year in the Model is entirely pay-for-reporting. For purposes of calculating the benchmark for the ACO's first performance year, CMS assumes a 100% quality score when calculating the discount and setting the prospective benchmark. In the event an ACO fails to successfully report during this pay-for-reporting year, CMS will retroactively adjust the discount and reconcile the ACO's financial performance accordingly.

Each year, the most recently available quality score is used in benchmark setting. At the time of financial settlement, the Benchmark is then updated to include an adjusted discount that reflects the actual quality score attained by the Next Generation ACO for the performance-year. For Next Generation ACOs that begin participation in the Model on January 1, 2018, the quality score used to calculate the final adjusted discount for CY2018 will be 100% if all quality data reporting requirements described in the Participation Agreement have been met. 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.

VIII. Monitoring and Oversight

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

A. Compliance Plan

Among the requirements described in the Participation Agreement, Next Generation ACOs are required to develop a compliance plan with at least the following attributes:

- Designation of a compliance official who is not legal counsel to the ACO and who reports directly to the ACO's governing body;
- Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;
- Compliance training programs for the ACO and its Next Generation Participants and Preferred Providers;
- A method for employees or contractors of the ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services

related to ACO activities to anonymously report suspected problems related to the ACO to the compliance official.
- A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

The ACO's compliance plan must be in compliance with all applicable laws and regulations and be updated periodically to reflect changes in those laws and regulations.

B. CMS Monitoring

CMS employs a range of methods to monitor and assess compliance by the Next Generation ACO, its Next Generation Participants and Preferred Providers with the terms of the Participation Agreement, including, but not limited to:

- Claims analyses to identify fraudulent behavior or program integrity risks such as inappropriate reductions in care, efforts to manipulate risk scores or aligned populations, overutilization, and cost-shifting to other payers or populations;
- Interviews with any individual or entity participating in ACO activities, including members of the ACO leadership and management, Next Generation Participants, and Preferred Providers;
- Interviews with Next Generation Beneficiaries and their caregivers;
- Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Next Generation Participants and Preferred Providers;
- Site visits to the ACO and its Next Generation Participants and Preferred Providers; and
- Documentation requests sent to the ACO, its Next Generation Participants, and/or Preferred Providers, including surveys and questionnaires.

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

C. Remedial Actions

Potential noncompliance with the terms of the Participation Agreement will trigger appropriate remedial actions based on the type of issue, degree of severity, and the ACO's compliance record while participating in the Model. Such actions may include, but are not limited to:

- Notification of the ACO and, if appropriate, the Next Generation Participant, and/or Preferred Provider of the violation;
- Requiring the ACO to provide additional information to CMS or its designees;
- Conducting on-site visits, interviewing Beneficiaries, or taking other actions to gather information;
- Placing the ACO on a monitoring and/or auditing plan developed by CMS;
- ACO education on how to operate in compliance with relevant standards;
- Request for Corrective Action Plan (CAP) detailing how an ACO will rectify noncompliance;
- Suspension of data sharing and reports to the ACO;
- Suspension or termination of infrastructure payments or other alternative payment mechanism and a requirement that the ACO terminate any agreements effectuating such

alternative payment mechanism by a date determined by CMS;

- Suspension or termination of the use of one or more benefit enhancements by the ACO or any Next Generation Participant or Preferred Provider;
- Termination of the ACO from the Next Generation Model;
- Suspension or termination of the availability of any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act;
- A demand that the ACO remove a Next Generation Participant or Preferred Provider from the Participant List or Preferred Provider List and to terminate its agreement, immediately or within a timeframe specified by CMS, with such Next Generation Participant or Preferred Provider with respect to this Model;
- Requirement that the ACO to terminate its relationship with any other individual or entity performing functions or services related to ACO activities; and
- Prohibition of the ACO from distributing Shared Savings to a Next Generation Participant or Preferred Provider.

IX. Data Sharing and Reports

A. Data Sharing

Subject to limitations in the Participation Agreement and in accordance with applicable law, CMS makes available to Next Generation ACOs several types of Medicare data for the sole purposes of developing and implementing activities related to coordinating care and improving the quality and efficiency of care for Next Generation Beneficiaries.

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

Data sharing is offered to Next Generation ACOs in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations for all aligned beneficiaries who were either: (1) not previously aligned to any ACO; or (2) previously aligned to an ACO but did not opt out of data sharing. The data and reports provided to the ACO do not include individually identifiable data for Next Generation Beneficiaries who have opted out of data sharing with the ACO and the Next Generation Model honors the data sharing opt-out decisions by beneficiaries who were previously given that choice while an aligned beneficiary in another Medicare ACO initiative. Next Generation ACOs are not required to notify newly aligned beneficiaries at the beginning of the performance year regarding the ACO's intent to request their claims data from CMS or to provide information or forms regarding the opportunity to decline data sharing; however, the ACO shall provide Next Generation Beneficiaries who inquire about and 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.

The data and reports provided to the ACO will omit substance abuse data for any Next Generation Beneficiaries who have not opted into substance abuse data sharing. Next Generation ACOs may inform each newly-aligned beneficiary, in compliance with applicable

laws and the terms of the Participation Agreement, that he/she may elect to allow the Next Generation ACO to receive beneficiary-level data regarding his or her utilization of substance abuse services, of the mechanism by which the beneficiary can make this election, and that 1-800-MEDICARE will answer any questions about data sharing of substance abuse services. CMS will provide Next Generation ACOs with the Substance Abuse Opt-In Form.

In addition to the data mentioned above and the reports listed below, Next Generation ACOs that elect the AIPBP payment mechanism will receive claims and payment information from CMS for the services furnished to Next Generation beneficiaries by Next Generation Participants and Preferred Providers. This information will be sent from CMS to the ACO on a frequent basis, at a minimum of once per month. CMS will exclude information regarding claims for services furnished to Next Generation Beneficiaries who have elected to decline data sharing and for claims for services related to the diagnosis and treatment of substance abuse furnished to Next Generation Beneficiaries because CMS does not reduce FFS Payments for these claims.

