Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Seamless Care Models Group
7205 Windsor Blvd
Baltimore, MD 21244

Next Generation ACO Model
Participation Agreement

Last Modified: December 14, 2015

Contents

PARTICIPATION AGREEMENT

This participation agreement ("**Agreement**") is between the CENTERS FOR MEDICARE & MEDICARE SERVICES ("**CMS**") and _____, an accountable care organization ("**ACO**").

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

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

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

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

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

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

The parties therefore agree as follows:

I. Agreement Term and Renewal

A. This Agreement will become effective when it is signed by both parties. The effective date of this Agreement (the "**Effective Date**") will be the date this Agreement is signed by the last party to sign it (as indicated by the date associated with that party's signature). This Agreement will conclude at the end of three Performance Years (the "**Initial Term**") or at the end of a renewal period, unless sooner terminated by either party in accordance with Section XIX.

B. The first Performance Year of this Agreement shall begin on January 1, 2016 (the "**Start Date**") and end on December 31, 2016. Subsequent Performance Years shall each be 12 months in duration, beginning on January 1.

C. CMS may offer to renew this Agreement for a renewal period of an additional two Performance Years. In deciding whether to offer to renew this Agreement, CMS may consider the ACO's actual spending in relation to the Performance Year Benchmark; the ACO's quality score performance; the ACO's history of compliance with the terms of this Agreement and Medicare program requirements; the results of a program integrity screening of the ACO, its Next Generation Participants, and its Next Generation Professionals; the ACO's ability to repay in full any Shared Losses and Other Monies Owed; and such other criteria CMS deems relevant. If CMS offers to renew this Agreement, CMS shall make a written offer to renew this Agreement at least 60 days before the expiration of the Initial Term. The ACO shall accept or reject such offer in writing by a date and in a manner specified by CMS.

II. Definitions

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

"Alternative Payment Mechanism" means the manner in which CMS will make interim payments to the ACO during a Performance Year. The two Alternative Payment Mechanisms available for selection are Infrastructure Payments and PBP.

"At-Risk Beneficiary" means a Beneficiary who—

A. Has a high risk score on the CMS-Hierarchical Condition Category (HCC) risk adjustment model;

B. Is considered high cost due to having two or more hospitalizations or emergency room visits each year;

C. Is dually eligible for Medicare and Medicaid;

D. Has a high utilization pattern;

E. Has one or more chronic conditions;

F. Has had a recent diagnosis that is expected to result in increased cost

G. Is entitled to Medicaid because of disability;

H. Is diagnosed with a mental health or substance abuse disorder; or

I. Meets such other criteria as specified in writing by CMS.

"Beneficiary" means an individual who is enrolled in Medicare.

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

"CCN" means a CMS Certification Number.

"Coordinated Care Reward" means payment from CMS to a Beneficiary to reward the Beneficiary for receiving at least a certain percentage of his or her total Medicare Parts A and B services from Next Generation Participants and Preferred Providers when the Beneficiary was a Next Generation Beneficiary. CMS will devise the methodology for determining which Beneficiaries are entitled to the payment and determining the manner in which it calculates and issues the payment.

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

"Days" means calendar days unless otherwise specified.

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

"FFS" means fee-for-service.

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

"Legacy TIN" means a TIN that a Next Generation Participant or Preferred Provider previously used for billing Medicare Parts A and B services but no longer uses to bill for those services, and includes a "sunsetted" Legacy TIN (a TIN that is no longer used for billing for Medicare Parts A and B services by any Medicare provider or supplier) or an "active" Legacy TIN (a TIN that may

be in use by a Medicare provider or supplier that is not a Next Generation Participant or Preferred Provider).

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

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

"Next Generation Participant" means an individual or entity that:

A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);

B. Is identified on the Participant List in accordance with Section IV;

C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;

D. Is not a Preferred Provider;

E. Is not a Prohibited Participant; and

F. Pursuant to a written agreement with the ACO, has agreed to participate in the Model, to report quality data through the ACO, and to comply with care improvement objectives and Model quality performance standards.

"Next Generation Professional" means a Next Generation Participant who is either:

A. A physician (as defined in section 1861(r) of the Act); or

B. One of the following non-physician practitioners:

1. Physician assistant who satisfies the qualifications set forth at 42 CFR § 410.74(a)(2)(i)-(ii);

2. Nurse practitioner who satisfies the qualifications set forth at 42 CFR § 410.75(b);

3. Clinical nurse specialist who satisfies the qualifications set forth at 42 CFR § 410.76(b);

4. Certified registered nurse anesthetist (as defined at 42 CFR § 410.69(b));

5. Certified nurse midwife who satisfies the qualifications set forth at 42 CFR § 410.77(a);

6. Clinical psychologist (as defined at 42 CFR § 410.71(d));

7. Clinical social worker (as defined at 42 CFR § 410.73(a)); or

8. Registered dietician or nutrition professional (as defined at 42 CFR § 410.134).

"NPI" means a national provider identifier.

"Other Monies Owed" means a monetary amount that represents a reconciliation of monthly payments made by CMS during a Performance Year, including payments made through Alternative Payment Mechanisms, and is neither Shared Savings nor Shared Losses. Such

calculations shall be made in accordance with Appendix B and reconciliation shall be performed pursuant to Section XIV.B.

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

"PBP" means the population-based payment Alternative Payment Mechanism in which CMS makes a monthly payment ("**Monthly PBP**") reflecting an estimate, based on historical expenditures, of the percentage of total expected Medicare Part A and/or Part B FFS payments for items and services furnished to Next Generation Beneficiaries by Next Generation Participants who have agreed to receive Reduced FFS Payments.

"PBP Fee Reduction" means the percentage by which Medicare FFS payments to selected Next Generation Participants for services furnished to Next Generation Beneficiaries are reduced to account for the monthly payments made by CMS to the ACO under PBP.

"Performance Year" means the 12-month period beginning on January 1 of each year during the term of this Agreement.

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

"Preferred Provider" means an individual or entity that:

A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);

B. Is identified on the Preferred Provider List in accordance with Section IV;

C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;

D. Is not a Next Generation Participant;

E. Is not a Prohibited Participant; and

F. Has agreed to participate in the Model pursuant to a written agreement with the ACO.

"Preferred Provider List" means the list of Preferred Providers that are approved by CMS for participation in the Next Generation Model, as updated from time to time in accordance with Section IV of this Agreement.

"Prohibited Participant" means an individual or entity that is: (1) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier, (2) an ambulance supplier, (3) a drug or device manufacturer, or (4) excluded or otherwise prohibited from participation in Medicare or Medicaid.

"Reduced FFS Payment" means the applicable Medicare FFS payment for covered items and services furnished by Next Generation Participants to Next Generation Beneficiaries, less the PBP Fee Reduction.

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

"Rural ACO" means an ACO in this Model for which at least 40 percent of the zip 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.

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

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

"TIN" means a federal taxpayer identification number.

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

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

III. ACO Composition

A. ACO Legal Entity

1. The ACO shall be a legal entity identified by a TIN formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates for purposes of the following:

   (a) Receiving and distributing Shared Savings;

   (b) Repaying Shared Losses or Other Monies Owed to CMS;

   (c) Establishing, reporting, and ensuring Next Generation Participant compliance with health care quality criteria, including quality performance standards; and

   (d) Fulfilling ACO Activities identified in this Agreement.

2. If the ACO was formed by two or more Next Generation Participants, the ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers.

3. If the ACO was formed by a single Next Generation Participant, the ACO's legal entity and governing body may be the same as that of the Next Generation Participant if the ACO satisfies the requirements of Section III.B.

4. The ACO is deemed to satisfy the requirements of Sections III.A.1 and III.A.2 if, as of the Effective Date, it was a Pioneer ACO pursuant to a Pioneer ACO Model Innovation Agreement or a Medicare Shared Savings Program ("**MSSP**") ACO pursuant to a participation agreement (as defined at 42 C.F.R. § 425.20).

5. During the term of this Agreement, the ACO shall not participate in the MSSP, the independence at home medical practice pilot program under section 1866E of the Act, another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings.

B. ACO Governance

1. General

(a) The ACO shall maintain an identifiable governing body with sole and exclusive authority to execute the functions of the ACO and make final decisions on behalf of the ACO. The ACO shall have a governing body that satisfies the following criteria:

i. The governing body has responsibility for oversight and strategic direction of the ACO and is responsible for holding ACO management accountable for the ACO's activities;

ii. The governing body is separate and unique to the ACO, except as permitted under section III.A.3;

iii. The governing body has a transparent governing process;

iv. When acting as a member of the governing body of the ACO, each governing body member has a fiduciary duty to the ACO, including the duty of loyalty, and shall act consistent with that fiduciary duty; and

v. The governing body shall receive regular reports from the designated compliance official of the ACO that satisfies the requirements of XVII.A.1.

(b) The ACO shall provide each member of the governing body with a copy of this Agreement.

2. Composition and Control of the Governing Body

(a) The ACO governing body shall include at least one Beneficiary served by the ACO who:

i. Does not have a conflict of interest with the ACO;

ii. Has no immediate family member with a conflict of interest with the ACO;

iii. Is not a Next Generation Participant or Preferred Provider; and

iv. Does not have a direct or indirect financial relationship with the ACO, a Next Generation Participant, or a Preferred Provider, except that such

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

(b) The ACO governing body shall include at least one person with training or professional experience in advocating for the rights of consumers ("**Consumer Advocate**"), who may be the same person as the Beneficiary and who:

i. Does not have a conflict of interest with the ACO;

ii. Has no immediate family member with a conflict of interest with the ACO;

iii. Is not a Next Generation Participant or Preferred Provider; and

iv. Does not have a direct or indirect financial relationship with the ACO, a Next Generation Participant, or a Preferred Provider, except that such person may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO.

(c) The ACO Governing body shall not include a Prohibited Participant, or an owner, employee or agent of a Prohibited Participant.

(d) If Beneficiary and/or consumer advocate representation on the ACO governing body is prohibited by state law, the ACO shall notify CMS and request CMS approval of an alternative mechanism to ensure that its policies and procedures reflect consumer and patient perspectives. CMS shall use reasonable efforts to approve or deny the request within 30 days.

(e) The governing body members may serve in similar or complementary roles or positions for Next Generation Participants or Preferred Providers.

(f) At least 75 percent control of the ACO's governing body shall be held by Next Generation Participants or their designated representatives. The Beneficiary and consumer advocate required under this Section shall not be included in either the numerator or the denominator when calculating the percent control.

3. Conflict of Interest

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

(a) Requires each member of the governing body to disclose relevant financial interests;

(b) Provides a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and

(c) Addresses remedial actions for members of the governing body that fail to comply with the policy.

C. ACO Leadership and Management

1. The ACO's operations shall be managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.

2. Clinical management and oversight shall be managed by a senior-level medical director who is:

   (a) A Next Generation Participant;

   (b) Physically present on a regular basis at any clinic, office, or other location participating in the ACO; and

   (c) A board-certified physician and licensed in a state in which the ACO operates.

D. ACO Financial Arrangements

1. The ACO shall not condition a Next Generation Participant's or Preferred Provider's participation in the Model, directly or indirectly, on referrals of items or services provided to Beneficiaries who are not aligned to the ACO.

2. The ACO shall not require that Next Generation Beneficiaries be referred only to Next Generation Participants or Preferred Providers or to any other provider or supplier. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Next Generation Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Next Generation Beneficiary's best medical interests in the judgment of the referring party.

3. The ACO shall not condition the eligibility of an individual or entity to be a Next Generation Participant or Preferred Provider on the individual's or entity's offer or payment of cash or other remuneration to the ACO or any other individual or entity.

4. The ACO, its Next Generation Participants, and/or Preferred Providers shall not take any action to limit the ability of a Next Generation Participant or Preferred Provider to make decisions in the best interests of the Beneficiary, including the selection of devices, supplies and treatments used in the care of the Beneficiary.

5. The ACO shall notify CMS within 15 days after becoming aware that any Next Generation Participant or Preferred Provider is under investigation or has been sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges). If a Next Generation Participant or Preferred Provider is under investigation or has been sanctioned but not excluded from Medicare program participation, CMS may take any of the actions set forth in Section XIX.

6. By the date specified in Section III.D.7, below, the ACO shall have a written agreement with each of the individuals and entities that are approved by CMS to be Next Generation Participants or Preferred Providers that complies with the following criteria:

   (a) The only parties to the agreement are the ACO and the Next Generation Participant or Preferred Provider.

   (b) The agreement requires the Next Generation Participant or Preferred Provider to agree to participate in the Model, to engage in ACO Activities, to comply with the applicable terms of the Model as set forth in this Agreement, and to comply with all applicable laws and regulations (including, but not limited to, those specified at Section XVII.D). The ACO shall provide each Next Generation Participant and Preferred Provider with a copy of this Agreement.

   (c) The agreement expressly sets forth the Next Generation Participant's or Preferred Provider's obligation to comply with the applicable terms of this Agreement, including provisions regarding the following: participant exclusivity, quality measure reporting, and continuous care improvement objectives for Next Generation Participants; Voluntary Alignment; Beneficiary freedom of choice; Benefit Enhancements; the Coordinated Care Reward; participation in evaluation, shared learning, monitoring, and oversight activities; the ACO compliance plan; and audit and record retention requirements.

   (d) The agreement requires the Next Generation Participant or Preferred Provider to update its Medicare enrollment information (including the addition and deletion of Next Generation Professionals that have reassigned to the Next Generation Participant or Preferred Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.

   (e) The agreement requires the Next Generation Participant or Preferred Provider to notify the ACO of any changes to its Medicare enrollment information within 30 days after the change.

   (f) The agreement requires the Next Generation Participant or Preferred Provider to notify the ACO within seven days of becoming aware that it is under investigation or has been sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).

   (g) The agreement permits the ACO to take remedial action against the Next Generation Participant or Preferred Provider (including the imposition of a corrective action plan, denial of incentive payments such as Shared Savings distributions, and termination of the ACO's agreement with the Next Generation Participant or Preferred Provider) to address noncompliance with the terms of the Model or program integrity issues identified by CMS.

(h) The agreement is for a term of at least one year, but permits early termination if CMS requires the ACO to remove the Next Generation Participant or Preferred Provider pursuant to Section XIX.A.1.

(i) The agreement requires the Next Generation Participant to complete a close-out process upon termination or expiration of the agreement that requires the Next Generation Participant to furnish all quality measure reporting data.

7. The ACO shall have fully executed written agreements in place that meet the requirements set forth in Section III.D.6 by the following dates:

(a) For agreements with individuals and entities approved by CMS to be Next Generation Participants –

i. For 2016 (Performance Year 1), by the Start Date.

ii. For each subsequent Performance Year, by the date the ACO certifies its list in accordance with Section IV.E.5.

