Next Generation ACO Model: Frequently Asked Questions
April 13, 2015

General Model Questions

1. **How does this ACO model differ from the Pioneer ACO Model (Pioneer) and the Medicare Shared Savings Program?**
   
   **A.** The Next Generation ACO Model is distinct from the Medicare Shared Savings Program and Pioneer in a number of ways. The Model offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using refined benchmarking methods that reward both attainment and improvement in cost containment and that ultimately transition away from comparisons to an ACO’s historical expenditures. The Model also offers a selection of payment mechanisms to enable a graduation from fee-for-service (FFS) reimbursements to capitation. 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 home visits, telehealth services, and skilled nursing facility services; (2) opportunities to receive a reward payment for receiving care from the ACO and certain affiliated 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. This is in accordance with the Department of Health and Human Services’ “Better, Smarter, Healthier” approach to improving our nation’s health care and setting clear, measurable goals to move the Medicare program—and the health care system at large—toward paying providers based on quality, rather than quantity, of 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’ 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. Are current Medicare Shared Savings Program ACOs or Pioneer ACOs eligible to apply for this model?
   A. Yes, participants in the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model may apply, as well as all other organizations that meet applicant eligibility requirements, which are in Section V of the Next Generation ACO Model Request for Applications (RFA). Applicants with prior participation in a CMS program or demonstration will be asked in the Next Generation ACO Model application to demonstrate good performance and conduct in the previous initiative. ACOs may not simultaneously participate in the Next Generation ACO Model and the Medicare Shared Savings Program or the Pioneer ACO Model.

4. How will CMS select participants for the model?
   A. 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 of the RFA. In addition, applicants should demonstrate that their organizational structures promote the goals of the Model by including diverse sets of providers who will demonstrate a commitment to high quality care. Lastly, applicants with prior participation in a CMS program or demonstration will be asked to demonstrate good performance and conduct in the previous initiative. CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review of the applicant, its providers/suppliers, preferred providers, its affiliates or any relevant individuals or entities.

5. Is this a capitated ACO model?
   A. In Performance Year 2 (2017), Next Generation ACOs will have the option to participate in the capitation payment mechanism. Capitation will be one of four available payment mechanisms from which the ACO will select. Capitation in the Next Generation ACO Model is a payment mechanism, which is distinct from the risk arrangement that the ACO selects. All ACO benchmarks will be calculated the same way, independent of the respective payment mechanism and risk arrangement an ACO selects. Next Generation ACOs will not be required to elect capitation and may continue to participate in any of the other three payment mechanisms once capitation becomes available.

Capitation will function by estimating total annual expenditures for aligned beneficiaries and paying that projected amount to the ACO in a per-beneficiary per-month (PBPM) payment with some money withheld to cover anticipated care by providers not participating in capitation. A Next Generation ACO participating in capitation will be responsible for paying claims for its Next Generation Providers/Suppliers and Next Generation Capitation Affiliates with whom the ACO has written agreements regarding capitation.

6. What happens if the projected trend is higher or lower than the experienced trend?
   A. Under limited circumstances, CMS would 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 will be 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 will continue to use historical expenditures to develop the ACO’s baseline and benchmark for Performance Years 1 through 3. The baseline is risk-adjusted and trended, as described in the RFA, before 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 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 Providers/Suppliers. 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 Provider/Supplier 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. In addition, beneficiaries that seek care through their aligned ACO at a high rate could receive a coordinated care reward from CMS, providing an incentive to maintain their care relationship over the long term.

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 will also permit 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 year one. If we say now that we are interested, do we have to participate in Performance Year 1? Can we elect to participate in later years?

A. Aside from the coordinated care reward, which is entirely CMS-funded and automatically applies to all Next Generation Beneficiaries, 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. For the coordinated care reward, CMS will make direct payments to each Next Generation beneficiary aligned to Next Generation ACOs who receives at least a certain percentage of his or her Medicare services from Next Generation Providers/Suppliers, Preferred Providers, and Affiliates.