B. De-identified Reports

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

1. Monthly Expenditure Reports

Next Generation ACOs receive standard monthly and year-to-date information on total Medicare expenditures and expenditures for selected categories of services for Next Generation Beneficiaries. This aggregate information does not include individually identifiable information for Next Generation Beneficiaries who have opted out of data sharing, but does incorporate de-identified information. This report summarizes claims based on the previous month's expenditures but includes no claims run-out. Finally, a monthly claims lag report shows the differences between claim and date of service.

2. Quarterly Benchmark Reports

CMS provides quarterly benchmark reports (BRs) to ACOs 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 financial settlement report. In the event that data contained in the BRs conflicts with data provided from any other source, the data in the BRs controls with respect to year-end financial settlement.

3. Other

Other reports include:

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

X. Evaluation

All Next Generation ACOs are required to cooperate with efforts to conduct an independent, federally funded evaluation of the model by CMS and/or its designees as described in the Participation Agreement, which may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation assesses the impact of the Next Generation Model on the goals of better health, better health care, and lower per beneficiary expenditures in accordance with Section 1115A(b)(4) of the Act. The evaluation will be used to inform policy makers about the effect of Next Generation Model concepts relative to health care delivery under Original Medicare and other models of care. To do so, the evaluation will seek to understand the behaviors of providers and beneficiaries, the impacts of increased financial risk, the effects of various payment arrangements and benefit enhancements, the impact of the model on beneficiary engagement and experience, and other factors. The ACO must require its Next Generation Participants and Preferred Providers to participate and cooperate in any such independent evaluation activities conducted by CMS and/or its designees. The ACO shall also 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.

XI. Information Resources for Beneficiaries and Providers

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

XII. Application Scoring and Selection

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

As part of the Next Generation ACO Model application process, applicants will be asked questions specific to their proposed implementation of benefit enhancements, alternative payment mechanisms, and risk arrangements. Acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement, alternative payment mechanism, or risk arrangement. Responses to questions regarding proposed implementation will assess interest in Model design elements and assist with CMS planning and Model implementation.

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

XIII. Duration of Agreement

The Next Generation ACO Model Participation Agreement will have an initial term that consists of one performance year for ACOs entering in CY 2018. The first performance year for 2018 entrants will extend from January 1, 2018 until December 31, 2018. Following the initial performance year, there will be the potential for an extension of two performance years. Subsequent performance years will each begin on January 1 and last 12 months, ending on December 31.

In choosing whether to extend an ACO's participation in the Model for the additional two performance years, CMS may consider a variety of factors, including whether the Next Generation ACO generated savings and/or met performance standards or other Model requirements during the prior performance year. CMS also reserves the right to terminate or modify the design of the Model at any time in accordance with section 1115A(b)(3)(B) of the Act.

XIV. Learning and Diffusion Resources

CMS supports Next Generation ACOs in accelerating their progress by providing them with opportunities to both learn about achieving performance improvements and share experiences with one another and with participants in other CMS Innovation Center initiatives. This is accomplished through a "learning system" for the Next Generation ACOs. The learning system uses various group learning approaches to help Next Generation ACOs effectively share experiences, track progress, and rapidly adopt new methods for improving quality, efficiency, and population health. Next Generation ACOs are required to participate in the learning system by attending periodic conference calls and meetings and actively sharing tools and ideas.

XV. Public Reporting

The Next Generation Model emphasizes transparency and public accountability. At a minimum, Next Generation ACOs are required to publicly report information regarding their (1) organizational structure, including identification of the members of the ACO's governing body and the ACO's Next Generation Participants and Preferred Providers; (2) Shared Savings and Shared Losses information; and (3) performance on the quality measures described in Appendix E. Specific public reporting requirements will be clearly described in the Participation Agreement.

XVI. Termination

CMS reserves the right to review the status of a Next Generation ACO and terminate the ACO's

Participation Agreement or require the ACO, as a condition of continued participation, to terminate its agreement with a Next Generation Participant or Preferred Provider, for reasons associated with poor performance, non-compliance with the terms and conditions of the Participation Agreement, or program integrity issues. CMS also reserves the right to terminate the ACO's Participation Agreement if CMS determines that it no longer has the funds to support the Model or if CMS terminates the Model pursuant to Section 1115A(b)(3)(B) of the Social Security Act. Specific reasons and procedures for termination will be clearly outlined in the Participation Agreement.

XVII. Amendment

CMS may modify the terms of the Next Generation Model in response to stakeholder input and to reflect the agency's experience with the Model. The terms of the Next Generation Model as set forth in this Request for Applications may differ from the terms of the Next Generation Model as set forth in the Participation Agreement between CMS and the Next Generation ACO. Unless otherwise specified in the Participation Agreement, the terms of the Participation Agreement, as amended from time to time, shall constitute the terms of the Next Generation Model.

Appendices

Appendix A: Letter of Intent Template

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp. The privacy policy can be found as the first link in the left-hand side of the screen.

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

Section A. Organization and Contact Information

1. Applicant Name
   Organization Name:
   Doing Business As (if applicable):
   Organization Type:
   Organization TIN/EIN:
   Street Address:
   City:
   State:
   ZIP Code:
   Website (if applicable):
2. Applicant Primary Contact
   Primary Contact's First Name:
   Primary Contact's Last Name:
   Title/Position:
   Business Phone Number:
   Business Phone Number Extension:
   Alternative Phone Number (e.g., cell phone):
   E-mail Address (you may submit only one application per e-mail address):
   Is the Primary Contact's address the same as the organization's address entered above?:
   If no:
   Street Address:
   City:
   State:
   ZIP Code:
3. Applicant Secondary Contact
   Secondary Contact's First Name:
   Secondary Contact's Last Name:
   Title/Position:
   Business Phone Number:
   Business Phone Number Extension:
   Alternative Phone Number (e.g., cell phone):
   E-mail Address:

Is the Secondary Contact's address the same as the organization's address entered above?:
If no:
Street Address:
City:
State:
ZIP Code:

Section B. Letter of Intent

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

6. Medicare ACO Name (Please put N/A if this is not applicable):
7. If a Medicare ACO, what is the ACO identifier (e.g., P123 or A123)? (Please put N/A if this is not applicable.)
8. If a Medicare ACO, does the Applicant ACO expect the entire ACO to transition to the Next Generation ACO Model? (No TINs/Participants will remain in the ACO's current Medicare ACO initiative).
9. If a Medicare ACO, does the Applicant ACO anticipate only some TINs/Participants to transition to the Next Generation ACO Model? (Some TIN/Participants will remain in the current initiative while others will join the Next Generation ACO Model).
   8a. Does the Applicant ACO anticipate TIN changes for the transitioning participants?
10. Current Medicare Shared Savings Program Track.
11. End of current ACO initiative Participation Agreement
12. Is the Applicant ACO or are any of the proposed ACO Participants currently participating in an ACO with a payer other than Medicare?
13. How many of the counties your proposed ACO will service are considered rural?
14. Please provide us with your expected number of aligned Medicare beneficiaries in 2018.