(b) For agreements with individuals or entities approved by CMS to be Preferred Providers on the list specified in Section IV.C.4, by the Start Date, unless the ACO has elected to defer participation of Preferred Providers until February 1, 2016.

(c) By February 1, 2016, if the ACO has elected to defer participation of Preferred Providers until February 1, 2016. If the ACO has elected to defer participation of Preferred Providers, none of the individuals or entities approved by CMS to be Preferred Providers and identified on the list specified in Section IV.C.4 may participate in the Model until February 1, 2016. If the ACO has elected such deferral, it must:

- Check the following box:

☐ The ACO elects to defer participation of Preferred Providers until February 1, 2016

- By no later than the Start Date of the Model, notify each individual or entity on the list identified in Section IV.C.4 that the ACO has elected to defer participation of Preferred Providers and that the ACO's Preferred Providers will begin participation on February 1, 2016, regardless of when the written agreement is signed.

(d) For agreements with individuals or entities approved by CMS in accordance with Section IV.E.5 to be Preferred Providers for any subsequent Performance Year, by the date the ACO certifies its list for such Performance Year.

(e) For agreements with individuals or entities approved by CMS to be added as Preferred Providers during any Performance Year in accordance with Section IV.D.1, by the date the ACO requests the addition of the individual or entity to the Preferred Provider List.

8. The ACO shall not distribute Shared Savings to any Next Generation Participant or Preferred Provider that has been terminated pursuant to Section XIX.A.1.

9. CMS provides no opinion on the legality of any contractual or financial arrangement that the ACO, a Next Generation Participant, or a Preferred Provider has proposed, implemented, or documented. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

IV. Next Generation Participants and Preferred Providers

A. General

1. Next Generation Participants and Preferred Providers will be included on the Participant List or Preferred Provider List only upon the prior written approval of CMS.

2. CMS shall maintain the Participant List and Preferred Provider List in a manner that permits the ACO to review the list.

3. The ACO shall maintain current and historical Participant Lists and Preferred Provider Lists in accordance with Section XVIII.

B. Initial Next Generation Participant List

1. The parties acknowledge that the ACO submitted to CMS a proposed list of Next Generation Participants, identified by name, NPI, TIN, Legacy TIN (if applicable), and CCN (if applicable). The proposed list also identified which individuals and entities, if any, had agreed to receive a PBP Fee Reduction, and specified the Benefit Enhancements, if any, in which each individual or entity had agreed to participate.

2. CMS states that it has reviewed the proposed list of Next Generation Participants and conducted a program integrity screening on the proposed Next Generation Participants.

3. CMS states that it has submitted to the ACO a list of individuals and entities that it approved to be Next Generation Participants. The ACO states that it reviewed the list and made any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Model as of the Start Date pursuant to a written agreement.

4. The ACO states that it has submitted to CMS an initial Participant List that the ACO has certified is a true, accurate and complete list identifying all of the ACO's Next Generation Participants approved by CMS to participate in the Model as of the Start Date and with whom the ACO will have a fully executed written agreement meeting the requirements in Section III.D.6. The ACO further states that the initial Participant List specifies which Next Generation Participants, if any, have agreed to receive a PBP Fee Reduction, and designates the Benefit

Enhancements, if any, in which each Next Generation Participant has agreed to participate.

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

C. Initial Preferred Provider List

1. The parties acknowledge that the ACO submitted to CMS a proposed list of Preferred Providers identified by name, NPI, TIN, Legacy TIN (if applicable), and CCN (if applicable), and the Benefit Enhancements, if any, in which each individual or entity had agreed to participate.

2. CMS states that it has reviewed the proposed list of Preferred Providers and conducted a program integrity screening on the proposed Preferred Providers.

3. CMS states that it has submitted to the ACO a list of individuals and entities that it has approved to be Preferred Providers. The ACO states that it has reviewed the list and made any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Model.

4. The ACO states that it has submitted to CMS an initial Preferred Provider List that the ACO has certified is a true, accurate and complete list identifying all of the ACO's Preferred Providers approved by CMS to participate in the Model as of the date specified in Section III.D.7.b.i, and with whom the ACO will have, by the date specified in Section III.D.7.b.i, a fully executed written agreement meeting the requirements in Section III.D.6. The ACO further states that the initial Preferred Provider List specifies the Benefit Enhancements, if any, in which each Preferred Provider has agreed to participate.

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

D. Updating Lists During the Performance Year

1. Additions to a List

(a) The ACO shall not request the addition of a Next Generation Participant except in accordance with Section IV.E.

(b) The ACO shall not add an individual or entity to the Preferred Provider List during a Performance Year without prior written approval from CMS. If the ACO wishes to add an individual or entity to the Preferred Provider List during a Performance Year, it shall submit a request to CMS in the form and manner specified by CMS. CMS may reject the request on the basis that the individual or entity fails to satisfy the definition of Preferred Provider, or on the basis of information obtained from a program integrity screening. If CMS approves the request, the individual or entity will be added to the Preferred Provider List effective on the date the addition is approved by CMS.

2. Removals from a List

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

3. Updating Enrollment Information

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

E. Annual Updates to Participant List and Preferred Provider List

1. Proposed Participant and Preferred Provider Lists

Prior to the second and subsequent Performance Years, the ACO shall submit to CMS by a date and in a manner specified by CMS proposed lists identifying each individual or entity that the ACO expects to participate in the Model as a Next Generation Participant or Preferred Provider effective at the start of the next Performance Year ("**Proposed Participant List**" and "**Proposed Preferred Provider List,**" respectively). CMS shall specify a submission deadline for the proposed lists that is no later than 90 days before the start of the next Performance Year. The proposed lists must –

(a) Identify each individual or entity by name, NPI, TIN, Legacy TIN (if applicable), and CCN (if applicable);

(b) Identify the individuals and entities, if any, that have agreed to a PBP Fee Reduction; and

(c) Identify the Benefit Enhancements, if any, in which each individual or entity has agreed to participate.

2. ACO Notice to Proposed Participants and Preferred Providers

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

(a) State that the individual or entity and any relevant TINs through which it bills Medicare will be identified on the relevant list;

(b) Specify, if applicable, that the list will indicate that the individual has agreed to a PBP Fee Reduction; and

(c) State that participation in the Model may preclude the individual from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.

3. ACO Notice to TINs

At least 30 days prior to submitting its proposed Participant List and proposed Preferred Provider List to CMS, the ACO shall furnish written notification to the executive of any TIN through which a Next Generation Participant or Preferred Provider bills Medicare. Such notification must:

(a) Identify by name and NPI any individual associated with the TIN that will be identified on the ACO's Proposed Participant List or Proposed Preferred Provider List and whether the individual has agreed to a PBP Fee Reduction; and

(b) Inform the entity that an individual's participation in the ACO may preclude the entire TIN from receiving payment adjustments through the value-based payment modifier under section 1848(p) of the Act and from participating in the MSSP.

4. CMS Review of Proposed Lists

(a) With respect to each individual and entity identified on the Proposed Participant List and Proposed Preferred Provider List, CMS shall conduct a program integrity screening, including a review of the individual's or entity's history of Medicare program exclusions, current or prior law enforcement investigations, or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.

(b) CMS may reject any proposed Next Generation Participant or Preferred Provider on the basis of the results of a program integrity screening, history of program integrity issues, or if it determines that the individual or entity does not satisfy the definition of Next Generation Participant or Preferred Provider.

(c) No later than 60 days before the start of the next Performance Year, CMS shall submit to the ACO a preliminary list of individuals and entities that CMS has approved to be Next Generation Participants effective at the start of the next Performance Year (including PBP Fee Reduction and Benefit Enhancement information, as applicable) and a preliminary list of individuals and entities that it has approved to be Preferred Providers (including Benefit Enhancement information, as applicable) effective at the start of the next Performance Year.

5. ACO Certification of Lists

(a) The ACO shall review the preliminary list of approved Next Generation Participants, make any necessary corrections to it (including the removal of any individuals or entities that have not agreed to participate in the Model pursuant to a written agreement with the ACO or are otherwise ineligible to participate), and return the list (as corrected by the ACO, if applicable) to CMS with a certification that it is a true, accurate, and complete lists of the individuals and entities that are approved by CMS to be Next Generation Participants effective January 1 of the relevant Performance Year. The certified list submitted to CMS shall be the Participant List effective January 1 of the relevant Performance Year. The ACO shall update such list in accordance with this Agreement.

(b) The ACO shall review the preliminary list of approved Preferred Providers, make any necessary corrections to it (including the removal of any individuals or entities that have not agreed to participate in the Model for the next Performance Year pursuant to a written agreement with the ACO or are otherwise ineligible to participate), and return the list (as corrected by the ACO, if applicable) to CMS with a certification that it is a true, accurate, and complete list of the individuals and entities that are approved by CMS to be Preferred Providers effective January 1 of the relevant Performance Year. The certified list submitted to CMS shall be the Preferred Provider List effective January 1 of the relevant Performance Year. The ACO shall update such list in accordance with this Agreement.

F. Non-Duplication and Exclusivity of Participation

1. The ACO and its Next Generation Participants may not participate in any other Medicare shared savings initiatives, as described in Appendix A.

2. CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and in the implementing regulations at 42 C.F.R. § 425.114(a) regarding participation in a model tested under section 1115A of the Act that involves shared savings as they apply to Preferred Providers, subject to the conditions and requirements set forth in Appendix A.

3. The ACO and its Next Generation Participants and Preferred Providers are bound by the participation overlap provisions set forth in Appendix A.

V. Beneficiary Alignment, Engagement, and Protections

A. Beneficiary Alignment

1. CMS shall, according to the methodology set forth in Appendix B, use an analysis of evaluation and management services furnished by Next Generation Professionals to Beneficiaries to align Beneficiaries to the ACO for the purposes of the Next Generation ACO Model.

2. The removal of a Next Generation Participant or Preferred Provider from the Next Generation Participant List or Preferred Provider List, pursuant to Section IV.D, will not affect the alignment of Next Generation Beneficiaries to the ACO for the Performance Year during which the removal becomes effective.

B. Alignment Minimum

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

C. Voluntary Alignment

1. General

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

2. Influencing or Attempting to Influence the Beneficiary

(a) The ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities are prohibited from providing gifts or other remuneration to Beneficiaries as inducements for influencing a Beneficiary's decision to complete or not complete a Voluntary Alignment Form.

(b) The ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities shall not, directly or indirectly, commit any act or omission, nor adopt any policy, that coerces or otherwise influences a Beneficiary's decision to complete or not complete a Voluntary Alignment Form, including but not limited to the following:

i. Offering of anything of value to the Beneficiary;

ii. Including the Voluntary Alignment Form and instructions with any other materials or forms, including but not limited to materials requiring the signature of the Beneficiary; and

iii. Withholding or threatening to withhold medical services or limiting or threatening to limit access to care.

(c) For purposes of Section V.H.2, any items or services provided in violation of this Section V.C.2 will not be considered to have a reasonable connection to the medical care of the Beneficiary.

3. Enforcement

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

4. Modification or Elimination of Voluntary Alignment

Notwithstanding Section XXI.D, CMS may amend this Agreement without ACO consent to revise or remove the provisions of Appendix C.

D. Beneficiary Notifications

1. Within 30 days after CMS has provided the ACO with its Next Generation Beneficiary alignment list for a Performance Year, the ACO shall provide Next Generation Beneficiaries notice in writing that they have been aligned to the ACO for the Performance Year.

2. CMS shall provide the ACO with a template letter indicating letter content that the ACO shall not change and places in which the ACO may insert its own original content.

3. Pursuant to Section V.E, the ACO shall obtain CMS approval of the final notification letter content, which includes the ACO's own original content, prior to sending letters to Next Generation Beneficiaries.

E. Descriptive ACO Materials and Activities

1. The ACO shall not use, and shall prohibit its Next Generation Participants and Preferred Providers from using Descriptive ACO Materials or Activities until reviewed and approved in their entirety by CMS.

2. Descriptive ACO Materials or Activities are deemed approved 10 business days following their submission to CMS if:

   (a) The ACO certifies in writing its compliance with all the marketing requirements under this section; and

   (b) CMS does not disapprove the Descriptive ACO Materials or Activities.

3. CMS may issue written notice of disapproval of Descriptive ACO Materials or Activities at any time, including after the expiration of the 10 day review period.

4. The ACO, Next Generation Participants, Preferred Providers, or any other individuals or entities performing functions or services related to ACO activities, as applicable, must immediately discontinue use of any Descriptive ACO Materials or Activities disapproved by CMS.

5. Any material changes to CMS-approved Descriptive ACO Materials and Activities must be reviewed and approved by CMS before use.

6. The ACO shall retain copies of all written and electronic Descriptive ACO Materials and Activities and appropriate records for all other Descriptive ACO Materials and Activities provided to Next Generation Beneficiaries in a manner consistent with Section XVIII.

F. Availability of Services

1. The ACO shall require its Next Generation Participants and Preferred Providers to make Medically Necessary Covered Services available to Next Generation Beneficiaries in accordance with applicable laws, regulations and guidance. Next Generation Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR § 405, Subpart I.

2. The ACO and its Next Generation Participants and Preferred Providers shall not take any action to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services with the purpose of trying to ensure alignment in a future period.

G. Beneficiary Freedom of Choice

1. Consistent with section 1802(a) of the Act, neither the ACO nor any Next Generation Participant, Preferred Provider, or other individuals or entities performing functions or services related to ACO Activities shall commit any act or omission, nor adopt any policy, that inhibits Next Generation Beneficiaries from exercising their freedom to obtain health services from providers and suppliers who are not Next Generation Participants or Preferred Providers. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Next Generation Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Next Generation Beneficiary's best medical interests in the judgment of the referring party.

2. Notwithstanding the foregoing, the ACO may communicate to Next Generation Beneficiaries the benefits of receiving care with the ACO. All such communications shall be deemed Descriptive ACO Materials and Activities. CMS may provide the ACO with scripts, talking points or other materials explaining these benefits.

H. Prohibition on Beneficiary Inducements

1. General Prohibition

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

remuneration to Beneficiaries to induce them to receive items or services from the ACO, Next Generation Participants, or Preferred Providers, or to induce them to continue to receive items or services from the ACO, Next Generation Participants or Preferred Providers.

2. Exception

(a) Consistent with the provisions of Section V.H.1, and subject to compliance with all other applicable laws and regulations, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities may provide in-kind items or services to Beneficiaries if the following conditions are satisfied:

i. There is a reasonable connection between the items and services and the medical care of the Beneficiary; and

ii. The items and services are preventive care items and services or advance a clinical goal for the Beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition.