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

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

A. During 2016 (the first performance year of the Next Generation ACO Model), Next Generation ACOs may offer aligned beneficiaries the option to confirm their care relationship with specific Next Generation ACO Model Providers/Suppliers. This process is called voluntary alignment. If the beneficiary does confirm the care relationship, the beneficiary will remain aligned to the Next Generation ACO Model in 2017. This process will be repeated annually (e.g., in 2017, ACOs may offer aligned beneficiaries the option to voluntarily align for 2018).

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.

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

A. All organizations interested in applying to the Next Generation ACO Model for the January 1, 2016 start date must submit a Letter of Intent (LOI) by May 1, 2015. Only organizations that submit an LOI will be able to complete an application. Applications for 2016 are due June 1, 2015. Information about the 2017 start date will be released in spring 2016. To complete an LOI and find more information about the model, please visit the Next Generation ACO Model website.

Letter of Intent and Application

13. May an organization submit both a Letter of Intent (LOI) for the Next Generation ACO Model and a Notice of Intent (NOI) for the Medicare Shared Savings Program?

A. Although an ACO is not permitted to participate in the Next Generation Model and the Medicare Shared Savings Program simultaneously, ACOs may submit both a Next Generation LOI and a Medicare Shared Savings Program NOI. The Next Generation LOI and the Medicare Shared Savings Program NOI are both non-binding.
14. Will an existing ACO be able to apply to the Next Generation Model, but ultimately remain in its current model or program for 2016?
   A. An existing ACO (in the Medicare Shared Savings Program or the Pioneer Model, for example) may apply to be a Next Generation ACO, and then choose later this year whether or not to terminate current participation and join Next Generation or continue in its current ACO initiative or model. The ACO would have to select final participation before the start of 2016. CMS is still working to determine the exact date by when the ACO must make this final choice.

15. Is it possible for Medicare Shared Savings Program ACOs to join Next Generation if they are in the first or second years of the three-year agreement?
   A. Yes. Medicare Shared Savings Program ACOs may leave the Medicare Shared Savings Program prior to the end of the three-year agreement. ACOs should consult their current agreements for terms and conditions regarding termination.

16. I am a current participant in the Medicare Shared Savings Program or another Medicare ACO with slightly less than 10,000 aligned beneficiaries. May I apply to the Next Generation Model with an increased number of providers/suppliers (and therefore, an increased number of aligned beneficiaries)?
   A. Yes. For all ACOs that apply to the Next Generation ACO Model, CMS will perform a minimum beneficiary count during the application review period. This minimum beneficiary count will determine beneficiaries eligible for alignment under this Model based on qualifying services received from the providers/suppliers included in the application for the Next Generation ACO. ACOs must have 10,000 aligned beneficiaries in order to qualify for acceptance into the Next Generation Model, unless located in a rural area as defined in the glossary of the RFA. Please note, ACOs may not participate in multiple shared savings programs at the same time -- for example, ACOs cannot concurrently participate in Next Generation and the Medicare Shared Savings Program.

17. The Letter of Intent (LOI) asks for an expected number of aligned Medicare beneficiaries in 2016. How should an ACO estimate this?
   A. To respond to this question in its LOI, an ACO that is currently in the Medicare Shared Saving Program or is an ACO initiative tested by the Center for Medicare and Medicaid Innovation should use the most recent count of aligned beneficiaries that it has from its current ACO initiative or program. If the ACO is new, an estimation based on Medicare beneficiaries treated by the ACO’s primary care physicians is acceptable. Lastly, the question is optional for LOI submission, so an ACO may omit this information if it is unable to estimate this value. During the application review period, CMS will perform a minimum beneficiary count for all potential Next Generation ACOs that will determine beneficiaries eligible for alignment under this Model based on qualifying services received from the providers/suppliers included in the application for the Next Generation ACO.