Appendix B: Glossary of Key Definitions

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

ALL-INCLUSIVE POPULATION-BASED PAYMENTS (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.

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 (as described in Section VI.C.1); (2) Telehealth Expansion (as described in Section VI.C.2); and (3) Post-Discharge Home Visits (as described in Section VI.C.3).

INFRASTRUCTURE PAYMENT: means the Alternative Payment Mechanism under which CMS makes monthly per-Next Generation Beneficiary payments to the ACO to support ACO activities.

NPI: National provider identifier.

NEXT GENERATION BENEFICIARY: means a Medicare beneficiary who is aligned to a Next Generation ACO for a given Performance Year as described in Section VI.B and has not subsequently been excluded from the aligned population of the ACO.

NEXT GENERATION PARTICIPANT: means an individual or entity that: (1) is a Medicare-enrolled provider (as defined at 42 C.F.R. § 400.202) or supplier (as defined at 42 C.F.R. § 400.202); (2) is identified on the ACO's list of Next Generation Participants by name, National Provider Identifier (NPI), TIN, Legacy TIN (if applicable), and CMS Certification Number (CCN) (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Preferred Provider; (5) is not a Prohibited Participant; and (6) 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.

OTHER MONIES OWED: means a monetary amount owed by either CMS or the ACO 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, and reconciliation shall be performed, in accordance with the terms of the Participation Agreement.

POPULATION-BASED PAYMENTS: 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.

PREFERRED PROVIDER: means an individual or entity that: (1) is a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202); (2) is identified on the ACO's list of Preferred Providers by name, National Provider Identifier (NPI), TIN, Legacy TIN (if applicable), and CMS Certification Number (CCN) (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Next Generation Participant; (5) is not a Prohibited Participant; and (6) has agreed to participate in the Model pursuant to a written agreement with the ACO.

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.

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

SHARED LOSSES: means the monetary amount owed to CMS by the ACO according to the applicable risk arrangement and the Participation Agreement due to expenditures for Medicare Parts A and B items and services furnished to Next Generation Beneficiaries in excess of the ACO's performance year benchmark.

SHARED SAVINGS: means the monetary amount owed to the ACO by CMS in accordance with the applicable risk arrangement and Participation Agreement due to expenditures for Medicare Parts 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: The process whereby beneficiaries may voluntarily align to a Next Generation ACO as described in section VI.B.4 and the Participation Agreement.

Appendix C: Example Benchmark Calculation

The following table is an example discount calculation. This example uses the same hypothetical ACO to illustrate each component of the discount calculation. In a Next Generation ACO's (NGACO's) first performance year in the Model, a quality score of 100% will be used, so long as the ACO successfully reports on the quality measures. This example is an illustrative CY 2016 benchmark, but the calculations would be performed in the same way for CY 2018.

Item	Baseline (CY2014)		Benchmark (CY 2016)
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	2.25%		2.25%
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			1.08%
LESS: NGACO discount[4]			$9.89
Benchmark[5]			$906.08

[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 PY risk score to the base-year risk score (subject to a ±3% limit). The example assumes the PY 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).

Appendix D: Example Alternative Payment Mechanism Calculations

Normal FFS Payment + Monthly Infrastructure Payment

- Calculating the Infrastructure Payments:
    - For a given performance year, a Next Generation ACO has 25,000 aligned beneficiaries, selects infrastructure payments as an alternative payment mechanism, and elects to participate in the 100% shared savings/losses risk arrangement.
    - Each month, the ACO receives $150,000 ($6 PBPM x 25,000 beneficiaries) in infrastructure payments from CMS. Over the course of the performance year, the ACO receives $1,800,000 in infrastructure payments from CMS.
- Year-End Reconciliation:
    - Using the benchmark methodology described in Section V.A, the ACO has a benchmark of $300,000,000.
    - Scenario 1: Over the course of the performance year, $298,000,000 is paid out in Medicare FFS claims for the ACO's aligned beneficiaries. The ACO has achieved shared savings of $2,000,000, as compared to the benchmark. CMS has paid the ACO $1,800,000 in infrastructure payments that must be recouped. CMS will pay the ACO $200,000, representing the shared savings achieved by the ACO minus the infrastructure payments to be recouped.
    - Scenario 2: Over the course of the performance year, $301,000,000 is paid out in Medicare FFS claims for the ACO's aligned beneficiaries. The ACO has losses of $1,000,000, as compared to the benchmark. CMS has already paid the ACO $1,800,000 in infrastructure payments that must be recouped. The ACO must pay CMS $2,800,000, of which $1,000,000 is shared losses and $1,800,000 is other monies owed to CMS.