(b) For each in-kind item or service provided by a Next Generation Participant or Preferred Provider under V.H.2.a, above, the ACO shall maintain records of the following:

i. The nature of the in-kind item or service;

ii. The identity of each Beneficiary that received the in-kind item or service;

iii. The identity of the individual or entity that furnished the in-kind item or service; and

iv. The date the in-kind item or service was furnished.

I. HIPAA Requirements

1. The ACO acknowledges that it is a covered entity or a business associate, as those terms are defined in 45 CFR § 160.103, of Next Generation Participants who are covered entities.

2. The ACO shall have all appropriate administrative, technical, and physical safeguards in place before the start of the first Performance Year to protect the privacy and security of protected health information in accordance with 45 CFR § 164.530(c).

3. The ACO shall maintain the privacy and security of all Model-related information that identifies individual Beneficiaries in accordance with the Health Insurance Portability and Accountability (HIPAA) Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of protected health information by covered entities, as well as applicable state laws and regulations.

VI. Data Sharing and Reports

A. General

1. Subject to the limitations discussed in this Agreement, the Data Use Agreement (DUA) (Appendix D), the Data Sharing and Reports Appendix (Appendix E), and in accordance with applicable law, CMS may provide certain data and reports to the ACO upon request by the ACO including but not limited to those described herein.

2. The ACO represents and warrants that the use of this data will be only to develop and implement activities related to coordinating care and improving the quality and efficiency of care for the Next Generation Beneficiaries.

3. The data and reports provided to the ACO shall not include individually identifiable data for Next Generation Beneficiaries who have opted out of data sharing with the ACO. Data and reports provided to the ACO shall not include substance abuse data for any Next Generation Beneficiaries who have not opted into substance abuse data sharing, as described in Section VI.D of this Agreement.

B. Data Privacy Compliance and Indemnity

1. The ACO shall comply with all laws pertaining to the data provided by CMS under this Agreement, including without limitation the standards for the privacy of individually identifiable health information and the security standards for the protection of electronic protected health information promulgated pursuant to the HIPAA and the Health Information Technology for Economic and Clinical Health Act.

2. The ACO shall indemnify the Government and its officers, agents, and employees acting for the Government against any liability, including costs and expenses, incurred as the result of: (a) a violation by the ACO of such laws or improper or illegal use of any data furnished under this Agreement; or (b) any libelous or other unlawful matter contained in such data. The provisions of this paragraph do not apply unless the Government provides notice to the ACO as soon as practicable of any third party claim or suit, affords the ACO an opportunity under applicable laws, rules, or regulations to participate in the defense thereof, and obtains the ACO's consent to the settlement of any suit or claim other than as required by final decree of a court of competent jurisdiction.

C. Beneficiary Rights to Opt Out of Data Sharing

1. The ACO shall provide Next Generation Beneficiaries who inquire about and wish to modify their data sharing preferences information about how to modify their data sharing preferences via 1-800-MEDICARE.

2. The ACO shall allow Next Generation Beneficiaries to reverse a data sharing preference at any time by calling 1-800-MEDICARE.

3. CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in this Model, the MSSP, or the Pioneer ACO Model.

4. The ACO may affirmatively contact a Next Generation Beneficiary who has elected to decline data sharing no more than one time in a given Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Next Generation Beneficiaries outside of a clinical setting.

5. In the event that a Next Generation Professional is terminated from the ACO for any reason, if that departing Next Generation Professional is the sole Next Generation Professional in the ACO to have submitted claims for a particular Next Generation Beneficiary during the 12-month period prior to the effective date of the termination, CMS shall opt the Next Generation Beneficiary out of all data-sharing under this Section VI within 30 days of the effective date of the termination, unless—

   (a) The Next Generation Beneficiary affirmatively consents to continued data sharing with the ACO through an authorization that meets the requirements under 45 CFR 164.508(b); or

   (b) The Next Generation Beneficiary has become the patient of another Next Generation Professional.

6. Notwithstanding the foregoing, an ACO shall receive data regarding substance abuse treatment only if the Next Generation Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved form pursuant to Section VI.D.

7. CMS shall opt into data sharing a Next Generation Beneficiary who was opted out of data sharing solely due to the termination of a Next Generation Professional if he/she is subsequently aligned to the ACO, unless the Next Generation Beneficiary affirmatively opts out of data sharing according to this Section VI.C.

D. Beneficiary Substance Abuse Data Opt-In

1. The ACO may inform each newly-aligned Next Generation Beneficiary, in compliance with applicable law:

   (a) That he/she may elect to allow the ACO to receive Beneficiary-level data regarding the utilization of substance abuse services;

   (b) Of the mechanism by which the Next Generation Beneficiary can make this election; and

   (c) That 1-800-Medicare will answer any questions regarding data sharing of substance abuse services.

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

E. Certification of Data and Information

1. With respect to data and information that are generated or submitted by the ACO, Next Generation Participants, Preferred Providers, or other individuals or entities

performing functions or services related to ACO Activities, the ACO shall ensure that an individual with the authority to legally bind the individual or entity submitting such data or information certifies the accuracy, completeness, and truthfulness of the data and information to the best of his or her knowledge information , knowledge and belief. Such certifications are a condition of receiving Shared Savings and Other Monies Owed.

2. At the end of each performance year, an individual with the legal authority to bind the ACO must certify to the best of his or her knowledge, information, and belief—

   (a) That the ACO, its Next Generation Participants, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities are in compliance with program requirements; and

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

VII. Care Improvement Objectives

A. General

1. The ACO shall implement processes and protocols that relate to the following objectives for patient-centered care:

   (a) Promotion of evidence-based medicine, such as through the establishment and implementation of evidence-based guidelines at the organizational or institutional level. An evidence-based approach would also regularly assess and update such guidelines.

   (b) Process to ensure Beneficiary/caregiver engagement, and shared decision making processes employed by Next Generation Participants that takes into account the Beneficiaries' unique needs, preferences, values, and priorities. Measures for promoting Beneficiary engagement include, but are not limited to, the use of decision support tools and shared decision making methods with which the Beneficiary can assess the merits of various treatment options in the context of his or her values and convictions. Beneficiary engagement also includes methods for fostering what might be termed "health literacy" in Beneficiaries and their families.

   (c) Coordination of Beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote Beneficiary monitoring, and other enabling technologies).

(d) Providing Beneficiaries access to their own medical records and to clinical knowledge so that they may make informed choices about their care.

(e) Ensuring individualized care for Beneficiaries, such as through personalized care plans.

(f) Routine assessment of Beneficiary and caregiver and/or family experience of care and seek to improve where possible.

(g) Providing care that is integrated with the community resources Beneficiaries require.

2. The ACO shall require its Next Generation Participants to comply with and implement these designated processes and protocols, and shall institute remedial processes and penalties, as appropriate, for Next Generation Participants that fail to comply with or implement a required process or protocol.

B. Outcomes-Based Contracts with Other Purchasers

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

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

VIII. ACO Quality Performance

A. Quality Scores

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

B. Quality Measures

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

C. Quality Measure Reporting

1. The ACO must completely, timely, and accurately report quality measure data and shall require its Next Generation Participants to cooperate in quality measure reporting. Complete reporting means that the ACO meets all of the reporting requirements including timing and reporting the requested data for all measures.
2. CMS shall use the following sources for quality reporting:
   (a) ACO reporting via the Group Practice Reporting Option (GPRO) Web Interface tool;
   (b) ACO reporting of results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other patient experience surveys;
   (c) Medicare claims submitted for service to Next Generation Beneficiaries; and
   (d) Any other relevant data shared between the ACO and CMS pursuant to this Agreement.
3. For each Performance Year, the ACO is responsible for procuring a CMS-approved vendor to conduct the CAHPS or other patient experience surveys. The ACO is responsible for paying for the surveys for ensuring that the survey results are transmitted to CMS by a date and in a manner established by CMS.

D. Quality Performance Scoring

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

IX. 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 future regulation.

X. ACO Selections and Approval

A. ACO Selections

For each Performance Year, by a date and in a manner determined by CMS, the ACO shall notify CMS of the following:

1. The ACO's selected Risk Arrangement from the alternatives described in Appendix B;
2. The ACO's selected Alternative Payment Mechanism, if any;
3. The Benefit Enhancements, if any, that it elects to offer through its Next Generation Participants and Preferred Providers; and
4. The ACO's decision with respect to participation in Voluntary Alignment pursuant to Section V.C and Appendix C.

B. Risk Arrangement Approval

1. The ACO's Risk Arrangement selection for the first Performance Year shall be deemed approved upon execution of this Agreement.
2. In the second and subsequent Performance Years—
   (a) If the ACO's Risk Arrangement selection is the same as that of the previous Performance Year, the selection shall be deemed approved.
   (b) If the ACO's Risk Arrangement selection is different than that of the previous Performance Year, CMS shall accept or reject the ACO's Risk Arrangement selection according to the criteria set forth in Appendix B. Within 15 days of the ACO's submission of its Risk Arrangement selection for a Performance Year, CMS shall send the ACO written notice of approval or rejection of the selected Risk Arrangement.
   (c) If CMS rejects the ACO's Risk Arrangement selection for a Performance Year, the ACO will operate under the same Risk Arrangement as in the immediately preceding Performance Year.

C. Alternative Payment Mechanism Approval

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

XI. Benefit Enhancements

A. General

1. The ACO may elect to provide one or more Benefit Enhancements for a Performance Year. For each Benefit Enhancement elected under Section X, the ACO shall submit an "**Implementation Plan**" to CMS in a manner and by a date determined by CMS.

2. If the ACO elects to provide one or more Benefit Enhancements for a Performance Year, the ACO's Next Generation Participants and Preferred Providers, as indicated on the relevant Participant List and Preferred Provider List under Section IV, may submit claims for services furnished pursuant to a Benefit Enhancement as described in this Section during the Performance Year for which the ACO elected to provide the Benefit Enhancement. Appendices I, J, and K shall apply to this Agreement only if the ACO elected under Section X to provide the relevant Benefit Enhancement for a given Performance Year.

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

B. 3-Day SNF Rule Waiver Benefit Enhancement

1. Appendix I shall apply to this Agreement for any Performance Year for which the ACO submits an Implementation Plan for the 3-Day SNF Rule Waiver Benefit Enhancement.

2. The ACO shall require that, in order to be eligible to submit claims for services furnished to Next Generation Beneficiaries pursuant to the 3-Day SNF Rule Waiver Benefit Enhancement, an entity must be:

   (a) A Next Generation Participant or Preferred Provider;

   (b) A skilled-nursing facility ("**SNF**") or a hospital or critical access hospital that has swing-bed approval for SNF services ("**Swing-Bed Hospital**");

   (c) Designated on the Participant List or Preferred Provider List as participating in the 3-Day SNF Rule Waiver Benefit Enhancement; and

   (d) Approved by CMS according to the criteria described in Appendix I.

3. If CMS notifies the ACO that a SNF or Swing-Bed Hospital has not been approved for participation in the 3-Day SNF Rule Waiver Benefit Enhancement under this Section XI.B, but the provider is otherwise eligible to be a Next Generation Participant or Preferred Provider, the ACO may either remove the provider from the Participant List or Preferred Provider List, or amend the relevant list to reflect that the provider will not participate in the 3-Day SNF Rule Waiver Benefit Enhancement. The ACO shall amend the relevant list no later than 30 days after the date of the notice from CMS.

C. Telehealth Expansion

1. Appendix J shall apply to this Agreement for any Performance Year for which the ACO submits an Implementation Plan for the Telehealth Expansion Benefit Enhancement.

2. In order to be eligible to bill for telehealth services furnished to Next Generation Beneficiaries pursuant to the Telehealth Expansion Benefit Enhancement, an individual or entity must be:

   (a) A Next Generation Professional or Preferred Provider who is a physician or other practitioner;

   (b) Authorized under relevant Medicare rules and state law to bill for telehealth services;

   (c) Designated on the Participant List or Preferred Provider List as participating in the Telehealth Expansion Benefit Enhancement; and

   (d) Approved by CMS according to the criteria described in Appendix J.

3. The ACO shall ensure that Next Generation Participants and Preferred Providers do not substitute telehealth services for in-person services when in-person services are more clinically appropriate.

4. The ACO shall ensure that Next Generation Participants and Preferred Providers only furnish Medically Necessary telehealth services and do not use telehealth services to prevent or deter a Beneficiary from seeking or receiving in-person care when such care is Medically Necessary.

D. Post-Discharge Home Visits

1. Appendix K shall apply to this Agreement for any Performance Year for which the ACO submits an Implementation Plan for the Post-Discharge Home Visits Benefit Enhancement.

2. In order to be eligible to submit claims for post-discharge home visits furnished to Next Generation Beneficiaries pursuant to the Post-Discharge Home Visit Benefit Enhancement, the supervising physician or other practitioner must be:

   (a) Either

      i. A Next Generation Professional or Preferred Provider [who is a physician or other practitioner]; or

      ii. Eligible under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and

   (b) Designated on the Next Generation Participant List or Preferred Provider List as participating in the Post-Discharge Home Visit Benefit Enhancement.

3. The individual performing services under this Benefit Enhancement must be either:

(a) "Auxiliary personnel" as defined at 42 CFR § 410.26(a)(1); or

(b) Authorized under applicable state law to perform such functions.

4. The ACO shall ensure that post-discharge home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

E. Requirements for Termination of Benefit Enhancements

1. The ACO must obtain CMS consent before voluntarily discontinuing any Benefit Enhancement during a Performance Year.

2. In the event that during a Performance Year a Benefit Enhancement will cease to be in effect with respect to the ACO or any Next Generation Participant or Preferred Provider pursuant to Section XIX, the effective date of such termination shall be the date specified by CMS in the notice to the ACO.

   (a) Within 30 days after the effective date of termination, the ACO shall send notice in writing to the affected Beneficiaries and/or Next Generation Beneficiaries. Such notification shall state that following a date that is 90 days after the effective date of termination or the end of the Performance Year, whichever is sooner, the Benefit Enhancement will no longer be covered by Medicare and the Beneficiary may be responsible for the payment of such services.

   (b) CMS shall cease coverage of claims for a terminated Benefit Enhancement 90 days after the effective date of such termination.

3. In the event that the ACO elects to discontinue a Benefit Enhancement through the selection process under Section X of this Agreement, the ACO shall notify all its Next Generation Participants and Preferred Providers no later than 30 days prior to the start of the subsequent Performance Year.

F. Termination of Benefit Enhancements upon Termination

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

XII. Coordinated Care Reward

A. Reward Payment

CMS shall make direct Coordinated Care Reward payments to eligible Beneficiaries and Next Generation Beneficiaries according to a methodology determined by CMS.