18. How are rural versus urban ACOs defined?
   A. The definition of rural ACO is located in the glossary found in Appendix B of the RFA. As described in the RFA, an ACO will be considered rural if any of its primary service areas are located in a rural county. Census tracts with Rural Urban Commuting Area Codes (RUCA) 4 through 10 will be considered rural, and micropolitan areas will be considered rural for the purposes of the Next Generation Model. See: http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx for more information on RUCA codes.
19. Do SNFs hoping to become a SNF affiliate need to complete the Letter of Intent?
   A. No, SNFs participating with an ACO as an affiliate do not separately need to submit an LOI to the Next Generation ACO Model. Only ACO entities with intentions to apply to be a Next Generation ACO need to complete the LOI and not individual providers/suppliers, preferred providers, or affiliates.

20. Are ACOs required to have signed agreements with all providers/suppliers at the time of submitting an application?
   A. No, agreements between ACOs and Next Generation Providers/Suppliers do not need to be completed at the time of submitting an application. However, ACOs will submit lists of proposed providers/suppliers as part of the Next Generation application. All provider/supplier agreements must be signed and in compliance with model requirements at the time the ACO signs the Model’s participation agreement. ACOs will submit lists of Next Generation Providers/Suppliers, Preferred Providers and SNF Affiliates after the application is submitted, but prior to signing the participation agreement. Capitation Affiliates will not need to be identified prior to the start of the first performance year (2016), as capitation will not start until 2017.

21. Must providers participate in Next Generation ACOs at the whole-TINs level, or will NPIs within TINs be used to determine participation?
   A. No, entire TINs do not need to participate. The Next Generation Model is a split-TIN model, which means participation is identified by the unique TIN/NPI combination, and not all NPIs within a TIN are required to participate.

22. May ACOs that operate in multiple states apply to the Next Generation Model?
   A. ACOs may have providers from multiple contiguous states so long as the mix of providers is material to the ACO’s clinical integration and coordination and reflects the normal care patterns of the ACO’s beneficiaries. ACOs may not pool unrelated providers across noncontiguous states for reasons not related to providing coordinated, clinically integrated care to aligned beneficiaries.

23. How do ACOs access the online application?
   A. All ACOs that intend to apply to the Next Generation ACO Model must first submit a Letter of Intent (LOI). After submitting an LOI, the ACO will receive an LOI ID number that is required to gain access to the application. The link to the online application is located on the Next Generation Model’s webpage: http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/ under the Additional Information heading. Clicking on the link to the online application connects to a landing page of the application portal that asks for a username and password. If it’s the applicant’s first time accessing the application, click on “Request Application Access” just below the box for username and password. Applicants will then be prompted to enter the LOI ID number and e-mail used when submitting the LOI. Applicants will then create a username and password for ongoing access to the portal.

Financial Model

24. When will Next Generation ACOs receive the financial methodology paper?
   A. Below is a preliminary timeline for key milestones related to the financial methodology and ACO decision-making. The financial methodology paper will contain further detail as to how calculations will be performed, but the parameters of the model, such as the range of the
discount and the risk adjustment cap, are already defined in the RFA and sample calculations are included in Appendix C.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOI Due Date</td>
<td>May 1, 2015</td>
</tr>
<tr>
<td>Application Due Date</td>
<td>June 1, 2015</td>
</tr>
<tr>
<td>Providers/Suppliers List Submitted</td>
<td>June 1, 2015</td>
</tr>
<tr>
<td>Financial Methodology Paper</td>
<td>Mid-Summer 2015</td>
</tr>
<tr>
<td>Preferred Provider List Submitted</td>
<td>Early Fall 2015</td>
</tr>
<tr>
<td>Agreements Signed</td>
<td>Fall 2015</td>
</tr>
<tr>
<td>Alignment Run and Benchmark Calculated</td>
<td>Mid-Late Fall 2015</td>
</tr>
<tr>
<td>Implementation Plans and SNF Affiliate List Submitted (if applicable)</td>
<td>Mid-Late Fall 2015</td>
</tr>
<tr>
<td>Start of 1st Performance Year</td>
<td>January 1, 2016</td>
</tr>
</tbody>
</table>

25. 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.