Population-Based Payment (PBP)

- Calculating the PBP:
    - For a given performance year, a Next Generation ACO has 25,000 aligned beneficiaries, selects PBP as an alternative payment mechanism, and elects to participate in the 100% shared savings/losses risk arrangement.
    - Next Generation Participants and Preferred Providers that have agreed to participate in PBP have consented to a 10% PBP Fee Reduction to their Medicare FFS claims pursuant to a PBP Fee Reduction Agreement.
    - Using historic claims, CMS projects that Next Generation Participants and Preferred Providers participating in PBP accounted for $12,000,000 in spending for aligned beneficiaries in the calendar year prior to the performance year.
    - Since the Next Generation Participants and Preferred Providers are taking a 10% PBP Fee Reduction, the ACO will receive a monthly PBP payment of $100,000 per month from CMS (10 percent of $12,000,000, divided over 12 months).
    - Over the course of the performance year, the ACO is paid $1,200,000 in PBP, and FFS payments on claims for services furnished to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers that have consented to receive the PBP Fee Reduction are reduced by the 10% PBP Fee Reduction.
- Year-end reconciliation: CMS will reconcile total Monthly PBP Payments separately from the annual financial settlement with the ACO's benchmark to determine the ACO's Shared Savings or Shared Losses.
    - Determining Shared Savings or Losses: Using the benchmark methodology described in Section V.A, the ACO has a benchmark of $300,000,000. CMS would have paid $295,000,000 in FFS claims for Next Generation Beneficiaries, including claims for services furnished by Next Generation Participants and Preferred Providers and by providers/suppliers that are not affiliated with the ACO. Reconciliation would be based on the amount of the FFS payments that would have been made in the absence of any applicable PBP Fee Reduction. This ACO generated $5,000,000 in savings.
    - Reconciling PBP Payments: CMS paid the ACO $1,200,000 in PBP payments over the course of the performance year. During reconciliation, it is determined that, pursuant to the 10% PBP Fee Reductions, the FFS claims of PBP-participating Next Generation Participants and Preferred Providers were actually reduced by $1,300,000. CMS owes the ACO $100,000 in Other Monies Owed.

All-Inclusive Population-Based Payment (AIPBP)

- Calculating the AIPBP:
    - For a given performance year, an ACO has 25,000 aligned beneficiaries, selects AIPBP as an alternative payment mechanism, and elects to participate in the 100% shared savings/losses risk arrangement.

    - Using historic claims, CMS projects that Next Generation Participants and Preferred Providers participating in PBP accounted for $12,000,000 in spending for aligned beneficiaries in the calendar year prior to the performance year.
    - Since the Next Generation Participants and Preferred Providers are taking a 100% AIPBP Fee Reduction, the ACO will receive a monthly AIPBP payment of $1,000,000 per month from CMS (100 percent of $12,000,000, divided over 12 months).
- Over the course of the performance year, the ACO is paid $12,000,000 in AIPBP, and FFS payments on claims for services furnished to Next Generation Beneficiaries by Next Generation Participants and Preferred Providers that have consented to receive the AIPBP Fee Reduction are reduced by the 100% AIPBP Fee Reduction. Year-end reconciliation: CMS will reconcile total Monthly AIPBP Payments separately from the annual financial settlement with the ACO's benchmark to determine the ACO's Shared Savings or Shared Losses.
    - Determining Shared Savings or Losses: Using the benchmark methodology described in Section V.A, the ACO has a benchmark of $300,000,000. Over the course of the year, CMS adjudicates $295,000,000 in FFS claims for Next Generation Beneficiaries. To calculate savings/losses against the benchmark, CMS will use the amount that would have been paid for services furnished by AIPBP-participating Next Generation Participants and Preferred Providers absent the AIPBP Fee Reduction, in addition to the amount s CMS did pay for services furnished by other providers/suppliers. This ACO achieved savings of $5,000,000.
    - Reconciling AIPBP Payments:
        - Scenario 1: Upon reconciliation, it is determined that AIPBP-participating Next Generation Participants and Preferred Providers submitted claims for $13,000,000. CMS must pay the ACO an additional $1,000,000 in Other Monies Owed so that the total amount of AIPBP payments paid to the ACO equals the exact amount by which claims were reduced during the Performance Year.
        - Scenario 2: Upon reconciliation, it is determined that AIPBP-participating Next Generation Participants and Preferred Providers submitted claims for $11,000,000. The ACO must pay CMS $1,000,000 in Other Monies Owed so that the total amount of AIPBP payments paid to the ACO equals the exact amount by which claims were reduced during the Performance Year.

Appendix E: Next Generation Model Quality Measures (CY2017)

For purposes of illustration, the following quality measures are the measures for use in establishing quality performance standards in the second Performance Year of the Model (CY 2017).

The column "2017 Starters (ACO PY1)" represents that all measures are pay-for-reporting ("R") for ACOs that began participation in the Model on January 1, 2017, and the column "2016 Starters (ACO PY2)" represents whether the measure is pay-for-reporting ("R") or pay-for-performance ("P") for ACOs that began participation in the Model on January 1, 2016.

Domain	ACO Measure #	Measure Title	Method of Data Submission	R—Reporting P—Performance	
				2017 Starters (ACO PY1)	2016 Starters (ACO PY2)
AIM: Better Care for Individuals					
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

Domain	ACO Measure #	Measure Title	Method of Data Submission	R—Reporting P—Performance	
				2017 Starters (ACO PY1)	2016 Starters (ACO PY2)
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

Domain	ACO Measure #	Measure Title	Method of Data Submission	R—Reporting P—Performance	
				2017 Starters (ACO PY1)	2016 Starters (ACO PY2)
AIM: Better Care for Populations					
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
	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

Domain	ACO Measure #	Measure Title	Method of Data Submission	R—Reporting P—Performance	
				2017 Starters (ACO PY1)	2016 Starters (ACO PY2)
Clinical Care for At Risk Population - Diabetes	ACO - 27 ACO - 41	Diabetes Composite (All or Nothing Scoring): ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control ACO - 41: Diabetes: Eye Exam	CMS Web Interface	R	P
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.

Appendix F: Applicant Selection Criteria and Scoring Template

Selection Domain	Applicant Selection Criteria	Points
Organizational Structure	• Demonstrate a history of collaboration between Providers/Suppliers and/or a credible plan for how the proposed Next Generation Participants will work together in the Model; • Have an organizational structure that promotes patient-centered care and the goals of the Model. The applicant ACO is made up of a diverse set of proposed Next Generation Participants that demonstrate a clear commitment to providing high quality, coordinated care to beneficiaries.	10
Leadership and Management	• Have a governance structure that is clearly defined and demonstrates commitment to providing high quality care to beneficiaries consistent with the three-part aim of better health, better care, and lower costs; • Have a multi-stakeholder board comprised of well-qualified individuals that adequately and collectively represent the interests of patients and providers;	10