B. ACO Obligations and Limitations Regarding the Coordinated Care Reward

1. The ACO shall ensure that all Next Generation Participants and Preferred Providers will, upon any Next Generation Beneficiary's inquiry about the Coordinated Care Reward, provide an accurate and current list of all Next Generation Participants and Preferred Providers, either in hard copy or by reference to the ACO's website, to the Next Generation Beneficiary.

2. The ACO shall ensure that all Next Generation Beneficiaries will be directed by the ACO, Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to 1-800-MEDICARE to obtain additional information about the Coordinated Care Reward.

3. The ACO and its Next Generation Participants and Preferred Providers may communicate in writing with Next Generation Beneficiaries regarding the coordinated care reward. Any such written materials must comply with the requirements under Section V.E of this Agreement.

4. The ACO shall ensure that any communication with Next Generation Beneficiaries regarding the Coordinated Care Reward, whether by the ACO, a Next Generation Participant, or Preferred Provider, clearly conveys that CMS is solely responsible for the terms and payment of the coordinated care reward and that the reward does not limit the Beneficiaries' freedom of choice of Medicare providers and suppliers.

5. The ACO shall not, and shall ensure that its Next Generation Participants, Preferred Providers, and any other individuals or entities performing services related to ACO Activities do not, provide gifts or other remuneration to Next Generation Beneficiaries as inducements for receiving the Coordinated Care Reward or to influence a Next Generation Beneficiary's decision to qualify for the Coordinated Care Reward.

XIII. ACO Benchmark

A. Prospective Benchmark

1. For each Performance Year, CMS shall determine the ACO's Performance Year Benchmark according the methodology in Appendix B.

2. No later than 15 days before the beginning of each Performance Year, CMS shall provide the ACO with a report ("**Performance Year Benchmark Report**") consisting of the ACO's Performance Year Benchmark.

3. On a quarterly basis during each Performance Year, CMS shall provide the ACO with a financial report ("**Quarterly Financial Report**"). The Quarterly Financial Report may comprise adjustments to the Performance Year Benchmark resulting from updated information regarding any factors that affect the Performance Year Benchmark calculation in Appendix B.

B. Trend Adjustments

1. At its sole discretion, CMS may make retroactive adjustments to the Performance Year Benchmark if CMS determines any policies and/or events during the Performance Year render the trend used in calculating the Performance Year Benchmark inaccurate or inappropriate for payment purposes.
2. If CMS determines that any such policies and/or events have occurred, CMS shall adjust the Performance Year Benchmark according to the methodology in Appendix B.
3. CMS shall make a reasonable effort to notify the ACO of any adjustments to the Performance Year Benchmark made under this Section XIII.B. Such notification shall not limit CMS' discretion to make determinations regarding retroactive adjustment under this Section.
4. In order to accommodate the trend adjustment, CMS may at its sole discretion delay settlement under Section XIV.C of this Agreement for the affected Performance Year for no more than 60 days.
5. Except for revisions made pursuant to Section XIV.C.4, no trend adjustments shall be made under this Section XIII.B after the issuance of the settlement report for the relevant Performance Year.

XIV. Payment

A. General

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

B. Alternative Payment Mechanisms

1. General

The ACO may elect to receive Infrastructure Payments or PBP, but not both. The ACO shall select such Alternative Payment Mechanism, if any, and CMS shall approve or reject the ACO's selection, in accordance with Section X.

2. Infrastructure Payments

(a) If the ACO selects and CMS approves participation in Infrastructure Payments, CMS shall make payments to the ACO in accordance with the methodology in Appendix G.

(b) The ACO shall spend the amounts received as Infrastructure Payments only on ACO Activities.

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

3. Population-Based Payments (PBP)

(a) If the ACO selects and CMS approves participation in Population-Based Payments, CMS shall make monthly payments ("**Monthly PBP**") to the ACO in accordance with the methodology in Appendix H.

(b) Preferred Providers shall not be eligible to receive Reduced FFS Payments.

(c) As part of settlement for a Performance Year under Section XIV.C, CMS shall calculate the difference between the total Monthly PBP amounts that CMS paid the ACO during the Performance Year and the total amount by which all FFS payments were reduced during the Performance Year in accordance with Appendix H. Any difference would constitute Other Monies Owed and may be subject to recoupment during settlement under Section XIV.C.

i. If the amount CMS paid in Monthly PBP is greater than the total amount by which FFS payments were reduced, the ACO shall pay CMS the difference as Other Monies Owed.

ii. If the amount CMS paid in Monthly PBP is less than the total amount by which FFS payments were reduced, CMS shall pay the ACO the difference as Other Monies Owed.

(d) If, as a result of provider appeals or additional claims adjustments after the initial PBP reconciliation as described in XIV.B.3, CMS pays an amount in excess of the Reduced FFS Payment for any item or service furnished to a Next Generation Beneficiary by a Next Generation Participant receiving Reduced FFS Payments, the ACO shall owe CMS the difference between the total amount CMS actually paid for such item or service and the total amount of the Reduced FFS Payment for such claim. Such difference would constitute Other Monies Owed and be subject to recoupment during settlement under Section XIV.C.

C. Settlement

1. General

(a) Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses and the amount of Other Monies Owed. CMS shall calculate Shared Savings, Shared Losses, and Other Monies Owed according to the methodology in Appendix B.

(b) CMS shall make reasonable efforts to issue the settlement report for each Performance Year no later than 180 days after the end of the Performance Year.

(c) Any amounts determined to be owed as a result of a settlement or revised settlement upon reopening shall be paid in accordance with Section XIV.C.5.

2. Error Notice

(a) The settlement report will be deemed final 30 days after the date it is issued, unless the ACO submits to CMS written notice of an error in the mathematical calculations in the settlement report within 30 days after the settlement report is issued ("**Timely Error Notice**").

(b) Upon receipt of a Timely Error Notice, CMS shall review the calculations in question and any mathematical issues raised by the ACO in its written notice.

(c) If CMS issues a written determination that the settlement report is correct, the settlement report is final on the date the written determination is issued.

(d) If CMS issues a revised settlement report, the revised settlement report is final on the date it is issued.

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

3. Deferred Settlement

(a) The ACO may elect, in a manner and by a date specified by CMS, to defer settlement for a period not to exceed 180 days ("**Deferred Settlement**").

(b) As a condition of Deferred Settlement, CMS may require the ACO to increase the amount of its financial guarantee under Section XIV.C in an amount and by a date determined by CMS.

4. Settlement Reopening

(a) For a given Performance Year, for a period of one year following issuance of the settlement report for that performance year, or until issuance of the settlement report for the subsequent performance year, whichever comes earlier, CMS reserves the right to reopen the settlement report in order to include payments or recoupments specified in Section 3.9 of Appendix B that were not included in the initial settlement, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO.

(b) CMS reserves the right, for a period of six years following the end of the term or termination of this Agreement, to reopen a final settlement report in order to recalculate the amounts owed, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO if, as a result of later inspection, evaluation, investigation, or audit, it is determined that the amount due to the ACO by CMS or due to CMS by the ACO has been calculated in error due to CMS data source file errors, computational errors, or other similar CMS technical errors.

(c) The parties shall pay any amounts determined to be owed as a result of a reopening under this Section XIV.C.4 in accordance with Section XIV.C.5.

(d) CMS may reopen and revise a settlement report at any time in the event of fraud or similar fault by the ACO, a Next Generation Participant or Preferred Provider.

5. Payment of Amounts Owed

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

(b) If the ACO owes CMS Shared Losses or Other Monies Owed as a result of a final settlement, or revised settlement upon reopening, the ACO shall pay CMS in full within 30 days after the relevant settlement report is deemed final.

(c) If CMS does not timely receive payment in full, the remaining amount owed will be considered a delinquent debt subject to the provisions of Section XIV.E.

6. Transition from the ACO Investment Model (AIM)

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

D. Financial Guarantee

1. The ACO must have the ability to repay all Shared Losses and Other Monies Owed for which it may be liable under the terms of this Agreement and shall provide a financial guarantee for each Performance Year in accordance with the terms set forth in Appendix L.

2. The ACO shall submit such documentation of such financial guarantee for the first Performance Year to CMS by a date determined by CMS, and thereafter in accordance with Appendix L.

3. Any changes made to a financial guarantee must be approved in advance by CMS.

4. Nothing in this Agreement or its Appendices shall be construed to limit the ACO's liability to pay any Shared Losses or Other Monies Owed in excess of the guarantee amount.

E. Delinquent Debt

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

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

A. Evaluation Requirement

1. General

(a) The ACO shall participate and cooperate in any independent evaluation activities conducted by CMS and/or its designees aimed at assessing the impact of the Model on the goals of better health, better health care, and lower Medicare per capita costs for Next Generation Beneficiaries. The ACO shall require its Next Generation Participants and Preferred Providers to participate and cooperate in any such independent evaluation activities conducted by CMS and/or its designees.

(b) The ACO shall ensure that it has written agreements and/or legal relationships with any individuals and entities performing functions and services related to ACO Activities, that are necessary to ensure CMS or its designees can carry out evaluation activities.

2. Primary Data

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

(a) Site visits;

(b) Interviews with Next Generation Beneficiaries and their caregivers;

(c) Focus groups of Next Generation Beneficiaries and their caregivers;

(d) Interviews with ACO, Next Generation Participant and Preferred Provider staff;

(e) Focus groups with ACO, Next Generation Participant and Preferred Provider staff;

(f) Direct observation of Beneficiary interactions with Next Generation Participant and Preferred Provider staff, care management meetings among

Next Generation Participant and Preferred Provider staff, and other activities related to the ACO's participation in the Model; and

(g) Surveys.

3. Secondary Data

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

(a) Survey data from CAHPS surveys;

(b) Clinical data such as lab values;

(c) Medical records; and

(d) ACO Implementation Plans.

B. Shared Learning Activities

1. The ACO shall participate in CMS-sponsored learning activities designed to strengthen results and share learning that emerges from participation in the Model.

2. The ACO shall participate in periodic conference calls, site visits, and virtual or in-person meetings, and actively share resources, tools and ideas as prescribed by CMS.

C. Site Visits

1. The ACO shall cooperate in periodic site visits by CMS and/or its designees in order to facilitate evaluation, shared learning activities, or the fulfilment of the terms of this Agreement.

2. CMS shall schedule site visits with the ACO no fewer than 15 days in advance. To the extent practicable, CMS will attempt to accommodate the ACO's request for particular dates in scheduling site visits. However, the ACO may not request a date that is more than 60 days after the date of the initial site visit notice from CMS.

3. The ACO shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during site visits.

4. Notwithstanding the foregoing, CMS may perform unannounced site visits at the office of any Next Generation Participant or Preferred Provider at any time to investigate concerns about the health or safety of Next Generation Beneficiaries or other program integrity issues.

5. Nothing in this Agreement shall be construed to limit or otherwise prevent CMS from performing site visits permitted by applicable law or regulations.

D. Rights in Data and Intellectual Property

1. CMS may use any data obtained pursuant to the Next Generation ACO Model to evaluate the Model and to disseminate quantitative results and successful care management techniques, to other providers and suppliers and the public. Data to be disseminated may include results of patient experience of care and quality of life surveys as well as measures based upon claims and medical records. The ACO will be permitted to comment on evaluation reports for factual accuracy but may not edit conclusions or control the dissemination of reports.

2. Notwithstanding any other provision in this Agreement, all proprietary trade secret information and technology of the ACO or its Next Generation Participants and Preferred Providers is and shall remain the sole property of the ACO, the Next Generation Participant, or Preferred Provider and, except as required by federal law, shall not be released by CMS without the express written consent of the ACO. The regulation at 48 CFR § 52.227-14, "Rights in Data-General" is hereby incorporated by reference into this Agreement. CMS does not acquire by license or otherwise, whether express or implied, any intellectual property right or other rights to the ACO's, Next Generation Participants', or Preferred Providers' proprietary information or technology.

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

XVI. Public Reporting and Release of Information

A. ACO Public Reporting and Transparency

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

   (a) Organizational information including all of the following:

      i. Name and location of the ACO;

      ii. Primary contact information for the ACO;

      iii. Identification of all Next Generation Participants and Preferred Providers;

      iv. Identification of all joint ventures between or among the ACO and any of its Next Generation Participants and Preferred Providers;

      v. Identification of the ACO's key clinical and administrative leaders and the name of any company by which they are employed; and

      vi. Identification of members of the ACO's governing body and the name of any entity by which they are employed.

   (b) Shared Savings and Shared Losses information, including:

i. The amount of any Shared Savings or Shared Losses for any Performance Year;

ii. The proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for Beneficiaries; and

iii. The proportion of Shared Savings distributed to Next Generation Participants and Preferred Providers.

(c) The ACO's performance on the quality measures described in Appendix F.

B. ACO Release of Information

1. The ACO, its Next Generation Participants, and Preferred Providers shall obtain prior approval from CMS during the term of this Agreement and for six months thereafter for the publication or release of any press release, external report or statistical/analytical material that materially and substantially references the ACO's participation in the Model or the ACO's financial arrangement with CMS. External reports and statistical/analytical material may include, but are not limited to, papers, articles, professional publications, speeches, and testimony.

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

XVII. Compliance and Oversight

A. ACO Compliance Plan

1. The ACO shall have a compliance plan that includes at least the following elements:

(a) A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body;

(b) Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;

(c) A method for employees or contractors of the ACO, its Next Generation Participants and Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to anonymously report suspected problems related to the ACO to the compliance official;

(d) Compliance training for the ACO and its Next Generation Participants and Preferred Providers;

(e) A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

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

B. CMS Monitoring and Oversight Activities

1. CMS shall conduct monitoring activities to evaluate compliance by the ACO, its Next Generation Participants, and Preferred Providers with the terms of this Agreement. Such monitoring activities may include, without limitation:

   (a) Interviews with any individual or entity participating in ACO Activities, including members of the ACO leadership and management, Next Generation Participants, and Preferred Providers;

   (b) Interviews with Next Generation Beneficiaries and their caregivers;

   (c) Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Next Generation Participants and Preferred Providers;

   (d) Site visits to the ACO and its Next Generation Participants and Preferred Providers; and

   (e) Documentation requests sent to the ACO, its Next Generation Participants, and/or Preferred Providers, including surveys and questionnaires.

2. In conducting monitoring and oversight activities, CMS or its designees may use any relevant data or information including, without limitation, all Medicare claims submitted for items or services furnished to Next Generation Beneficiaries.

3. CMS shall, to the extent practicable and as soon as practicable, provide the ACO with a comprehensive schedule of planned comprehensive annual audits related to compliance with this Agreement.

   (a) Such schedule does not preclude the ability of CMS to conduct more limited, targeted or ad hoc audits as necessary.

   (b) CMS may alter such schedule without the consent of the ACO. CMS shall notify the ACO within 15 days of altering such schedule.

