CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Next Generation Accountable Care Organization (ACO) Model: Frequently Asked Questions

General Model Questions

1. How does the Next Generation ACO Model ("the Model") differ from the Medicare Shared Savings Program?

A. The Next Generation ACO Model is distinct from the Medicare Shared Savings Program in a number of ways. The Model offers financial arrangements with higher levels of risk and reward, using refined benchmarking methods that reward both attainment and improvement in cost containment. The Model also offers a selection of payment mechanisms to enable a graduation from fee-for-service (FFS) payment to all-inclusive population based payments (AIPBP), also referred to as capitation in earlier Model materials. Also central to the Next Generation ACO Model are several "benefit enhancement" tools to help ACOs improve engagement with beneficiaries, such as: (1) greater access to post-discharge home visits, telehealth services (asynchronous and synchronous), and skilled nursing facility services; (2) opportunities to receive a reward payment for receiving an Annual Wellness Visit from ACO providers; (3) a process that allows beneficiaries to confirm their care relationship with ACO providers; and (4) greater collaboration between CMS and ACOs to improve communication with beneficiaries about the characteristics and potential benefits of ACOs in relation to their care.

2. How is an ACO different from Medicare Advantage (MA)?

A. A Medicare Advantage plan is another way for a Medicare beneficiary to get Medicare coverage, namely through a private insurer that has been approved by Medicare. ACOs, on the other hand, are groups of providers that serve Original Medicare beneficiaries.

All of CMS's ACO models are part of the Original Medicare Program and follow Original Medicare rules and processes, and ACO beneficiaries have freedom of choice to go to Original Medicare providers.

Beneficiaries aligned to Next Generation ACOs maintain Original Medicare benefits. For example, there is beneficiary freedom of choice of provider, as opposed to the defined provider network of an MA plan. There is no requirement that a beneficiary receives services from an ACO, nor is there additional premium paid by the beneficiary for being in an ACO. Beneficiaries may receive a reward for receiving the majority of their care from ACO providers, but are not penalized in any way for seeing non-ACO providers. The Next Generation ACO Model does not require beneficiary enrollment. Beneficiaries are aligned to ACOs through claims, which voluntary alignment supplements by allowing beneficiaries to confirm a care relationship with an ACO provider.

3. How did CMS select participants for the model?

A. CMS evaluated 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 of the RFA. In addition, applicants demonstrated that their

organizational structures promotes the goals of the Model by including diverse sets of providers who would demonstrate a commitment to high quality care. Lastly, applicants with prior participation in a CMS program or demonstration were asked to demonstrate good performance and conduct in the previous initiative.

4. May the ACO communicate to patients about its Next Generation participants – who they are and why the ACO has selected them?

A. The Next Generation ACO Model has specific terms and guidelines regarding communications with beneficiaries, but CMS supports the dissemination by ACOs of information identifying all providers associated with the ACO. Beneficiary awareness of and engagement with ACO-directed care is a central component of the Model.

5. Is this a capitated ACO model?

A. Beginning in Performance Year 2 (2017), Next Generation ACOs had the option to participate in a capitation-like payment mechanism, called All-Inclusive Population-Based Payments (AIPBP). AIPBP is one of four available payment mechanisms from which the ACO can select. AIPBP in the Next Generation ACO Model is a payment mechanism, which is distinct from the risk arrangement that the ACO selects. All ACO benchmarks are calculated the same way, independent of the respective payment mechanism and risk arrangement an ACO selects.

AIPBP functions by estimating total annual expenditures for care furnished to aligned beneficiaries by AIPBP-participating providers and paying that projected amount to the ACO in a per-beneficiary per-month (PBPM) payment. Next Generation ACOs that participate in AIPBP are responsible for paying claims for their AIPBP-participating Next Generation Participants and Preferred Providers with whom the ACO has written agreements regarding AIPBP.

6. What happens if the projected trend is higher or lower than the experienced trend?

A. Under limited circumstances, CMS will adjust the trend in response to price changes that have a substantial expected impact on ACO expenditures. Trend adjustments are intended to prevent ACOs from being unfairly penalized or rewarded for major payment changes beyond their control. The terms and conditions for trend adjustments in this Model are in the Next Generation ACO Model Participation Agreement.

7. How does this model address concerns of current ACOs that it becomes more difficult to earn savings every year?

A. The Next Generation ACO Model addresses this concern in two ways: (1) by incorporating relative efficiency into the discount; and (2) through the development of a long-term benchmarking methodology for Performance Years 4 and 5.