Selection Domain	Applicant Selection Criteria	Points
	• Demonstrate an effective governance structure plan, including a governing body and/or organizational mechanisms to make decisions, distribute payments, and obtain resources necessary to achieve the three-part aim; • Have identified, or demonstrated plans to identify, executives and lead staff throughout the organization with responsibility for clinical, financial, management, HIT, and quality improvement functions; • If applicable, demonstrate good conduct in prior CMS programs, demonstrations, and/or models.	
Financial Plan and Risk-Sharing Experience	• Demonstrate experience in the past 3 years with outcomes-based contracts (that meet stated outcomes-based contract definition); • If applicable, demonstrate good performance in past CMS programs, demonstrations, and/or models; • Demonstrate past experience with outcomes-based contracts for a minimum of 10,000 lives; • Document significant degrees of financial risk and revenue derived from outcomes-based contracts;	30

Selection Domain	Applicant Selection Criteria	Points
	• Document reductions in medical expenditures achieved through previous outcomes-based contracts; • Demonstrate a credible plan for converting the preponderance of revenue to outcomes-based contracts; • Have an ACO funding approach (including any savings/losses distribution, if applicable) that demonstrates: (1) a strong commitment to the three-part aim of better health, better care, and lower costs; and (2) a credible plan for ensuring repayment to Medicare of the ACO's share of losses relative to the benchmark.	
Patient Centeredness	• Demonstrate the ability to engage beneficiaries and their caregivers in shared decision making, taking into account patient preferences and choices; • Have a feasible plan to establish mechanisms to conduct patient outreach and education on the benefits of care coordination; • Demonstrate the ability to effectively involve beneficiaries in care transitions to improve the continuity and quality of care across settings;	20

Selection Domain	Applicant Selection Criteria	Points
	• Demonstrate the ability to engage and activate beneficiaries at home to improve self-management; • Have mechanisms to evaluate patient satisfaction with access and quality of care, including choice of providers and choice in care settings.	
Clinical Process Improvement, Care Coordination, and Data Capacity	Clinical Process Improvement (10 points) • Present a strong, credible, coordinated, and feasible plan to realize the three-part aim of better health, better care, and lower costs; • Provide a credible plan for incorporating medication management into the care coordination approach; • Demonstrate past experience designing, implementing, and assessing the effectiveness of specific care improvement interventions. Care Coordination (10 points) • Demonstrate existing capacity or plans to expand capacity to coordinate care through an interdisciplinary team structure that includes practitioners with the necessary areas of expertise and appropriate staffing to meet the needs of complex patients;	30

Selection Domain	Applicant Selection Criteria	Points
	• Demonstrate a history of collaboration among major stakeholders in the community being served, including incorporation of relevant social services in care plans and management; • Demonstrate a compelling plan to succeed in the areas of quality improvement and care coordination. Data Capacity (10 points) • Provide a clear and detailed plan for a majority of eligible professionals in the organization to meet EHR meaningful use criteria and requirements; • Have population health management tools and functions or concrete plans to develop and invest in such tools and functions; • Have the ability, or credible plans to develop the ability, to electronically exchange patient records across Next Generation Participants, Preferred Providers, and other providers in the community to ensure continuity of care; • Have the ability to, or a credible plan to gain the ability to, share performance feedback on a timely basis with Next Generation Participants and Preferred Providers.	
Total		100

Appendix G: Application Template

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

The application can be found and completed at: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model. It is located approximately ½ of the way down the page under the heading "How to Apply." Questions about the application for the Next Generation ACO Model should be emailed to NextGenerationACOModel@cms.hhs.gov.

Background Information

1. ACO Organization Information
    1. Organization Name
    2. Organization TIN/EIN
    3. Street Address
    4. City
    5. State
    6. Zip Code
    7. Website, if applicable
2. ACO Organization Profile
    1. Type of Applicant organization. Check only one:
        i. Medical group practice
        ii. Network of individual practices (e.g., IPA)
        iii. Hospital system(s)
        iv. Integrated delivery system
        v. Partnership of hospital system(s) and medical practices
        vi. Other, please describe
    2. Does the Applicant ACO include any of the following types of providers or facilities? Check all that apply:
        i. Cancer or specialty hospitals
        ii. Psychiatric hospital or other mental or behavioral health facility
        iii. Hospital(s) receiving disproportionate share (DSH) payments or uncompensated care payments from Medicare or Medicaid
        iv. Critical Access Hospital (CAH)
        v. Other rural hospital
        vi. Federally Qualified Health Center (FQHC)
        vii. Other community health centers
        viii. Skilled nursing facility (SNF)
        ix. Inpatient rehabilitation facility (IRF)
        x. Home Health Agency (HHA)
        xi. Other post-acute care facility

3. Is the Applicant ACO, or are any of its proposed Next Generation Participants, currently participating in the following Medicare initiatives for which beneficiary overlap is not permitted? Check all that apply:
    i. None
    ii. Care Management for High-Cost Beneficiaries Demonstration
    iii. Comprehensive ESRD Care Initiative (CEC)
    iv. Comprehensive Primary Care Plus (CPC+)
    v. Independence at Home Medical Practice Demonstration (IAH)
    vi. Medicare Health Care Quality Demonstration Programs (including Indiana Health Information Exchange and North Carolina Community Care Network)
    vii. Multi-payer Advanced Primary Care Practice Demonstration with a shared savings arrangement (MAPCP)
    viii. Medicare Shared Savings Program (MSSP)
    ix. Other (please specify):
4. Is the Applicant ACO or any of the proposed Next Generation Participants, currently participating in the Bundled Payment for Care Improvements (BPCI) Model? For more information: http://innovation.cms.gov/initiatives/Bundled-Payments/. If YES, please check all Model(s) that apply:
    i. Model 1
    ii. Model 2
    iii. Model 3
    iv. Model 4
5. Please provide an executive summary describing Applicant ACO. This includes, the Applicant ACO's: composition, including the number of hospitals, number of skilled nursing facilities, types of providers/suppliers (primary care and types of specialists); geographic service area including where most of the Applicant ACO's patients reside, if the service area encompasses urban, suburban, and/or rural locations, and if the area includes underserved beneficiaries. Please include any other applicable narrative describing the ACO.
6. Please attach a copy of certificate of incorporation or other documentation that the Applicant ACO is recognized as a legal entity by the state in which it is located.
7. Using the provided template, please upload an Excel spreadsheet identifying the proposed Next Generation Participants that will constitute the Applicant ACO. Please include the name, address, and appropriate identifiers for individual providers/suppliers (e.g., individual physicians, non-physician practitioners), group providers/suppliers (e.g., physician group practices), and institutional providers (e.g., critical access hospital, acute care hospital, skilled nursing facility), and the Applicant's Next Generation ACO Service Areas.
8. As described in the Federal Trade Commission and the Department of Justice Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Programs ("Antitrust Policy Statement"), does the Applicant organization's share of any common service, where two or more of its proposed Next Generation Participants are providing that service to patients from the same Primary Service Area, exceed 50%? (To calculate the Primary Service Area, please access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/sharedsavingsprogram/Calculations.html. Organizations

that are fully integrated entities and/or were formed before March 23, 2010 may answer N/A.