C. ACO Compliance with Monitoring and Oversight Activities

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

D. Compliance with Laws

1. Agreement to Comply

(a) The ACO shall comply with, and shall require all Next Generation Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to comply with the applicable

terms of this Agreement and all applicable statutes regulations, and guidance, including without limitation: (a) federal criminal laws; (b) the False Claims Act (31 U.S.C. § 3729 et seq.); (c) the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the civil monetary penalties law (42 U.S.C. § 1320a-7a); and (e) the physician self-referral law (42 U.S.C. § 1395nn).

(b) This Agreement does not waive any obligation of the ACO or the ACO's Next Generation Participants or Preferred Providers to comply with the terms of any other CMS contract, agreement, model, or demonstration.

2. State Recognition

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

3. Reservation of Rights

(a) Nothing contained in this Agreement or in the application process for the Next Generation ACO Model is intended or can be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of the Inspector General, or CMS of any right to institute any proceeding or action for violations of any statutes, rules or regulations administered by the Government, or to prevent or limit the rights of the Government to obtain relief under any other federal statutes or regulations, or on account of any violation of this Agreement or any other provision of law. This Agreement cannot be construed to bind any Government agency except CMS and this Agreement binds CMS only to the extent provided herein.

(b) The failure by CMS to require performance of any provision of this Agreement does not affect CMS's right to require performance at any time thereafter, nor does a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

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

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

5. Other Government Authority

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

XVIII. Audits and Record Retention

A. Right to Audit and Correction

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

1. The ACO's compliance with this Agreement;
2. The quality of the services performed under this Agreement; and
3. The ability of the ACO to bear the risk of potential losses and to repay any losses to CMS.

B. Maintenance of Records

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

1. To maintain and give the Government, including CMS, HHS, and the Comptroller General or their designees, access to all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the ACO's compliance with this Agreement, the quality of services furnished to Next Generation Beneficiaries, the ACO's right to and distribution of Shared Savings, and the ACO's obligation and ability to repay any Shared Losses or Other Monies Owed to CMS.
2. To maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:
   (a) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the ACO at least 30 calendar days before the normal disposition date; or
   (b) There has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its Next Generation Participants, Preferred Providers, or

other individuals or entities performing functions or services related to ACO Activities, in which case the records shall be maintained for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

XIX. Remedial Action and Termination

A. Remedial Action

1. If CMS determines that any provision of this Agreement may have been violated, CMS may take one or more of the following actions:

   (a) Notify the ACO and, if appropriate, the Next Generation Participant, and/or Preferred Provider of the violation;

   (b) Require the ACO to provide additional information to CMS or its designees;

   (c) Conduct on-site visits, interview Beneficiaries, or take other actions to gather information;

   (d) Place the ACO on a monitoring and/or auditing plan developed by CMS;

   (e) Require the ACO to remove a Next Generation Participant or Preferred Provider from the Participant List or Preferred Provider List and to terminate its agreement, immediately or within a timeframe specified by CMS, with such Next Generation Participant or Preferred Provider with respect to this Model;

   (f) Require the ACO to terminate its relationship with any other individual or entity performing functions or services related to ACO Activities;

   (g) Prohibit the ACO from distributing Shared Savings to a Next Generation Participant or Preferred Provider;

   (h) Request a corrective action plan ("**CAP**") from the ACO that is acceptable to CMS, in which case, the following requirements apply:

      (i) The ACO shall submit a CAP for CMS approval by a deadline established by CMS; and

      (ii) The CAP must address what actions the ACO will take (or will require any Next Generation Participant, Preferred Provider or other individual or entity performing functions or services related to ACO Activities to take) within a specified time period to ensure that all deficiencies will be corrected and that the ACO will be in compliance with the terms of this Agreement;

   (i) Amend this Agreement without the consent of the ACO to provide that any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act will be inapplicable;

   (j) Amend this Agreement without the consent of the ACO to deny the use of any Alternative Payment Mechanism by the ACO or any Next Generation Participant and to require that the ACO terminate any agreements effectuating

such Alternative Payment Mechanism by a date determined by CMS, in which case, the ACO (and any Next Generation Participant, if applicable) shall be paid under normal FFS following the effective date determined by CMS, and Other Monies Owed will be calculated and paid in accordance with Section XIV.C and Appendix B;

(k) Discontinue the provision of data sharing and reports to the ACO under Section VI;

(l) Amend this Agreement without the consent of the ACO to deny the use of one or more Benefit Enhancements by the ACO or any Next Generation Participant or Preferred Provider and to require that the ACO terminate any agreements effectuating such Benefit Enhancements by a date determined by CMS.

2. CMS may impose additional remedial actions or terminate this Agreement pursuant to Section XIX.B if CMS determines that remedial actions were insufficient to correct noncompliance with the terms of this Agreement.

B. Termination of Agreement by CMS

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

1. CMS determines that the Agency no longer has the funds to support the Model;
2. CMS terminates the Model pursuant to Section 1115A(b)(3)(B) of the Act;
3. CMS determines that the ACO:

(a) Has failed to comply with any term of this Agreement or any other Medicare program requirement, rule, or regulation;

(b) Has failed to comply with a monitoring and/or auditing plan;

(c) Has failed to submit, obtain approval for, implement or fully comply with the terms of a CAP;

(d) Has failed to demonstrate improved performance following any remedial action;

(e) Has taken any action that threatens the health or safety of a Beneficiary or other patient;

(f) Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model;

(g) Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency;

(h) Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action; or

(i) Assigns or purports to assign any of the rights or obligations under this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS.

4. CMS determines that one or more of the ACO's Next Generation Participants or Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model; or

5. The state in which the ACO operates enters into an arrangement with CMS that is based on a statewide global or per-capita Medicare payment.

C. Termination of Agreement by ACO

1. Termination during the Performance Year

(a) The ACO may terminate this Agreement prior to the end of the Performance Year upon at least 60 days advance written notice to CMS. Such notice shall specify the effective date of termination.

(b) Termination by the ACO shall be subject to the ACO's fulfillment of the requirements under Section XIX.E.

2. Termination with Transition to the MSSP

(a) If the ACO terminates this Agreement in accordance with Section XIX.C.1, above, and intends to transition to the MSSP beginning on January 1 of the following year, the ACO may continue to participate in data sharing under Section VI of the Agreement if it furnishes CMS with a written notice of its intent to terminate this Agreement and transition to MSSP ("**Transition Notice**") beginning with the next Performance Year. The Transition Notice shall:

i. Provide that the ACO or a new legal entity formed by its Next Generation Participants will submit or has already submitted a notice of intent to apply for participation as an ACO in the MSSP effective January 1 of the following year by the deadline established under the MSSP; and

ii. Include a statement that the ACO would like to continue to participate in the data sharing described in Section VI for the remainder of the Performance Year in which the termination is effective.

(b) The ACO shall comply with all applicable terms of this Agreement until the effective date of the ACO's termination from the Model.

(c) If the ACO qualifies to participate in the MSSP but does not enter into a participation agreement under 42 CFR § 425.200, data sharing under Section VI shall terminate one calendar day after the deadline under the MSSP to submit a signed participation agreement for the applicable agreement period.

(d) Should the ACO fail to qualify to participate in the MSSP, data sharing under Section VI will terminate on the date that CMS provides notice under 42 CFR

§ 425.206(b) that the application has been denied or upon completion of all appeals under 42 CFR Part 425, subpart I, whichever occurs later.

(e) Termination of the Agreement under this Section XIX.C.2 shall not affect the rights and obligations of the parties under Sections VI and XV, which shall survive the termination of this Agreement and shall remain in effect for the remainder of the Performance Year in which the ACO furnished a Transition Notice.

(f) CMS will not be liable for any costs that are incurred by the ACO, its Next Generation Participants or Preferred Providers in connection with either the ACO's termination from the Model or the transition to MSSP.

D. Financial Settlement upon Termination

1. If this Agreement is terminated by either party, except as otherwise provided in this section, CMS shall conduct settlement for the entire Performance Year in which the Agreement is terminated in accordance with Section XIV.C of this Agreement.
2. If this Agreement is terminated by CMS under Section XIX.B, CMS shall not make any payments of Shared Savings to the ACO, and the ACO shall remain liable for any Shared Losses, for the Performance Year in which termination becomes effective.
3. If the ACO voluntarily terminates this Agreement pursuant to Section XIX.C.1 with an effective date on or before April 1, the ACO shall be neither eligible to receive Shared Savings nor liable for Shared Losses for such Performance Year.
4. Upon termination or expiration of this Agreement, the ACO shall immediately pay all Other Monies Owed to CMS and shall remain liable for any amounts included in a settlement report issued for any Performance Year in accordance with Section XIV.C.5.

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

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

XX. Limitation on Review and Dispute Resolution

A. Limitations on Review

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

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

B. Dispute Resolution

1. Right to Reconsideration

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

(a) Such a request for reconsideration by the ACO must satisfy the following criteria:

   i. The request must be submitted to a designee of CMS ("reconsideration official") who—

A. Is authorized to receive such requests; and

B. Did not participate in the determination that is the subject of the reconsideration request.

ii. The request must contain a detailed, written explanation of the basis for the dispute, including supporting documentation.

iii. The request must be made within 30 days of the date of the determination for which reconsideration is being requested via email to CMS at the address specified in Section XXI.A or such other address as may be specified by CMS.

(b) Requests that do not meet the requirements of Section XX.B.1(a) will be denied by the reconsideration official.

(c) Within 10 business days of receiving a request for reconsideration, the reconsideration official will send to the ACO and to CMS a written acknowledgement of receipt of the reconsideration request. Such an acknowledgement will set forth:

i. The review procedures; and

ii. A briefing schedule that permits each party to submit only one written brief, including any evidence, for consideration by the reconsideration official in support of the party's position. The submission of any additional briefs or supplemental evidence will be at the sole discretion of the reconsideration official.

2. Standards for reconsideration.

(a) The parties shall proceed diligently with the performance of this Agreement during the course of any dispute arising under the Agreement.

(b) The reconsideration will consist of a review of documentation that is submitted timely and in accordance with the standards specified by the reconsideration official.

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

3. Reconsideration determination.

(a) The reconsideration determination will be based only upon

i. Position papers and supporting documentation that are timely submitted to the reconsideration official and meet the standards for submission; and

ii. Documents and data that were timely submitted to CMS in the required format before the agency made the determination that is the subject of the reconsideration request.

(b) The reconsideration official will issue to CMS and to the ACO a written notification of the reconsideration determination. Absent unusual circumstances, written notification will be issued within 60 days of receipt of timely filed position papers and supporting documentation.

(c) Effect of the Reconsideration Determination

i. The determination of the reconsideration official is final and binding.

ii. The reconsideration review process under this Agreement shall not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by other government agencies.

XXI. Miscellaneous

A. Agency Notifications and Submission of Reports

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

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

ACO: _____
_____
_____
_____
_____
_____

B. Notice of Bankruptcy

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

this Agreement and final payment by the ACO under this Agreement has been made.

C. Severability

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

D. Entire Agreement; Amendment

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

E. Survival

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

1. Section XVIII (Audits and Record Retention);
2. Section VI.B (Data Privacy Compliance and Indemnity);
3. Section VIII.C. (Quality Measure Reporting);
4. Section XVII.C (Compliance and Oversight); and
5. Section XV. A (Evaluation Requirement).

F. Precedence

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

G. Change of ACO Name

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

H. Prohibition on Assignment

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

I. Change in Control

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

J. Certification

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

K. Execution in Counterpart

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

facsimile or ".pdf" signature page were an original thereof.

[SIGNATURE PAGE FOLLOWS]

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

ACO:

Date: _____ By: _____

_____
Name of authorized signatory

_____
Title

CMS:

Date: _____ By: _____

_____
Name of authorized signatory

_____
Title

Appendices

A. Non-Duplication Waiver and Participant Exclusivity
B. Next Generation ACO Alignment and Financial Reconciliation
C. Voluntary Alignment
D. Data Use Agreement
E. Data Sharing and Reports
F. Quality Measures
G. Alternative Payment Mechanism - Infrastructure Payments
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I. Benefit Enhancement - 3-Day SNF Rule Waiver
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K. Benefit Enhancement - Post-Discharge Home Visits
L. Financial Guarantees - Requirements and Guidance
M. ACO Proprietary Information

Next Generation ACO Model

Appendix A

Non-Duplication Waiver and Participant Overlap

I. Waiver

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

II. ACO Overlap

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

B. If the ACO is otherwise eligible, the ACO may participate in other Medicare demonstrations or models. CMS may issue guidance or work directly with the ACO in determining how participation in certain demonstrations or models can be combined with participation in the Next Generation ACO Model.

III. Next Generation Participant and Preferred Provider Overlap

A. Pursuant to section 1899(b)(4)(A), a Next Generation Participant may not also be an ACO participant, ACO provider/supplier and/or ACO professional in an accountable care organization in the MSSP.

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

C. A Next Generation Participant who is a non-primary care specialist according to Appendix B of this Agreement may be a Next Generation Participant in another accountable care organization in this Model, a Pioneer Provider/Supplier in the Pioneer ACO Model, or serve in an equivalent role in or any other model or program in which such non-primary care specialists are not required to be exclusive to one participating entity.

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

1. Preferred Provider for one or more other accountable care organizations participating in the Next Generation ACO Model;

2. Subject to Section III.B of this Appendix, Next Generation Participant in one or more other accountable care organizations participating in the Next Generation ACO Model;

3. Pursuant to the waiver in Section I of this Appendix, ACO participant, ACO provider/supplier and/or ACO professional in an accountable care organization in the MSSP; and/or

4. Role similar in function to the Next Generation Participant in another shared savings initiative.

Next Generation ACO Model

Appendix B

Next Generation ACO Alignment and Financial Reconciliation

Table of Contents

Next Generation ACO Model Benchmarking Methods

1.0 Introduction

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

The Model offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using benchmarking methods that: (1) reward quality performance; (2) reward both attainment of and improvement in cost containment; and (3) ultimately transition away from reference to ACO historical expenditures. The Model offers a choice of two risk arrangements that determine the portion of the savings or losses that accrue to the ACO. The risk arrangement applies to the difference between actual expenditures and the prospective benchmark.

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

2.0 Overview of the Next Generation ACO Model Benchmark

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

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

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

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

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

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

2.1 NGACO baseline expenditure

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

2.2 Projected regional trend

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

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

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

2.3 Risk adjustment

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

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

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

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

2.4 Efficiency- and quality-adjusted discount

The Performance Year Benchmark will be calculated by applying to the risk-adjusted trended baseline an efficiency- and quality-adjusted discount that will range from 0.5% to 4.5%. The adjusted discount is:

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

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

2.4.1 Quality adjustment to the standard discount

The standard discount will be reduced by up to 1% depending on the quality score attained by the NGACO in the Performance-Year. The quality adjustment to the standard discount in PY1/CY2016 for an NGACO whose agreement is effective January 1, 2016, will be 100% if the NGACO submits all data required to calculate a quality score in PY1 as described in the Participation Agreement. The quality adjustment to the standard discount in PY2/CY2017 for an NGACO whose agreement is effective January 1, 2017, will be 100% if the NGACO submits all data required to calculate a quality score in PY2.