As in current ACO models, the Next Generation ACO Model continues to use historical expenditures to develop the ACO's baseline and benchmark for Performance Years 1 through 3. The baseline is risk-adjusted, trended, and then a discount is applied. The discount incorporates regional and national efficiency, and ACOs that have already attained cost efficiency compared to their regions will have a more favorable (reduced) discount. Under this approach, ACOs achieve savings through year-to-year improvement over historic expenditures (improvement), but the magnitude by which they must improve will vary based on relative efficiency (attainment). This recognizes past achievements of efficient ACOs.

CMS may employ an alternative benchmarking methodology in Performance Years 4 and 5 of the Model. The principles for this alternative methodology, which focus on de-emphasizing historical expenditures and more heavily weighting attainment, are described in the RFA.

8. How does this model address concerns that high turnover in beneficiary alignment may hamper the effectiveness of care interventions and thus limit the gains for these investments?

A. The Next Generation ACO Model seeks to mitigate fluctuations in the aligned beneficiary population and respect beneficiary preferences by supplementing claims-based alignment with voluntary alignment. Under voluntary alignment, Next Generation ACOs may offer beneficiaries the option to confirm or deny their care relationships with specific Next Generation Participants. This beneficiary input will be reflected in alignment for the subsequent year (e.g., during Performance Year 1, beneficiaries can confirm relationships that affect alignment for Performance Year 2, provided such beneficiaries meet other eligibility criteria). Confirmations of care relationships through voluntary alignment supersede claims-based attributions. For example, a beneficiary who indicates that a Next Generation Participant is her main source of care may be aligned with the ACO, even if claims-based alignment would not result in alignment. This enables more alignment continuity across performance years.

9. In this model, when ACOs take accountability for the total cost of care, do beneficiaries still have open access, as with Original Medicare?

A. Yes. A core principle of the Next Generation ACO Model is to protect Original Medicare fee-for-service (FFS) beneficiaries' freedom to seek the services and health care providers of their choice. Beneficiaries retain full freedom of choice of providers and suppliers, as well as all rights and beneficiary protections of Original Medicare.

The Next Generation ACO Model seeks to help providers and suppliers engage beneficiaries in their care through benefit enhancements that directly improve the patient experience. The Next Generation ACO Model also permits ACOs to designate Preferred Providers, in order to allow ACOs to establish relationships with providers and suppliers along the care continuum that emphasize high-value services and management of beneficiaries' care.

10. My ACO is interested in benefit enhancements, but, depending on all the terms and conditions, we may not want to implement some or any in our first year in the Model. If we say now that we are interested, do we have to participate in 2018? Can we elect to participate in later years?

A. Next Generation ACOs do not have to participate in any of the benefit enhancements in any given performance year. ACOs may elect to participate in each of the benefit enhancements on an annual basis.

An ACO may choose not to implement all or any of the offered benefits enhancements. Applicants were asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the Next Generation ACO Model was not contingent upon an ACO implementing any particular benefit enhancement. Specific terms and conditions for participation in the benefit enhancements are in the participation agreement.

11. What benefit enhancements are available for Next Generation ACOs?

A. Next Generation ACOs could elect to participate in three benefit enhancements in 2016 and 2017,

including a waiver of the three-day skilled nursing facility rule, telehealth service coverage in non-Health Professional Shortage Areas, allowing for a beneficiary to receive telehealth services at their place of residence, and allowing auxiliary personnel (e.g., licensed clinician) to perform "incident to" post-discharge home visit services under the general supervision of a Next Generation Participant or Preferred Provider two times in a 30-day period. For 2018, the telehealth benefit enhancement will include asynchronous (i.e., store and forward) telehealth coverage of dermatology and ophthalmology services. The post-discharge home visits benefit enhancement will allow for nine visits in a 90-day period, rather than two visits in a 30-day period.

12. I am a beneficiary. How can I join a Next Generation ACO?

A. Next Generation ACOs that decide to participate in voluntary alignment will send letters directly to eligible beneficiaries with information regarding voluntary alignment and the potential benefit enhancements available to beneficiaries aligned to Next Generation ACOs. Beneficiaries cannot enroll in the Next Generation ACO Model. Beneficiaries eligible for voluntary alignment may be contacted by a participating Next Generation ACO.

13. How do I apply to the Next Generation ACO Model?

A. The Model has and continues to receive interest by ACOs to participate. However, we are no longer accepting applications.