i. Yes
ii. No
iii. N/A, formed before March 23, 2010
iv. N/A, fully integrated entity

Contact Information

A. Applicant Primary Contact
   1. First Name
   2. Last Name
   3. Title/Position
   4. Business Phone Number
   5. Business Phone Number Ext.
   6. Alternate Phone Number
   7. E-mail Address
   8. Street Address
   9. City
   10. State
   11. Zip Code
   12. Secondary Contact? Yes/No

B. Applicant Secondary Contact
   1. First Name
   2. Last Name
   3. Title/Position
   4. Business Phone Number
   5. Business Phone Number Ext.
   6. Alternate Phone Number
   7. E-mail Address
   8. Street Address
   9. City
   10. State
   11. Zip Code

C. ACO Executive Contact
   1. First Name
   2. Last Name
   3. Title/Position
   4. Business Phone Number
   5. Business Phone Number Ext.
   6. Alternate Phone Number
   7. E-mail Address
   8. Street Address
   9. City
   10. State
   11. Zip Code

D. ACO IT/Technical Contact

1. First Name
2. Last Name
3. Title/Position
4. Business Phone Number
5. Business Phone Number Ext.
6. Alternate Phone Number
7. E-mail Address
8. Street Address
9. City
10. State
11. Zip Code

Leadership and Management

A. Leadership Team

1. Please provide a proposed organizational chart for the Applicant ACO. The proposed organizational chart should depict the legal structure, the proposed composition of the ACO (e.g., all of the TINs and organizations the ACO proposes will participate in the ACO as Next Generation Participants), and any relevant committees.
2. Please describe the contractual and/or employment relationships between and among the Applicant ACO and proposed Next Generation Participants, as well as any contractual and/or employment relationships with other partners or entities that will provide services to the ACO.
3. Please upload:
    i. A sample contract or an amendment or addendum to a current contract between the ACO and proposed Next Generation Participants; and
    ii. A sample contract or an amendment or addendum to a current contract between the ACO and any other partners or entities that will provide services to the ACO (if applicable).
4. For the physicians the ACO proposes will participate in the ACO, please report the following. The term "primary employer" below refers to the employer for whom the physician delivers health services (not just to Medicare patients) and that the physician considers to be their primary place of employment (e.g., accounts for the majority of the physician's income).
    i. The total number of physicians the ACO proposes will participate in the ACO.
    ii. The total number of such physicians for whom the ACO is their primary employer. Physicians whose primary employer is a hospital or group practice directly owned by the ACO or one of its subsidiaries should be treated as physicians whose primary employer is the ACO.
    iii. The total number of such physicians for whom a non-ACO hospital (i.e., hospital that is not directly owned by the ACO or one of its subsidiaries) is their primary employer.
    iv. The total number of such physicians whose primary employer is a non-ACO group practice (i.e., group practice that is not directly owned by the ACO or one of its subsidiaries) with 10 or more physicians.

v. The total number of such physicians whose primary employer is a non-ACO group practice (i.e., group practice that is not directly owned by the ACO or one of its subsidiaries) with less than 10 physicians.

5. Please describe the history of the Applicant organization and its major member organizations in terms of prior business relationships (if any) and collaboration between members on care improvement or cost containment efforts (if any).
6. Does the applicant organization have a leadership team exclusive to the Next Generation ACO?
    i. Yes
    ii. No
7. Please complete the table below with information specific to the Applicant ACO's proposed leadership team. The leadership team may include, but is not limited to: key executives; finance officers; clinical improvement officers; compliance officers; information systems leadership; and the individual responsible for maintenance and stewardship of clinical data. If specific individuals have not yet been identified, please note that in the Leadership Team Member column and provide the anticipated date by which the individual will be identified.

Leadership Team Member	Position/Role
Example Name 1	Example Role 1

B. Legal Entity and Governing Body
    1. For Next Generation ACOs that are formed by two or more Next Generation Participants, the ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers. If, however, the Next Generation ACO is a Medicare Shared Savings Program ACO, then the ACO legal entity may be the same as that of the existing legal entity, provided all other requirements are met. Please select one:
        i. Applicant Next Generation ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers.
        ii. Applicant ACO is a Medicare Shared Savings Program ACO and Applicant ACO will be the same as that of the existing legal entity.

    2. Please complete the table below for the Applicant ACO's proposed governing body:

Name	Title	Expertise	Beneficiary (Y/N)	Consumer Advocate (Y/N)	Percent of Control
Name 1	Title 1				

    3. Please describe how responsibilities and accountability will be shared across the leadership team and governing body structures in the Applicant ACO.
    4. Please describe how the governing body will ensure that the interests of beneficiaries and providers will be represented adequately. Specifically, explain the following:

i. The role of the independent Medicare beneficiary and the independent consumer advocate who will participate in the governing body;
ii. The rationale of the proposed or existing composition of the governing body and voting power distribution.

5. Please provide a narrative explanation of why the Applicant ACO wishes to participate in the Next Generation Model and how participation in the Model will help CMS, the Applicant ACO, and the proposed Next Generation Participants achieve the goals of better health, better care, and lower costs for Medicare beneficiaries.
6. Please upload the compliance plan intended for use by the Applicant ACO.
7. Disclose any sanctions, investigations, probations, actions or corrective action plans that the applicant ACO, its owners or managers, and/or other participating organizations, entities, or individuals, including the applicant's proposed Next Generation Participants, are currently undergoing or have undergone in the last five years.
    i. Please provide this information using the table below.