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

2.4.2 Efficiency adjustments to standard discount

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

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

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

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

2.7 Illustrative Example of Benchmark Calculation

Table 2.7 illustrates the benchmark calculation.

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

	Baseline (CY2014)		Benchmark
ACO baseline (CY2014) expenditure:	**$876.54**		$876.54
Projected PY1/CY2016 regional trend adjustment:			**$30.36**
Projected PY1/CY2016 national trend:	3.00%		
CY2016 GAF trend adjustment	0.45%		
Projected PY1/CY2016 regional trend:	3.46%		
Trended baseline[1]			**$906.90**
PY1 baseline risk adjustment factor[2]			**1.010**
Risk-adjusted trended baseline[3]			**$915.97**
Adjusted NGACO discount			
Standard discount	3.00%		**3.00%**
National baseline efficiency adjustment to the standard discount	-0.04%		-0.04%
National efficiency ratio	0.993		
Regional baseline efficiency adjustment to the standard discount	-0.13%		-0.13%
Regional efficiency ratio	0.987		
Quality adjustment to the standard discount			-1.00%
Quality- and efficiency-adjusted discount			**1.84%**
LESS: NGACO discount[4]			**$16.85**
Benchmark[5]			**$899.12**

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

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

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

[4] The NGACO discount is equal to the risk-adjusted trended baseline multiplied by quality- and efficiency-adjusted discount ($899.12 = 0.0184 x $915.97).

[5] The benchmark is equal to the risk-adjusted trended baseline less the NGACO discount ($899.12 = $915.97 – $16.85).

3.0 Definitions

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

3.1 Base and performance years

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

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

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

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

3.2 Entitlement categories

NGACO baseline and benchmark calculations are performed separately for:

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

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

3.3 NGACO region

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

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

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

3.4 Alignment-eligible beneficiaries

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

1. Is covered under Part A in January of the base- or performance-year and in every month of the base- or performance-year in which the beneficiary is alive;
2. Has no months of coverage under only Part A;
3. Has no months of coverage under only Part B;
4. Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
5. Has no months in which Medicare was the secondary payer; and,
6. Was a resident of the United States.

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

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

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

3.5 Aligned beneficiaries

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

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

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

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

1. The Next Generation Beneficiary was a resident of a county that was part of the ACO's service area in the last month of the 2-year alignment period but was a resident of a county that was not part of the ACO's service area in the performance-year.
2. During the base- or Performance-Year (respectively, for base-year and performance-year aligned beneficiaries) at least 50% of Qualified Evaluation and Management (QEM) services used by the Next Generation Beneficiary were from providers practicing outside the ACO's service area.

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

3.6 Reference beneficiaries

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

3.7 Expenditure

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

1. Inpatient claims;
2. Skilled Nursing Facility (SNF) claims;
3. Home Health Agency (HHA) claims;
4. Hospice claims.
5. Physician claims:

[5] Alignment methods are described in Appendix A.

6. Outpatient claims; and,
7. Durable Medical Equipment (DME) claims.

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

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

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

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

3.7.1 Exclusion of certain provider payments

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

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

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

3.7.2 Indirect Medicare Education and Disproportionate Share Hospital payments

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

3.7.3 Budget sequestration

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

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

3.7.4 Effect of Population-based Payment (PBP)

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

3.7.5 Adjustment for performance-based provider payment incentives

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

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

3.8 Capped expenditure

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

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

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

1. The PBPM cap on expenditures for the entitlement category for that year;
2. The number of months that the beneficiary accrued to the entitlement category during the year;

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

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

3.9 Provider payments made outside of standard claims systems

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

3.10 Quality Measures

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

4.0 NGACO benchmark for each entitlement category

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

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

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

5.0 Trended baseline

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

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

5.1 NGACO baseline expenditure

The baseline expenditure PBPM for an entitlement category is the total capped expenditure accrued to the entitlement category by all base-year aligned beneficiaries divided by the total months accrued to the entitlement category by those beneficiaries.

5.2 Projected regional trend

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

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

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

5.3 Projected national FFS trend

The projected national FFS expenditure trend (percentage growth rate) will be determined using assumptions and methods similar to those used by the Medicare Office of the Actuary (OACT) to calculate the Medicare Advantage (MA) county ratebook. OACT calculates a projected FFS United States Per Capita Cost (USPCC), which is used in the calculation of the ratebook.[7] Adjustments to the projected FFS USPCC may be made to take into account differences in the expenditure trend of the FFS population as a whole, and the subset of FFS beneficiaries eligible to be aligned to ACOs (see Section 3.5). The beneficiaries eligible for alignment to an NGACO (i.e., NGACO reference beneficiaries) are the vast majority of FFS beneficiaries.

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

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

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

[7] The methodology used by OACT to project the FFS spending is described in the Annual Report of the Trustees of the Federal Hospital insurance and Federal Supplementary Medical Insurance Trust Funds: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf. The projected FFS USPCC is used by OACT in the calculation of the Medicare Advantage county ratebook. The projected FFS USPCC for 2016 was published in the Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter published April 6: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf.

5.4 GAF trend adjustment

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

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

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

5.4.1 Calculation of GAF trend adjustment factors

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

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

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

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

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

5.4.2 GAF trend-adjusted baseline claims

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

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

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

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

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

6.0 Risk Adjustment of Trended Baseline

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

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

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

6.1 Risk scores

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

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

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

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

6.2 "Re-normalization" of Risk Scores

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

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

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

Using Aged/Disabled beneficiaries as an example,

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

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

6.3 Risk ratio

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

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

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

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

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

6.4 Risk-adjusted trended baseline

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

The risk-adjusted trended baseline will be retrospectively adjusted for final reconciliation based on the final risk scores for the Performance Year. For example, the PY1/CY2016 final risk scores are expected to be released in April 2017. The PY1/CY2016 final Benchmark will be updated to reflect the final PY1/CY2016 risk scores.

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

7.0 Quality- and efficiency-adjusted discount

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

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

The adjusted discount for an NGACO can, therefore, vary from 0.5% to 4.5% as shown in table 7.0.

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

	High efficiency / high quality ACO	Low efficiency / low quality ACO
The standard discount	3.0%	3.0%
MINUS: Regional efficiency adjustment[1]	1.0%	-1.0%
MINUS: National efficiency adjustment[2]	0.5%	-0.5%
MINUS: Quality adjustment	1.0%	0.0%
EQUALS: Quality- and efficiency-adjusted discount	0.5%	4.5%

[1] The regional efficiency adjustment may be a positive or negative value between +1.0% and -1.0%. An "efficient" (low cost) ACO has a positive efficiency adjustment which is subtracted from the standard discount. The regional efficiency adjustment therefore reduces the standard discount for a low cost ACO. An "inefficient" (high cost) ACO has a negative efficiency adjustment that is subtracted from the standard discount. The regional efficiency adjustment therefore increases the standard discount for a low cost ACO.

[2] The national efficiency adjustment may be a positive or negative value between +0.5% and -0.5%. An "efficient" (low cost) ACO has a positive efficiency adjustment which is subtracted from the standard discount. The national efficiency adjustment therefore reduces the standard discount for a low cost ACO. An "inefficient" (high cost) ACO has a negative efficiency adjustment that is subtracted from the standard discount. The national efficiency adjustment therefore increases the standard discount for a low cost ACO.

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

7.1 Quality adjustment to the standard discount

The quality adjustment to the standard Medicare savings requirement may be up to 1 percentage point. In other words, the standard discount of 3% may be reduced by as much as 1 percentage point based on the ACO's quality performance. A higher quality score reduces the standard discount by more than a lower quality score.

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

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

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

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

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

In PY2/CY2017, the initial prospective Benchmark will be based on a quality score of 100% as PY1 quality scores will not be available at the time that the Benchmark is calculated. When PY1 quality scores are calculated at mid-year PY2, CMS will update the Performance Year Benchmark.[8] For NGACOs with agreements effective January 1, 2017, the initial and mid-year update to the quality score will be 100%.

[8] The PY1 quality score for purposes of calculation of the PY1 quality adjustment to the standard discount will be 100% assuming the NGACO reports all quality measures. However, a PY1 "baseline" quality score based on the

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

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

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

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

7.1.3 Minimum Quality Requirement

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

7.2 Regional Baseline Efficiency Adjustment to the standard discount

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

In this context, "operating efficiency" indicates whether the ACO's baseline expenditure PBPM is higher or lower than the "average" baseline expenditure PBPM in the ACO's region.[9] Under this approach, ACOs achieve savings through year-to-year improvement over historic expenditures (improvement), but the magnitude by which they must improve will vary based on relative efficiency (attainment). The regional efficiency adjustment to the standard discount will be set prospectively. The regional baseline efficiency ratio will be calculated using capped expenditures for all NGACOs.

NGACO's performance on each quality measure will also be calculated. This PY1 "baseline" quality score will be used to calculate the mid-year quality adjustment to the standard discount in PY2.

[9] Risk adjustment and geographic pricing adjustment are applied to the regional efficiency adjustment. See below for details.

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

7.2.1 Regional baseline efficiency ratio

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

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

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

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

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

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

7.2.2 GAF baseline standardization factors

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

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

1. The incurred PBPM expenditure (reflecting the geographic pricing factors that Medicare used in the base-year to calculate payments to providers and suppliers); to

2. The county PBPM expenditure calculated after adjusting base year claims to remove the impact on payments to providers and suppliers of the geographic pricing factors that Medicare used in the base-year. [10]

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

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

7.2.3 GAF-adjusted baseline claims

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

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

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

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

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

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

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

1. The baseline expenditure (excluding IME and DSH) PBPM incurred by reference beneficiaries residing in the county; divided by

[10] The calculation of the baseline GAF adjustment will be normalized such that the adjustment neither increases nor decreases the total expenditure of the reference population. That is the adjusted claim amount for the reference population will equal the incurred claim amount.

2. The product of:
    a. The weighted average re-normalized risk score of reference beneficiaries residing in the county; and
    b. The baseline GAF standardization factor of the county.

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

7.2.5 Regional Efficiency Adjustment

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

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

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

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

Table 7.2.5 Regional efficiency adjustment for selected regional efficiency ratios

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

[1] The efficiency adjustment is subtracted from the standard discount. A positive adjustment therefore reduces the standard discount, and a negative adjustment increases it.

7.3 National Baseline Efficiency Adjustment to the Savings Requirement

The ratio of an ACO's historic expenditures to national FFS expenditures (national efficiency), or the "national efficiency ratio", will be used to calculate a "national efficiency" adjustment to the standard

discount. The national efficiency adjustment is intended to recognize the baseline expenditure "operating efficiency" of the NGACO when measured against a national norm.

In this context, "operating efficiency" simply means whether the ACO's baseline expenditure PBPM is higher or lower than the "average" baseline expenditure PBPM in the nation as a whole. Under this approach, ACOs achieve savings through year-to-year improvement over historic expenditures (improvement), but the magnitude by which they must improve will vary based on relative efficiency (attainment). The national efficiency adjustment to the standard discount will be set prospectively.

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

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

7.3.1 National Efficiency Ratio

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

1. The NGACO's risk- and GAF-adjusted baseline expenditure PBPM; and,
2. The national risk- and GAF-adjusted baseline expenditure PBPM. 11

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

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

7.3.2 National Efficiency Adjustment

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

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

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

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

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

Table 7.3.2. National efficiency adjustment for selected national efficiency ratios

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

[1] The efficiency adjustment is subtracted from the standard discount. A positive adjustment therefore reduces the standard discount, and a negative adjustment increases it.

8.0 NGACO Financial Settlement

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

1. The trended, risk adjusted ACO baseline; and,
2. The quality- and efficiency-adjusted discount. [12]

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

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

This can be expressed as a PBPM Benchmark by dividing the Benchmark expenditure by the number of person-months accrued during the Performance-Year by aligned beneficiaries. [13]

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

8.1 Savings/Losses Amount

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

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

1. Arrangement A: 80% shared savings/losses, 15% savings/losses cap
2. Arrangement B: 100% shared savings/losses, 15% savings/losses cap.

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

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

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

8.2 Alternative payment arrangements

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

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

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

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

Appendix A. Next Generation ACO Model Alignment Procedures

A.1 Alignment Years

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

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

A.2 Definitions used in alignment procedures

A.2.1 Alignment-eligible beneficiary

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

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

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

A.2.2 "Alignable" beneficiary

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

A.2.3 NGACO Service Area

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

A.2.4 Qualified Evaluation & Management services

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

In the case of claims submitted by physician practices, the specialty of the practitioner providing a primary care service will be determined by the CMS specialty code appearing on the claim. The specialty codes that identify primary care and selected non-primary care specialties are listed in Addendum A, Tables A-3 or A-4.

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

A.2.5 Primary care services

In the case of claims submitted by physician practices, a primary care service is identified by the HCPCS code appearing on the claim line. HCPCS codes identifying primary care services are listed in Addendum A, Table A-2.

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

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

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

A.2.6 Primary care specialists

A primary care specialist is a physician or non-physician practitioner (NPP) whose principal specialty is included in Addendum A, Table A-3.

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

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

A.2.7 Next Generation Participant

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

Next Generation Participants are identified by either:

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

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

A.2.8 Participating practice

A participating practice is:

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

A participating physician practice is identified by TIN.

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

A.2.9 Participating practitioner (professional)

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

A.2.10 Legacy practice identifiers

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

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

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

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

A.3 Quarterly exclusion of beneficiaries during the Performance Year

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

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

A.4 Alignment of beneficiaries

Next Generation Beneficiaries are identified prospectively, *prior to the start of the Performance Year.* Similarly, the beneficiaries who are aligned in each base-year for the purpose of calculating the baseline expenditure are identified on the basis of each beneficiary's use of QEM services in the 2-year alignment period ending *prior* to the start of the base-year.

Alignment of a beneficiary is determined by comparing:

1. The weighted allowable charge for all QEM services that the beneficiary received from each NGACOs' Next Generation Participants;
2. The weighted allowable charge for all QEM services that the beneficiary received from each physician practice (including institutional practices) whose members are not participating in an NGACO.