Financial Model

14. When will Next Generation ACOs receive the financial methodology paper?

A. The Next Generation Model's financial methodology paper for PY1 through PY3 is currently posted on the Next Generation website (link: https://innovation.cms.gov/Files/x/nextgenaco-methodology.pdf).

15. What does it mean that the Model uses a cross-sectional benchmarking approach?

A. The Next Generation Model benchmarking approach is cross-sectional, which means a baseline is calculated using beneficiaries that would have been aligned to the ACO in the time period before participation in this Model. Alignment is once again run prior to the start of each performance year to produce the list of prospectively aligned beneficiaries. Some of the same beneficiaries may be aligned in both the baseline period and performance year, but others who were aligned in the baseline period may no longer be seeking care from the ACO or may no longer be alignment eligible. Thus the populations between the baseline period and the performance period are not exactly the same, and risk adjustment is used to adjust for health status differences between the two populations.

16. Will the baseline be static, or will it change during the initial three performance years (2016-2018)? If our participant list changes, does our baseline get recalculated?

A. The *baseline year* will be static for the initial three years of the model (2016-2018). However, the *baseline dollar amount* could change because CMS will use an ACO's most recent Next Generation Participant list to calculate the beneficiaries that would have been aligned in the baseline year and their associated expenditures. The baseline will be calculated to be used in benchmark setting for PY1 (2016) based on the PY1 Next Generation Participants. In PY2 (2017), the same baseline year of historical data is used, but the baseline will once again be calculated, this time using the Next Generation Participant list for PY2 to reflect any changes. The baseline year is 2014 regardless of

whether the ACO joined the Model in 2016, 2017, or 2018.

17. How are HCC risk scores used in the model?

A. We use CMS Hierarchical Condition Category (HCC) model to determine an ACO's average risk score for the ACO's baseline year (2014) population and the ACO's average risk scores for the performance-year population. The benchmark is risk adjusted to reflect the change in average risk score between the base- and performance-year populations. The risk ratio is defined as the ratio of the average performance-year risk score to the average baseline-year risk score. The increase in average risk score between the baseline and performance year is capped at 3%, while the decrease in average risk score is limited to no less than the baseline-year risk score; put another way, the ratio is limited to between 1.00 – 1.03. Beginning in Performance Year 2 (2017), the Next Generation ACO Model also uses a prospective coding adjustment to account for coding intensity that is observed in the national population of beneficiaries eligible for alignment to a Next Generation ACO.

18. When are risk scores computed and when is the final risk ratio available to ACOs?

A. Risk scores for a given year are not available until spring of the following year. For example, in the case of Performance Year 1, 2016 risk scores are not available until spring 2017 (or spring 2018 for Performance Year 2). Thus the final risk ratio used to adjust the Performance Year 1 benchmark is not available until spring 2017 (or spring 2018 for Performance Year 2).

When we refer to "2016 risk scores," we mean risk scores that are meant to predict 2016 expenditures. Risk scores are predictive in the sense of using diagnoses for claims incurred in the prior year (for 2016 risk scores, claims incurred in 2015). The reason for the time lag in availability of final risk scores (spring 2017 for 2016 risk scores) is due to the need to account for run-out and other factors.

19. Is the 3% HCC risk score cap applicable per year or per contract?

A. The 3% risk adjustment cap applies to each performance year as compared to the baseline – the relevant calculation is the point difference between the average performance year risk score to the average performance year baseline year risk score. If this difference was +2% between the average risk scores for the baseline year and Performance Year 1, the ACO's risk ratio would reflect the entire 2% increase because that is below the cap. If then in the second performance year, the difference was +4%, which is over the cap, the ACO's risk score would only reflect a 3% increase (the capped limit).

20. Is Part D prescription drug spending included in the benchmark?

A. Part D prescription spending is not included in Next Generation ACO benchmarks at this time. ACOs are only accountable for total Parts A and B expenditures for aligned beneficiaries.

21. The Next Generation financial model includes a discount. What is the discount?

A. The discount is a quality and efficiency adjustment that is incorporated into each ACO's benchmark. The benchmark is calculated in four steps. First, CMS calculates the historic baseline expenditure. Then, the historic baseline is trended forward from the base year to the performance year. Next, the trended baseline is risk adjusted. Lastly, quality and efficiency adjustment (the discount) is applied to the risk adjusted, trended baseline. The discount will be calculated separately for each ACO using the given ACO's quality score and efficiency compared to its region and

national FFS expenditures. For example, if the baseline, trend, and risk adjustment calculations determine that an ACO is projected to spend $10,000 per beneficiary and the ACO's discount is determined to be 2%, the final benchmark is $9,800 per beneficiary.