Organization/Entity	Federal or State Agency or Accrediting Body (e.g., DOJ, OIG, The Joint Commission, State Survey Agencies)	Description of Infraction (including date)	Resolution Status (including date)
Organization 1	Agency 1		

ii. N/A, Applicant ACO, its owners or managers, and/or other participating organizations, entities or individuals, including the proposed Next Generation Participants, have no investigations, sanctions, penalties, or corrective action plans in the past five years.

Financial Experience and Information

A. Financial Experience and Information

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

ix. Please describe any additional sources of funding

B. Risk Sharing Experience

1. Please describe the Applicant ACO's performance under prior or current outcomes-based contracts, if any. Outcomes-based contracts must include: (1) financial accountability; (2) evaluation of patient experiences of care; and (3) substantial quality performance incentives. If applicable, please include arrangements under CMS programs, demonstrations, and models that meet the definition of outcomes-based contracts. Check N/A if no prior or current outcomes-based arrangements. Please also indicate the number of covered lives in outcomes-based contracts with any of the applicant ACO's proposed Next Generation Participants.
2. Please indicate the percentage of the Applicant ACO's total revenues (or an approximation based on the summation of revenue from the ACO's proposed Next Generation Participants) in the last fiscal year derived from outcomes-based contracts.

   Note: An ACO's total revenues include: (1) payments received by all proposed Next Generation Participants for clinical services (e.g., Fee-for-Service, per member per year, per member per month, and per episode); (2) supplemental payments proposed Next Generation participants received or returned due to financial risk after financial or cost reconciliation; (3) supplemental payments received as quality or cost bonuses by proposed Next Generation Participants. Total revenue excludes revenues not related to clinical services (e.g., rent, investments).

   i. Please describe how the Applicant ACO calculated the total revenues described above (e.g., which proposed Next Generation Participants were included, which services were included, which revenues not related to clinical services were excluded).
3. What is the business model for your organization as you transition from the financial incentives of FFS payment to those of risk-based and outcomes-based contracts? How has this been informed by your experience to date with risk-based and outcomes-based contracts?
4. Please describe the Applicant ACO's relationship (e.g., geographic, age, relative dominance in major areas of service delivery) to other health care entities in its market. Include information on what other organizations are its main competitors and the Applicant ACO's market share in its primary service area for professional and hospital services.
5. Please describe the history of collaboration among major stakeholders in the community being served and commitment from relevant community stakeholders to achieve seamless care. Include specific examples, if any.

C. Financial Plan if Selected for the Next Generation ACO Model

1. Please attest that that the Applicant ACO has been licensed by the state(s) in which it is located as a risk-bearing entity or that it is exempt from such licensure and/or other such requirements.
   i. Applicant ACO has been licensed as a risk-bearing entity in state(s) in which it will operate. Upload certification/documentation.
   ii. N/A (e.g., state does not have licensure requirement for ACOs or ACO not required to be licensed as risk-bearing entity).

iii. Applicant is required to obtain licensure, but it is not yet licensed as a risk-bearing entity. Please describe plans and timeline to become licensed, including the state and date of application submission. Please include the date by which licensure is anticipated.

2. Funding Ongoing ACO Activities
    i. Please describe how Applicant ACO intends to fund ongoing ACO Activities. Indicate how the funding plan supports the three-part aim of better health, better health care, and lower per-capita costs and how it ties individual providers/suppliers into the overall outcomes-based revenue strategy. To the extent applicable, please describe how the ACO proposes to distribute savings or losses among providers/suppliers and eligible affiliates.
    ii. Please describe how the Applicant ACO plans to ensure payment to Medicare of its share of losses relative to the benchmark and Other Monies Owed.
3. Please explain any plans the Applicant ACO has to better manage Medicare Part D utilization and expenditures. Please include any plans the ACO has to partner with Part D plans while preserving beneficiary choice. Please include information on the types of activities that would fall under a Part D partnership, such as data sharing or medication reconciliation.
4. Please indicate intended risk arrangement:
    i. Risk Arrangement A: Shared Performance Risk
    ii. Risk Arrangement B: Full Performance Risk
5. Please indicate intended payment mechanism. Payment mechanism is separate from risk arrangement. It dictates the method of payment for provider/supplier claims and affords the ACO the option of receiving monthly payments. Please select one.
    i. Normal FFS [No changes to FFS claims payment.]
    ii. Alternative Payment Mechanisms (select only one):
        1. Normal FFS with monthly infrastructure payments [Next Generation Participants and all other Medicare providers and suppliers that care for Next Generation Beneficiaries will have claims reimbursed by CMS through FFS. The ACO may elect to receive monthly infrastructure payments at an amount no greater than $6 PBPM. Monthly payments are reconciled and recouped in the final financial reconciliation calculation.]
        2. Population-based payments (PBP) [If the ACO selects the population-based payment (PBP) alternative payment mechanism, Next Generation Participants and Preferred Providers that agree to receive a PBP Fee Reduction will have Medicare FFS claims payments for services furnished to Next Generation Beneficiaries reduced by an agreed upon percentage. The ACO will receive a monthly payment commensurate with percentage taken out of providers/suppliers' FFS payments, which will be reconciled separately from the calculations of shared savings and losses.]
        3. All-Inclusive Population Based Payments (AIPBP) [If an ACO selects the AIPBP alternative payment mechanism, ACO participants and Preferred Providers that agree to participate in AIPBP and to receive the AIPBP Fee Reduction will have their Medicare FFS claims for

services furnished to Next Generation Beneficiaries reduced by 100%. The ACO will receive a monthly payment commensurate with the fee reductions and will be responsible for paying providers/suppliers in accordance with their written agreements and the Model's Participation Agreement. The total amount of AIPBP payments made to the ACO and the AIPBP Fee Reductions during the Performance Year will be reconciled separately from the calculations of shared savings and losses.]