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

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

A.5 Use of weighted allowable charges in alignment

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

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

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

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

A.6 The 2-stage alignment algorithm

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

1. **Alignment based on primary care services provided by primary care specialists.** If 10% or more of the allowable charges incurred on QEM services received by a beneficiary during the 2-year alignment period are obtained from physicians and practitioners with a primary care specialty as defined in Addendum A, Table A-3, then alignment is based on the allowable charges incurred on QEM services provided by primary care specialists.
2. **Alignment based on primary care services provided by selected non-primary care specialties.** If less than 10% of the QEM services received by a beneficiary during the 2-year alignment period are provided by primary care specialists, then alignment is based on the QEM services provided by physicians and practitioners with certain non-primary specialties as defined in Addendum A, Table A-4.

Provider specialty is determined by the specialty code that is assigned to the claim during claim processing, in the case of physician claims, or by the specialty associated with the NPI of the physician or NPP in the Medicare provider enrollment database in the case of certain FQHC, RHC and CAH2 claims.

A.7 Tie-breaker rule

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

A.8 Voluntary alignment

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

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

Table 2.1: Definition of base years and Performance Years

Period	Period covered[1]	Corresponding alignment years (AY)
Base Year (BY)	01/01/2014 – 12/31/2014	BY/AY1: 07/01/2011 – 06/30/2012 (AY2012)
		BY/AY2: 07/01/2012 – 06/30/2013 (AY2013)
Calendar Year 2015 (CY2015)	01/01/2015 – 12/31/2015	CY2015/AY1: 07/01/2012 – 06/30/2013 (AY2013)
		CY2015/AY2: 07/01/2013 – 06/30/2014 (AY2014)
Performance Year 1 (PY1)	01/01/2016 – 12/31/2016	PY1/AY1: 07/01/2013 – 06/30/2014 (AY2014)
		PY1/AY2: 07/01/2014 – 06/30/2015 (AY2015)
Performance Year 2 (PY2)	01/01/2017 – 12/31/2017	PY2/AY1: 07/01/2014 – 06/30/2015 (AY2015)
		PY2/AY2: 07/01/2015 – 06/30/2016 (AY2016)
Performance Year 3 (PY3)	01/01/2018 – 12/31/2018	PY3/AY1: 07/01/2015 – 06/30/2006 (AY2016)
		PY3/AY2: 07/01/2016 – 06/30/2017 (AY2017)

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

Table A-1. Evaluation & Management Services

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

Office or Other Outpatient Services	
99350	Established Patient, extensive

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

Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

Table A-2. Specialty codes used for alignment based on primary care specialists

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

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

Table A-3. Specialty codes used for alignment based on other selected specialists

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

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

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

B.1 Notational conventions

A bar over a variable generally means that it is a person-month weighted average value. Thus, $\bar{E}_{a,e,0}$ denotes the person-weighted average expenditure per month of aligned beneficiaries who accrue experience to entitlement category *e* in the base-year, and $\bar{R}_{a,e,0}$ denotes the person-weighted average risk-score of aligned beneficiaries who accrue experience to entitlement category *e* in the base-year.

PBPM means "per beneficiary per month" or "per beneficiary-month". The expenditure PBPM for an entitlement category is the average expenditure per eligible-month for Next Generation Beneficiaries accruing experience to the entitlement category. The expenditure PBPM is simply the total expenditure incurred by the Next Generation Beneficiaries accruing experience to the entitlement category divided by the total months accrued to the category.

A separate PBPM benchmark will be calculated for two entitlement categories, Aged/Disabled and ESRD. In the variables used in the formulas, the entitlement categories are identified by the subscript *e*.

The expenditure variables that are used in the formulas are all average PBPM expenditures.

The superscript *c* on an expenditure variable denotes capped expenditure.

The superscript *u* on an expenditure variable denotes uncapped expenditure.

The superscript *r* on a variable denotes a value for a county (the basic geographic building block for NGACO regions). The combination of the superscript *r* and the subscript *a* on a variable indicates that the variable represents a weighted average of the county-level variables using the months accrued by beneficiaries aligned with NGACO *a* who reside in each county *r* as weights.

B.2 NGACO savings or loss

The savings (or loss) incurred by an ACO is formally given by:

$$\mathfrak{P}_{a,t}^{c} = \mathfrak{B}_{a,t}^{c} - \mathfrak{E}_{a,t}^{c}$$

where

$\mathfrak{P}_{a,t}^{c}$= Aggregate savings (loss) incurred by NGACO *a* in Performance-Year *t*

$\mathfrak{B}_{a,t}^{c}$= Capped aggregate Performance Year Benchmark expenditure of NGACO *a* in Performance-Year *t*

$\mathfrak{E}_{a,t}^{c}$= Capped aggregate expenditure incurred of all Next Generation Beneficiaries aligned with NGACO *a* in Performance-Year *t*

B.3 Benchmark expenditure

The benchmark expenditure for a Performance Year is given by:

$$\mathfrak{B}^{c}_{a,t} = \frac{\sum_{e}\left(M_{a,\mathrm{e},t} \times \bar{B}^{c}_{a,e,t}\right)}{\sum_{e}\left(M_{a,\mathrm{e},t}\right)}$$

where

$\mathfrak{B}^{c}_{a,t}$ = the capped aggregate benchmark expenditure of NGACO *a* in Performance Year *t*

$M_{a,\mathrm{e},t}$ = the number of eligible months accrued during Performance Year *t* to entitlement category *e* by Next Generation Beneficiaries aligned with NGACO *a*

$\bar{B}^{c}_{a,e,t}$ = the capped benchmark expenditure PBPM of NGACO *a* for entitlement category *e* in Performance Year *t*

B.4 Benchmark PBPM for an entitlement category

The NGACO benchmark PBPM for an entitlement category is given by:

$$\bar{B}^{c}_{a,e,t} = \bar{E}^{c}_{a,e,t} \times \left[\left(1 + \hat{T}^{n}_{e,t}\right) \times \bar{L}^{r}_{a,e,t}\right] \times \lambda\left(\bar{R}_{a,e,0}, \bar{R}_{a,e,t}\right) \times \left[1 - \delta\left(\bar{S}_{a,e,0}, \bar{S}^{n}_{a,e,0}, \bar{S}^{r}_{a,e,0}, Q_{a,t-1}\right)\right]$$

where

$\bar{B}^{c}_{a,e,t}$ = the capped benchmark expenditure PBPM of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{E}^{c}_{a,e,t}$ = the capped baseline expenditure PBPM of NGACO *a* for entitlement category *e* in Performance Year *t*

$\hat{T}^{n}_{e,t}$ = the national projected trend for entitlement category *e* in Performance Year *t*

$\bar{L}^{r}_{a,e,t}$ = the average regional GAF trend adjustment for entitlement category *e* in Performance Year *t*

$\lambda(\ldots)$ = the risk adjustment to the baseline for eligibility category *e*, which is a function of the re-normalized average risk scores of beneficiaries accruing experience to the entitlement category in: (1) the base-year; and (2) the Performance-Year.

$\bar{R}_{a,e,0}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in the base-year

$\bar{R}_{a,e,\mathrm{t}}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in Performance Year *t*

$\delta(\ldots)$= the quality- and efficiency-adjusted discount for eligibility category *e*, which is a function of: (1) the standardized base-year expenditure PBPM of the NGACO for entitlement category *e*; (2) the average regional standardized base-year expenditure PBPM for entitlement category *e* in the NGACO's region; (3) the national standardized base-year expenditure PBPM for entitlement category *e*; and (4) the applicable quality score of the NGACO for the Performance-Year.

$\bar{S}_{a,e,0}$ = the GAF- and risk-standardized average expenditure PBPM of NGACO *a* for entitlement category *e* in the base-year

$\bar{S}^{n}_{a,e,0}$ = the national GAF- and risk-standardized average expenditure PBPM for entitlement category *e* in the base-year

$\bar{S}^{r}_{a,e,0}$ = the average GAF- and risk-standardized average expenditure PBPM in the region of NGACO *a* for entitlement category *e* in the base-year

$Q_{a,t-1}$ = the quality score attained by NGACO *a* in the year prior to the Performance-Year

B.5 Baseline expenditure PBPM for an entitlement category

The baseline expenditure PBPM for an entitlement category is given by:

$$\bar{E}^{c}_{a,e,0} = \frac{\mathfrak{E}^{c}_{a,0}}{M_{a,\mathrm{e},0}} = \frac{\sum_i \left(E^{c}_{i,a,e,0}\right)}{\sum_i \left(M_{i,a,e,0}\right)}$$

where

$\mathfrak{E}^{c}_{a,e,0}$= Capped aggregate expenditure incurred of all beneficiaries aligned with NGACO *a* in the base year

$E^{c}_{i,a,e,0}$= Capped expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$M_{i,a,e,0}$= Alignment-eligible months accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

B.6 Capped expenditure accrued to an entitlement category by a beneficiary

B.6.1 Capped base-year expenditure

The capped base-year expenditure accrued to an entitlement category by a beneficiary is given by:

$$E^{c}_{i,a,e,0} = \begin{cases} E^{u}_{i,a,e,0}, & E^{u}_{i,a,e,0} \leq M_{i,a,e,0} \times E^{99}_{e,0} \\ M_{i,a,e,0} \times E^{99}_{e,0}, & E^{u}_{i,a,e,0} > M_{i,a,e,0} \times E^{99}_{e,0} \end{cases}$$

where

$E^{c}_{i,a,e,0}$ = Capped expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$E^{u}_{i,a,e,0}$ = Uncapped (incurred) expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$E^{99}_{e,0}$ = 99th percentile of the PBPM expenditure accrued by all alignment-eligible (reference) beneficiaries in the base year

$M_{i,a,e,0}$ = Alignment-eligible months accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

B.6.1 Capped Performance-Year expenditure

The capped Performance-Year expenditure accrued to an entitlement category by a beneficiary is given by:

$$E^{c}_{i,a,e,t} = \begin{cases} E^{u}_{i,a,e,t}, & E^{u}_{i,a,e,t} \leq M_{i,a,e,t} \times E^{99}_{e,t} \\ M_{i,a,e,t} \times E^{99}_{e,t}, & E^{u}_{i,a,e,t} > M_{i,a,e,t} \times E^{99}_{e,t} \end{cases}$$

where

$E^{c}_{i,a,e,t}$ = Capped expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in Performance-Year *t*

$E^{u}_{i,a,e,t}$ = Uncapped (incurred) expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in Performance-Year *t*

$E^{99}_{e,t}$ = 99th percentile of the PBPM expenditure accrued by all alignment-eligible (reference) beneficiaries in Performance-Year *t*

$M_{i,a,e,t}$ = Alignment-eligible months accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in Performance-Year *t*

B.7 Regional GAF trend adjustment for an entitlement category

The regional GAF trend adjustment to the national trend is given by:

$$\bar{L}^{r}_{a,e,t} = \frac{\sum_{r}\left(M^{r}_{a,e,0} \times L^{r}_{e,t}\right)}{M_{a,\mathrm{e},0}}$$

where

$\bar{L}^{r}_{a,e,t}$ = the average Performance Year *t* regional GAF trend adjustment factor of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$\bar{L}^{r}_{e,t}$ = the Performance Year *t* regional GAF trend adjustment factor of base-year alignment-eligible beneficiaries residing in region (county) *r* who accrue experience to entitlement category *e*

$M^{r}_{a,e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year[14]

B.8 Risk adjustment to the trended baseline

The risk adjustment to the trended baseline is given by:

$$\lambda\left(\bar{R}_{a,e,0},\bar{R}_{a,e,t}\right) = f(x) = \begin{cases} 0.97, & \dfrac{\bar{R}_{a,e,t}}{\bar{R}_{a,e,0}} < 0.97 \\ \dfrac{\bar{R}_{a,e,t}}{\bar{R}_{a,e,0}}, & 0.97 \leq \dfrac{\bar{R}_{a,e,t}}{\bar{R}_{a,e,0}} \leq 1.03 \\ 1.03, & \dfrac{\bar{R}_{a,e,t}}{\bar{R}_{a,e,0}} > 1.03 \end{cases}$$

where

$\lambda(\ldots)$= the risk adjustment to the trended baseline

$\bar{R}_{a,e,0}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in the base-year

$\bar{R}_{a,e,\mathrm{t}}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in Performance Year *t*

B.8.1 Re-normalized base year average risk score for an entitlement category

The re-normalized base-year average risk score for an entitlement category is given by:

$$\bar{R}_{a,e,0} = \frac{\bar{H}_{a,e,0}}{\bar{H}^{n}_{e,0}}$$

where

[14] Note that $M_{a,\mathrm{e},0} = \sum_{r}\left(M^{r}_{a,e,0}\right)$. That is, the total months accruing to entitlement category *e* in the base year equals the sum across counties of the months accruing to the entitlement category by beneficiaries residing in the county equals in the base year.