22. With the discount replacing the MSR/MLR, how does that work on the loss side? For example, is the ACO exposed to first dollar losses based on the discounted benchmark or the undiscounted benchmark?

A. The discount is built into the benchmark, so all ACO benchmarks inherently include a discount—there is no undiscounted benchmark. Next Generation ACOs will receive first dollar shared savings for spending below the benchmark and are accountable for first dollar shared losses for spending above the benchmark.

23. Do infrastructure payments count as a medical expense in the reconciliation to determine shared savings/losses? Must all infrastructure payments be repaid to CMS?

A. No, infrastructure payments do not count in the total Parts A and B expenditures used to determine an ACO's savings or losses. Yes, all infrastructure payments must be repaid to CMS.

24. All-Inclusive Population-Based Payments (AIPBP) is available in 2017. Do ACOs have to participate in a lower risk arrangement before entering into AIPBP?

A. Risk arrangement and payment mechanism are independent in the Next Generation ACO Model. ACOs in either risk arrangement may select any of the available payment mechanisms, including AIPBP, and vice versa. Beginning in 2017, all Next Generation ACOs (regardless of start date) had the option to elect the AIPBP payment mechanism. ACOs are not required to elect AIPBP and can select one of the other three available payment mechanisms. The AIPBP payment mechanism became operational in April 2017.

25. Will ACOs participating in the AIPBP payment mechanism be allowed to determine payment rates for providers under capitation agreements, or is it mandated that current CMS Medicare payment rates be applied? How will the beneficiary liability be calculated?

A. Yes, ACOs are allowed to determine payment rates for providers under AIPBP arrangements and will not be required to pay AIPBP-participating providers 100 percent of FFS rates as long as payment arrangements are consistent with all applicable laws. Additional financial requirements for ACOs participating in AIPBP will be described in the Model's participation agreement. Beneficiary liabilities are not affected by the AIPBP payment mechanism, and will continue to be calculated based on what Medicare would have paid in the absence of the ACO participating in AIPBP.

26. Under Population Based Payments (PBP), do ACOs have the ability to elect FFS reduction percentages at the TIN/NPI level?

A. Yes, Next Generation ACOs have the ability to differentiate participation in PBP at the TIN/NPI level. The FFS reduction is set at the TIN level. This means that NPIs within a TIN may either choose the FFS reduction percentage agreed to by the TIN or not participate in PBP (no FFS reduction).

27. Will Payment Mechanism 2, normal FFS plus infrastructure payments, also require discounted FFS payments to participating providers?

A. No, infrastructure payments do not affect FFS claims processing. All providers' FFS claims are submitted and paid as normal, but the ACO also receives a monthly infrastructure payment.

28. Can an ACO change its selected payment mechanism during the three year Model agreement period --e.g., start with FFS and then move to PBP? Will CMS allow an ACO to opt into multiple payment mechanisms simultaneously?

A. Yes, each year the ACO has the ability to elect its payment mechanism for the upcoming performance year. ACOs are not required to move from normal FFS to any of the other payment mechanisms. No, each Next Generation ACO elects one payment mechanism for a given performance year. An ACO cannot select more than one payment mechanism for a give performance year (i.e., the ACO cannot elect AIPBP for some of its Next Generation Participants and PBP for others).

29. Under PBP and AIPBP, CMS projects the amount of spending that will occur from participating providers to pay the monthly amount to the ACO. How does CMS make this determination?

A. Each year, Next Generation ACOs select a payment mechanism for the upcoming performance year. If an ACO selects PBP, the ACO must have in place written agreements with all its PBP-participating Next Generation Participants and Preferred Providers to accept FFS fee reductions. Likewise, if an ACO selects AIPBP, the ACO will have written agreements regarding AIPBP with participating Next Generation Participants and Preferred Providers. CMS looks at past spending for aligned beneficiaries by providers participating in the given payment mechanism to project the percentage of care that those providers will account for in the upcoming performance year and adjust the monthly payment. For example, if, in past years, providers who have agreed to participate in AIPBP accounted for 75% of aligned beneficiary spending, the monthly payment will reflect an assumption that 75% of care will be from AIPBP-participating Next Generation Participants and Preferred Providers and 25% will be from other Medicare providers and suppliers.