26. 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 provider/supplier 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 based on the PY1 participating providers/suppliers. In PY2, the same baseline year of historical data is used, but the baseline will once again be calculated, this time using the participating provider/supplier list for PY2 to reflect any changes.

27. If CMS is going to prospectively determine risk-adjusted benchmarks prior to the beginning of the performance year, how will CMS calculate risk-scores without a full calendar year of claims/diagnosis codes?
   A. The CMS Hierarchical Condition Category (HCC) model is prospective. The HCC model uses past claims data to develop a score that is predictive of future risk and spending for a given beneficiary. In setting the benchmark for an ACO, CMS will use the most currently available HCC risk scores for aligned beneficiaries, which are based on a full 12 months of data, to adjust for health status.

28. Is the 3% HCC risk score cap 3% per year or 3% per contract?
A. The 3% risk adjustment cap applies to each performance year as compared to the baseline. For example, if there was 2% growth in the first performance year as compared to the baseline, the ACO’s risk score would reflect the entire 2% growth because that is below the cap. If in the second performance year, the growth since the baseline is now 4%, which is over the cap, the ACO’s risk score would increase by 3% (the capped limit). The cap also applies to HCC score decreases. For example, if an ACO’s risk score for a given performance year has decreased by 4% as compared to the baseline, the risk score decrease will be capped at 3%.

29. 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. CMS continues to look at options for Part D integration for future Model years.

30. The Next Generation financial model includes a discount. What is getting discounted?
   A. The discount is a calculated reduction of the prospective benchmark. The benchmark calculated for each ACO will include a discount based on quality, regional efficiency, and national efficiency. The discount is applied once the baseline has been calculated and the regional projected trend and risk adjustment have been applied. 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.

31. 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.

32. 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. However, yes, all infrastructure payments must be repaid to CMS, and ACOs that elect to receive infrastructure payments will be required to have in place a larger financial guarantee to assure this repayment.

33. The capitation payment mechanism is available in 2017. If an ACO starts in 2017, may that ACO immediately enter into the capitation payment mechanism? Do ACOs have to participate in the lower risk arrangement before entering into capitation?
   A. Risk arrangement and payment mechanism are independent in the Next Generation Model. ACOs in either risk arrangement may select any of the available payment mechanisms, including capitation in 2017, and vice versa. Beginning in 2017, all Next Generation ACOs (regardless of start date) will have the option to elect the capitation payment mechanism. ACOs are not required to elect capitation and could remain in any of the other three available payment mechanisms in 2017.

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

35. Under Population Based Payments (PBP), will ACOs have the ability to elect FFS reduction percentages at the TIN/NPI level?
   A. Yes, Next Generation ACOs will have the ability to differentiate FFS reductions at the TIN/NPI level.

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

37. Can an ACO change their 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 will have 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 will elect one payment mechanism for a given performance year.

38. Under PBP and capitation, CMS will project the amount of spending that will occur from participating providers to pay the monthly amount to the ACO. How will CMS make this determination?
   A. Each year, Next Generation ACOs will 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 participating providers/suppliers to accept FFS fee reductions. Likewise, if an ACO selects capitation, the ACO will have written agreements regarding capitation with participating providers/suppliers and affiliates. CMS will look 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 capitation accounted for 75% of aligned beneficiary spending, the monthly payment will reflect an assumption that 75% of care will be from capitated ACO providers and 25% will be from other providers and suppliers.

Benefit Enhancements and Beneficiary Coordinated Care Reward

39. May a Next Generation ACO increase the coordinated care reward amount out-of-pocket?
   A. No, the reward payments will be entirely funded by CMS, and ACOs are not permitted to increase the amount out-of-pocket.