Patient Centeredness and Beneficiary Engagement

A. Goals and Objectives

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

B. Beneficiary Engagement

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

Clinical Care Model

A. Care Coordination and Health IT Capability

1. Please describe the Applicant ACO's plan to achieve better health, better care, and lower costs through integrated and coordinated care interventions. Please address the following in your narrative:
    i. The Applicant ACO's use of interdisciplinary care teams to coordinate care for patients;
    ii. The Applicant ACO's methods and processes to coordinate care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care between providers (both inside and outside the ACO);
    iii. The Applicant ACO's use of HIT;
    iv. The Applicant ACO's strategies for improving beneficiary access to care;
    v. The Applicant ACO's development and use of population health management tools;
    vi. The Applicant ACO's plan to incorporate medication management into its care coordination approach; and,
    vii. Additional specific care interventions and tools.
2. Please provide the anticipated percentage of eligible professionals in the Applicant ACO that will have attested to Electronic Health Record (EHR) Stage 2 Meaningful Use Criteria by February 28, 2017. Please provide any additional information regarding the ability of Applicant ACO's eligible professionals to meet the Meaningful Use requirements.
3. Is the Applicant ACO a physician-based organization (e.g., convening entity is either a physician independent practice association (IPA); a physician practice management association; an individual physician group; or collection of physician groups)?
    i. Yes
    ii. No
    iii. If yes, please select one of the following categories that best reflects the EHR/HIT system functionality of the majority of ambulatory practices' in the applicant ACO:
        a. Paper chart based.
        b. Desktop access to clinical information, unstructured data, multiple data sources, intra-office/informal messaging.
        c. Beginning of a clinical data repository (CDR) with orders and results, computers may be at point-of-care, access to results from outside facilities.
        d. Electronic messaging, computers have replaced the paper chart, clinical documentation and clinical decision support.
        e. Computerized physician order entry (CPOE), Use of structured data for accessibility in electronic medical record (EMR) and internal and external sharing of data.
        f. Health Information Exchange (HIE) capable, sharing of data between the EMR and community based EHR, business and clinical intelligence.

4. Is the Applicant ACO hospital-based (e.g., convening entity is a physician hospital organization (PHO) or management service organizations (MSO) that includes hospitals)?
    i. Yes
    ii. No
    iii. If yes, please select one of the following categories that best reflects the functionality of the majority of providers' EMR/HIT systems in the Applicant ACO:
        a. Some clinical automation exists; however, systems allowing laboratory, pharmacy, and/or radiology services to be automated are not installed.
        b. Systems allowing laboratory, pharmacy, and radiology to be automated are installed.
        c. Computerized practitioner/physician order entry (CPOE) installed and available. If one patient service area has implemented CPOE and completed previous stages, this stage has been achieved.
        d. Closed loop medication administration environment implemented in at least one patient care service area. Electronic medication administration record (eMAR) system is implemented and integrated with CPOE and pharmacy.
        e. Full physician documentation/charting (structured templates) implemented for at least one patient care service area. Full radiology picture archive and communication system (PACS) implemented (i.e. all images available to physicians via intranet or other secure network.)
        f. Hospital has paperless EMR environment. Clinical information can be readily shared via Continuity of Care (CCD) electronic transactions with all entities within health information exchange networks (i.e., other hospitals, ambulatory clinics, sub-acute environments, employers, payers and patients).
5. Please describe the Applicant ACO's and proposed Next Generation Participants' ability to use EHR data and electronic tools to understand patient risk, risk stratify, and use this information for decision-making.
6. Please describe the Applicant ACO's and proposed Next Generation Participants' ability to transfer patient data and care plans between health care settings both inside and outside the ACO for purposes of care management and care coordination.
7. Please describe the experience of the proposed Next Generation Participants reporting on established clinical and patient satisfaction quality measures. Please be specific about the measure set and purpose for collection. If applicable, include a description of any formal, third-party assessments within the past two calendar years (2014-2016) of the Applicant ACO's performance on quality of care metrics relative to peers.
8. Please provide a narrative description and quantitative documentation of at least one illustrative instance in which the Applicant ACO has designed, implemented, and assessed the effectiveness of specific care improvement interventions. Include information on how the problem(s) was identified, why and how the intervention(s)

was selected and designed, how progress (or lack thereof) was measured, and any corrective action or adjustments made.

Benefit Enhancements Implementation

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

A. 3-Day SNF Rule
    1. Please indicate if the Applicant ACO and its proposed Next Generation Participants and proposed Preferred Providers would be interested in a waiver of the otherwise applicable requirement for a three-day inpatient stay prior to SNF admission:
        i. Yes
        ii. No
    2. If yes, please describe how a waiver of the 3-Day SNF Rule would help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
    3. If yes, please describe any Applicant ACO and/or proposed Next Generation Participant experience with a waiver of the 3-day SNF Rule (e.g., Medicare Advantage, PACE) or with direct access to SNFs for Medicare beneficiaries.

B. Post-Discharge Home Visits
    1. Please indicate if the Applicant ACO and its proposed Next Generation Participants and proposed Preferred Providers would be interested in billing for post-discharge home visits pursuant to the Post-Discharge Home Visit Benefit Enhancement:
        i. Yes
        ii. No
    2. If yes, please describe how reimbursement for post-discharge home visits would help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
    3. If yes, please describe any Applicant ACO or proposed Next Generation Participant experience with performing home visits—through clinical staff or partnering with other providers/suppliers—or any experience with innovations in home health care.

C. Telehealth
    1. Please indicate if the Applicant ACO and its proposed Next Generation Participants and proposed Preferred Providers would be interested in greater flexibility in performing telehealth services:
        i. Yes
        ii. No
    2. If yes, please describe how increased flexibility to perform telehealth services would help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.
    3. If yes, please describe any experience with live interactive telehealth services (either with Medicare or commercial arrangements).
    4. If yes, please describe any experience with other telehealth capabilities (e.g., remote monitoring, store-and-forward/asynchronous communication).

D. Please describe how the Applicant ACO will identify a network of Preferred Providers for using the benefit enhancements above. Specifically, what data and information would the Applicant ACO utilize for determining with which community providers/suppliers to affiliate for these purposes? What criteria would the Applicant ACO use for assessing the suitability of providers/suppliers to be selected as Preferred Providers?

Beneficiary Coordinated Care Reward

A. Please describe how the CMS-funded coordinated care reward to beneficiaries would help the Applicant ACO reduce total Medicare expenditures and improve care integration, quality assurance and patient safety.