Alignment

30. What codes define the evaluation and management (E&M) services that are used for alignment?

A. Information on claims-based alignment is described in Section VI.B.3 of the Request for Applications (RFA) and in Appendix A to the financial methodology paper posted on the Next Generation ACO Model website.

31. How does voluntary alignment supplement claims-based alignment?

A. Each fall, prior to the start of a performance year, CMS will run alignment using a claims- based methodology described in VI.B.3 of the RFA. For PY1, Next Generation ACOs' beneficiaries were only aligned through claims (with the exception of ACOs that may transition beneficiaries that voluntarily aligned under another Medicare ACO initiative). Going forward, ACOs will also have the option to allow beneficiaries to voluntarily align for the subsequent performance year. For example, for PY2 a Next Generation ACOs' aligned population consists of beneficiaries aligned through claims along with beneficiaries who, in PY1, elected to voluntarily align with the ACO for PY2. Figure 6.4 in the RFA provides a conceptual timeline for voluntary alignment.

32. Do Preferred Providers participate in alignment?

A. No, only Next Generation Participants are used for alignment. Table 5.1 in the RFA depicts the

various types of Next Generation entities and their associated functions.

33. Do service area boundaries apply to voluntary alignment?

A. Yes. In Section VI.B of the RFA there are general beneficiary eligibility requirements for alignment to an ACO. Those requirements also apply to voluntary alignment.

Quality and Program Reporting

34. Will ACOs that come to Next Generation from the Medicare Shared Savings Program or an existing Medicare ACO initiative also get pay-for-reporting in 2018?

A. Yes. In the Next Generation ACO Model, an ACO's quality score is used in determining the discount applied to the prospective benchmark. Each performance year, 100% is used as the quality score for all Next Generation ACOs. However, if an ACO fails to report, CMS will retroactively recalculate the discount to reflect this failure to report. Additional terms and conditions regarding failure to report quality data is in the participation agreement. It is also important to remember that the actual quality reported in PY1 will be used in setting the discount in later performance years.

35. Why has the EHR meaningful use measure been dropped for Next Generation ACOs?

A. CMS expects that ACOs who are ready and able to take on high levels of risk are already using Electronic Health Records (EHR) and already have robust systems in place. 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 MACRA) as prescribed through future regulation.

36. Is an ACO participating in the Next Generation ACO Model exempted from the Merit Based Incentive Payment System (MIPS) reporting requirements as long as they successfully collect and report required quality data through the Next Generation ACO Model quality reporting mechanisms?

A. Yes. For 2018, ACOs participating in the Next Generation ACO Model do not have to report quality measures to MIPS for all unique TINs/NPIs listed in the ACO's final participation file if the ACO reports all required quality measures completely and successfully.

37. If we have one TIN with 100 NPI providers but only 25 are Next Generation ACO providers, do the remaining 75 NPIs need to report to MIPS?

A. Yes. The remaining 75 NPIs are required to report to MIPS. They can participate in MIPS as an individual EP or as part of a group practice. Please review the available reporting mechanisms here:-https://qpp.cms.gov/.

38. Can NPIs that are not part of Next Generation ACO but share the same TIN report to MIPS through the Next Generation ACO Web Interface (WI)?

A. No. NPIs under the same TIN but not participating in the Next Generation ACO model are not eligible to report through the Next Generation ACO WI reporting and should report to MIPS independently. TINs/NPIs not listed on the NGACO final participant file should always report to MIPS independently. Please review the available reporting mechanisms here:

https://qpp.cms.gov/.

39. Once the performance year starts, can we add a new NPI that bills under a TIN that is already on the Next Generation ACO Participant Provider list for the current PY?

A. Yes, Next Generation ACO can add Participants once the performance year begins under limited circumstances.

40. Can specialists participate in multiple ACOs under the Next Generation ACO model? How do specialists participating in multiple Next Generation ACOs report to MIPS? Which ACO is responsible for ensuring that the MIPS reporting is completed on behalf of the specialist?

A. Yes, specialists can participate in multiple Next Generation ACOs. If you want your specialists to participate in an Advanced Alternative Payment Model (APM) under your ACO, list their unique TINs/NPIs on your participant list. If the "Shared TIN" is used among other Next Generation ACOs, CMS will apply a rule to ensure that the same TIN/NPI is credited only ONCE. Please note that specialists can have multiple TINs. Specialists who are NGACO participants are exempted from MIPS reporting. NGACOs will be reporting required Advanced APM quality measures on behalf of these specialists.