40. Does the beneficiary coordinated care reward count against an ACO’s savings? Is the amount paid out for the reward included in expenditures for financial reconciliation?
A. No, the beneficiary coordinated care reward is CMS-funded. CMS will make a direct payment to beneficiaries who qualify for the reward based on seeking a given percentage of care from Next Generation ACO providers/suppliers, preferred providers, and affiliates. The reward payment amount is not taken out of an ACO’s savings, is not included in the benchmark, and the amounts paid out throughout the year will not count as expenditures in the savings/losses calculation.

41. May the ACO communicate to patients about its Next Generation Preferred Providers – who they are and why?
   A. The Next Generation ACO Model will have specific terms and guidelines regarding communications with beneficiaries, but CMS intends to support the dissemination by ACOs of information identifying all providers and suppliers associated with the ACO. Beneficiary awareness of and engagement with ACO-directed care is a central component of the Model.

Alignment

42. Are the beneficiary eligibility criteria listed in Section VI.B.2 of the RFA consistent with the Pioneer ACO Model?
   A. Yes. The Next Generation Model will use the same methodology as the Pioneer Model to prospectively align beneficiaries with Next Generation ACOs, and the beneficiary eligibility criteria are consistent across the two models.

43. 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 RFA. As the Next Generation Model is using the same methodology as the Pioneer Model, the RFA provides a link to the Pioneer methodology paper, which contains the alignment codes.

44. 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 will only be 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 PY2, a Next Generation ACOs’ aligned populations will consist of beneficiaries aligned through claims along with beneficiaries who, in PY1, elected to voluntarily align with the ACO for PY2. Figure 6.3 in the RFA provides a conceptual timeline for voluntary alignment.

45. Do Preferred Providers participate in alignment?
   A. No, only Next Generation Providers/Suppliers are used for alignment. Table 5.1 in the RFA depicts the various types of Next Generation entities and their associated functions.

46. Do service area boundaries apply to voluntary alignment?
   A. Yes. In Section VLB 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

47. There are two TIN/NPI lists requested in the application – one for alignment and one for all providers/suppliers; will anyone on the ‘all’ list receive PQRS credit for reporting through the ACO?
   A. The application asks for two lists: providers/suppliers that will be used for alignment and all providers/suppliers in the ACO. These two lists taken together represent the totality of the ACO’s Next Generation Providers/Suppliers. CMS’ intent is that all providers and suppliers on the ACO’s final, Next Generation Provider/Supplier list would be covered for PQRS reporting. More information on the final policy will be in the participation agreement.

48. 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 2016?
   A. Yes. In Next Generation, an ACO’s quality score is used in determining the discount applied to the prospective benchmark. In PY1 (2016), 100% will be used as the quality score for all Next Generation ACOs. However, if an ACO fails to report in PY1, CMS will retroactively recalculate the discount to reflect this failure to report. Additional terms and conditions regarding failure to report quality data will be 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.

49. 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. ACOs will be asked to demonstrate EHR capabilities in the Model’s application, and this capacity will be an application selection criterion, including the percentage of eligible professionals in the Applicant ACO that have attested to Electronic Health Record (EHR) Stage 2 Meaningful Use Criteria by December 31, 2014.

50. Will Next Generation ACOs receive at least quarterly financial performance reporting?
   A. Yes. ACOs will receive various types of financial reports, including monthly and quarterly reports. ACOs will also, under the appropriate data use agreement (DUA), receive beneficiary claims data.

51. Can you provide information on the requirement that Next Generation ACOs enter into outcomes-based contracts with other purchasers?
   A. Outcomes-Based contracts are addressed in Section V.G of the RFA. CMS expects that in order to be successful undertaking this level of accountability and risk in the Next Generation Model, an organization should be developing outcomes-based revenue streams across all revenue to support systemic change in care systems and operations away from fee-for-service and towards fee-for-value. Outcomes-based contracts are those that include financial accountability (shared savings and/or financial risk), patient experience evaluations, and substantial quality performance incentives. While the ACO may be a unique entity for participation in the Next Generation ACO Model, the outcomes-based contracting calculation will look at ACO providers’/suppliers’ revenue in determining the proportion in outcomes-based arrangements. More information about this program requirement will be in the participation agreement.