$\bar{R}_{a,e,0}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in the base-year

$\bar{H}_{a,e,0}$ = the average base-year HCC risk score of beneficiaries aligned NGACO *a* in months accruing to entitlement category *e*

$\bar{H}^{n}_{e,0}$ = the average base-year HCC risk score of all alignment-eligible beneficiaries in months accruing to entitlement category *e* in the base-year

B.8.1.1 Base year average HCC risk score for an entitlement category for an NGACO

The base-year average HCC risk score of an NGACO for an entitlement category is given by:

$$\bar{H}_{a,e,0} = \frac{\sum_i \left(M_{i,a,\mathrm{e},0} \times H_{i,a,e,0}\right)}{\sum_i \left(M_{i,a,\mathrm{e},0}\right)} = \frac{\sum_i \left(M_{i,a,\mathrm{e},0} \times H_{i,a,e,0}\right)}{M_{a,\mathrm{e},0}} = \frac{\sum_i \sum_m \left(H_{i,m,a,e,0}\right)}{M_{a,\mathrm{e},0}}$$

where

$\bar{H}_{a,e,0}$ = the average base-year HCC risk score of beneficiaries aligned to NGACO *a* in months accruing to entitlement category *e*

$H_{i,a,e,0}$ = the average base-year HCC risk score of the *i*th beneficiary aligned with NGACO *a* in months accruing to entitlement category *e*

$H_{i,m,a,\mathrm{e},0}$ = the HCC risk score of the *i*th beneficiary aligned with NGACO *a* in each month *m* of the base year that accrues to entitlement category *e*

$M_{i,a,\mathrm{e},0}$ = the number of eligible months accrued to entitlement category *e* during the base year by the *i*th beneficiary aligned with NGACO *a*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued to entitlement category *e* during the base year by beneficiaries aligned with NGACO *a*

$\bar{H}^{n}_{e,0}$ = the average HCC risk score of all alignment-eligible beneficiaries for entitlement category *e* in the base-year

B.8.1.2 National average base year HCC risk score for an entitlement category

The base-year average HCC risk score of all alignment-eligible beneficiaries for an entitlement category is given by:

$$\bar{H}^{n}_{e,0} = \frac{\sum_a \left(M_{i,a,\mathrm{e},0} \times \bar{H}_{a,e,0}\right)}{\sum_a \left(M_{i,a,\mathrm{e},0}\right)} = \frac{\sum_a \sum_i \left(M_{i,a,\mathrm{e},0} \times H_{i,a,e,0}\right)}{\sum_a M_{a,\mathrm{e},0}} = \frac{\sum_a \sum_i \sum_m \left(H_{i,m,a,e,0}\right)}{M^{n}_{e,0}}$$

where

$\bar{H}^{n}_{e,0}$ = the average HCC risk score of all alignment-eligible beneficiaries for entitlement category *e* in the base-year

$\bar{H}_{a,e,0}$ = the average base-year HCC risk score of beneficiaries aligned NGACO *a* in months accruing to entitlement category *e*

$H_{i,a,e,0}$ = the average base-year HCC risk score of the *i*th beneficiary aligned with NGACO *a* in months accruing to entitlement category *e*

$H_{i,m,a,\mathrm{e},0}$ = the HCC risk score of the *i*th beneficiary aligned with NGACO *a* in each month *m* of the base year that accrues to entitlement category *e*

$M_{i,a,\mathrm{e},0}$ = the number of eligible months accrued to entitlement category *e* during the base year by the *i*th beneficiary aligned with NGACO *a*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued to entitlement category *e* during the base year by beneficiaries aligned with NGACO *a*

$M^{n}_{e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by all alignment-eligible beneficiaries

B.8.2 Re-normalized Performance-Year average risk score for an entitlement category

The re-normalized Performance-Year average risk score for an entitlement category is given by:

$$\bar{R}_{a,e,\mathrm{t}} = \frac{\bar{H}_{a,e,\mathrm{t}}}{\bar{H}^{n}_{e,t}}$$

where

$\bar{R}_{a,e,\mathrm{t}}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{H}_{a,e,\mathrm{t}}$ = the average HCC risk score of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{H}^{n}_{e,t}$ = the average HCC risk score of all alignment-eligible beneficiaries for entitlement category *e* in Performance Year *t*

B.8.2.1 Performance-Year average HCC risk score for an entitlement category for an NGACO

The Performance-Year average HCC risk score of an NGACO for an entitlement category is given by:

$$\bar{H}_{a,e,\mathrm{t}} = \frac{\sum_i \left(M_{i,a,\mathrm{e},t} \times H_{i,a,e,\mathrm{t}}\right)}{\sum_i \left(M_{i,a,\mathrm{e},t}\right)} = \frac{\sum_i \left(M_{i,a,\mathrm{e},t} \times H_{i,a,e,\mathrm{t}}\right)}{M_{a,\mathrm{e},t}} = \frac{\sum_i \sum_m \left(H_{i,m,a,e,\mathrm{t}}\right)}{M_{a,\mathrm{e},t}}$$

where

$\overline{H}_{a,e,\mathrm{t}}$ = the average Performance Year *t* HCC risk score of beneficiaries aligned NGACO *a* in months accruing to entitlement category *e*

$H_{i,a,e,\mathrm{t}}$ = the average Performance Year *t* HCC risk score of the *i*th beneficiary aligned with NGACO *a* in months accruing to entitlement category *e*

$H_{i,m,a,\mathrm{e},t}$ = the HCC risk score of the *i*th beneficiary aligned with NGACO *a* in each month *m* of Performance Year *t* that accrues to entitlement category *e*

$M_{i,a,\mathrm{e},t}$ = the number of eligible months accrued to entitlement category *e* during Performance Year *t* by the *i*th beneficiary aligned with NGACO *a*

$M_{a,\mathrm{e},t}$ = the number of eligible months accrued to entitlement category *e* during Performance Year *t* by beneficiaries aligned with NGACO *a*

$\overline{H}^{n}_{e,t}$ = the average HCC risk score of all alignment-eligible beneficiaries for entitlement category *e* in Performance Year *t*

B.8.2.2 National average Performance-Year HCC risk score for an entitlement category

The Performance-Year average HCC risk score of all alignment-eligible beneficiaries for an entitlement category is given by:

$$\overline{H}^{n}_{e,t} = \frac{\sum_a \left(M_{i,a,\mathrm{e},t} \times \overline{H}_{a,e,\mathrm{t}}\right)}{\sum_a \left(M_{i,a,\mathrm{e},t}\right)} = \frac{\sum_a \sum_i \left(M_{i,a,\mathrm{e},t} \times H_{i,a,e,\mathrm{t}}\right)}{\sum_a M_{a,\mathrm{e},t}} = \frac{\sum_a \sum_i \sum_m \left(H_{i,m,a,e,\mathrm{t}}\right)}{M^{n}_{e,t}}$$

where

$\overline{H}^{n}_{e,t}$ = the average HCC risk score of all alignment-eligible beneficiaries for entitlement category *e* in Performance Year *t*

$\overline{H}_{a,e,\mathrm{t}}$ = the average Performance Year *t* HCC risk score of beneficiaries aligned NGACO *a* in months accruing to entitlement category *e*

$H_{i,a,e,\mathrm{t}}$ = the average Performance Year *t* HCC risk score of the *i*th beneficiary aligned with NGACO *a* in months accruing to entitlement category *e*

$H_{i,m,a,\mathrm{e},t}$ = the HCC risk score of the *i*th beneficiary aligned with NGACO *a* in each month *m* of Performance Year *t* that accrues to entitlement category *e*

$M_{i,a,\mathrm{e},t}$ = the number of eligible months accrued to entitlement category *e* during Performance Year *t* by the *i*th beneficiary aligned with NGACO *a*

$M_{a,\mathrm{e},t}$ = the number of eligible months accrued to entitlement category *e* during Performance Year *t* by beneficiaries aligned with NGACO *a*

$M_{e,t}^{n}$ = the number of eligible months accrued during Performance Year *t* to entitlement category *e* by all alignment-eligible beneficiaries

B.9 Adjusted discount

The adjusted discount to the trended baseline is generally given by:

$$\delta\left(\bar{S}_{a,e,0}, \bar{S}^{r}_{a,e,0}, \bar{S}^{n}_{a,e,0}, Q_{a,t-1}\right)$$

A more complete statement of the adjusted discount expresses it as a sum of four factors:

$$\delta(\ldots) = D_t - \rho\left(\bar{S}_{a,e,0}, \bar{S}^{r}_{a,e,0}\right) - \nu\left(\bar{S}_{a,e,0}, \bar{S}^{n}_{a,e,0}\right) - \gamma\left(Q_{a,t-1}\right)$$

where

D_t = Standard discount that applies to the trended risk-adjusted baseline in Performance-Year *t* (equal to 0.03 (3%))

$\delta(\ldots)$= the adjusted discount applied to the risk-adjusted trended baseline for eligibility category *e*

$\rho(\ldots)$= the regional efficiency adjustment to the standard discount

$\nu(\ldots)$= the national efficiency adjustment to the standard discount

$\gamma(\ldots)$= the quality adjustment to the standard discount

$\bar{S}_{a,e,0}$ = the GAF- and risk-standardized average operating expenditure PBPM of NGACO *a* for entitlement category *e* in the base-year

$\bar{S}^{n}_{a,e,0}$ = the national GAF- and risk-standardized average operating expenditure PBPM for entitlement category *e* in the base-year

$\bar{S}^{r}_{a,e,0}$ = the average GAF- and risk-standardized average operating expenditure PBPM in the region of NGACO *a* for entitlement category *e* in the base-year

$Q_{a,t-1}$ = the quality score attained by NGACO *a* in the year prior to the Performance-Year

B.9.1 Regional efficiency adjustment to the standard discount

The regional efficiency adjustment to the standard discount is given by:

$$\rho\left(\bar{S}_{a,e,0},\bar{S}^{r}_{a,e,0}\right)=\begin{cases}+0.10, & \left(\frac{\bar{S}_{a,e,0}}{\bar{S}^{r}_{a,e,0}}\right)<0.9\\ \left(1-\frac{\bar{S}_{a,e,0}}{\bar{S}^{r}_{a,e,0}}\right)\times 0.10, & 0.9\le\left(\frac{\bar{S}_{a,e,0}}{\bar{S}^{r}_{a,e,0}}\right)\le 1.1\\ -0.10, & \left(\frac{\bar{S}_{a,e,0}}{\bar{S}^{r}_{a,e,0}}\right)>1.1\end{cases}$$

The national efficiency adjustment to the standard discount can also be stated in terms of an operating efficiency ratio:

$$\rho\left(O^{r}_{a,e.0}\right)=\begin{cases}+0.10, & O^{r}_{a,e.0}<0.9\\ \left(1-O^{r}_{a,e.0}\right)\times 0.10, & 0.9\le O^{r}_{a,e.0}\le 1.1\\ -0.10, & O^{r}_{a,e.0}>1.1\end{cases}$$

where

$\bar{S}_{a,e,0}$ = the GAF- and risk-standardized average operating expenditure PBPM of NGACO *a* for entitlement category *e* in the base-year

$\bar{S}^{r}_{a,e,0}$ = the average GAF- and risk-standardized average operating expenditure PBPM in the region of NGACO *a* for entitlement category *e* in the base-year

$O^{r}_{a,e.0}$ = the regional baseline operating efficiency ratio of NGACO *a* for entitlement category *e*

$$O^{r}_{a,e.0}=\frac{\bar{S}_{a,e,0}}{\bar{S}^{r}_{a,e,0}}$$

B.9.2 National efficiency adjustment to the standard discount

The national efficiency adjustment to the standard discount is given by:

$$\nu\left(\bar{S}_{a,e,0},\bar{S}^{n}_{a,e,0}\right)=\begin{cases}0.05, & \left(\frac{\bar{S}_{a,e,0}}{\bar{S}^{n}_{a,e,0}}\right)<0.9\\ \left(1-\frac{\bar{S}_{a,e,0}}{\bar{S}^{n}_{a,e,0}}\right)\times 0.05, & 0.9\le\left(\frac{\bar{S}_{a,e,0}}{\bar{S}^{n}_{a,e,0}}\right)\le 1.1\\ -0.05, & \left(\frac{\bar{S}_{a,e,0}}{\bar{S}^{n}_{a,e,0}}\right)>1.1\end{cases}$$

The national efficiency adjustment to the standard discount can also be stated in terms of an operating efficiency ratio:

$$\nu\left(O^{n}_{a,e.0}\right)=\begin{cases}0.05, & O^{n}_{a,e.0}<0.9\\ \left(1-O^{n}_{a,e.0}\right)\times 0.05, & 0.9\le O^{n}_{a,e.0}\le 1.1\\ -0.05, & O^{n}_{a,e.0}>1.1\end{cases}$$

where

$\bar{S}_{a,e,0}$ = the GAF- and risk-standardized average operating expenditure PBPM of NGACO *a* for entitlement category *e* in the base-year

$\bar{S}^{n}_{a,e,0}$ = the national GAF- and risk-standardized average operating expenditure PBPM for entitlement category *e* in the base-year

$O^{n}_{a,e.0}$ = the national baseline operating efficiency ratio of NGACO *a* for entitlement category *e*

$$O^{n}_{a,e.0} = \frac{\bar{S}_{a,e,0}}{\bar{S}^{n}_{a,e,0}}$$

B.9.3 Quality adjustment to the standard discount

The quality adjustment to the standard discount is generally given by:

$$\gamma(Q_{a,t-1}) = \begin{cases} 0.000, & requirements\ for\ calculation\ of\ a\ quality\ score\ not\ met \\ 0.010 \times Q_{a,t-1}, & requirements\ for\ calculation\ of\ a\ quality\ score\ met \end{cases}$$

where

$Q_{a,t-1}$ = the quality score attained by NGACO *a* in the year prior to the Performance-Year expressed as a value ranging from 0.0 to 1.0

For Performance Year 1:

$$\gamma(Q_{a,t}) = \begin{cases} 0.000, & requirements\ for\ calculation\ of\ a\ quality\ score\ not\ met \\ 0.010, & requirements\ for\ calculation\ of\ a\ quality\ score\ met \end{cases}$$

B.10 Standardized baseline expenditure PBPM for an entitlement category

B.10.1 Standardized NGACO baseline expenditure PBPM for an entitlement category

The standardized baseline expenditure PBPM of the NGACO is given by:

$$\bar{S}_{a,e,0} = \frac{\bar{C}^{c}_{a,e,o}}{\bar{G}^{r}_{a,e,t} \times \bar{R}_{a,e,0}}$$

where

$\bar{S}_{a,e,0}$ = the GAF- and risk-standardized average operating expenditure PBPM of NGACO *a* for entitlement category *e* in the base-year

$\bar{C}^{c}_{a,e,o}$ = the average capped operating expense PBPM accrued to entitlement category *e* by beneficiaries aligned with NGACO *a*

$\bar{G}^{r}_{a,e,t}$ = the average regional GAF baseline adjustment of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$\bar{R}_{a,e,0}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in the base-year

B.10.2 Standardized regional baseline expenditure PBPM for an entitlement category

The standardized regional baseline expenditure PBPM for an NGACO is given by:

$$\bar{S}^{r}_{a,e,0} = \frac{\sum_{r}\left(M^{r}_{a,e,0} \times S^{r}_{e,0}\right)}{M_{a,\mathrm{e},0}}$$

where

$\bar{S}^{r}_{a,e,0}$ = the average base-year regional GAF- and risk-standardized average operating expenditure PBPM of NGACO *a* for entitlement category *e*

$\bar{S}^{r}_{e,0}$ = the regional GAF- and risk-standardized average operating expenditure PBPM accrued in the base-year to entitlement category *e* by beneficiaries who reside in county *r*

$M^{r}_{a,e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year

B.10.3 Standardized national baseline expenditure PBPM for an entitlement category

The standardized national baseline expenditure PBPM is given by:

$$\bar{S}^{n}_{e,0} = \frac{\sum_{r}\left(M^{r}_{e,0} \times S^{r}_{e,0}\right)}{\sum_{r} M^{r}_{e,0}}$$

where

$\bar{S}^{n}_{e,0}$ = the base-year GAF- and risk-standardized average operating expenditure PBPM accrued in the base-year to entitlement category *e* of all alignment eligible-beneficiaries

$\bar{S}^{r}_{e,0}$ = the regional GAF- and risk-standardized average operating expenditure PBPM accrued in the base-year to entitlement category *e* by beneficiaries who reside in county *r*

$M^{r}_{e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

B.11 Base-year average operating expense PBPM

The average base-year operating expense PBPM is given by:

$$\bar{C}^{c}_{a,e,o} = \frac{\sum_i \left(M_{i,a,\mathrm{e},0} \times \bar{C}^{c}_{i,a,e,o} \right)}{\sum_i M_{i,a,\mathrm{e},0}}$$

where

$\bar{C}^{c}_{a,e,o}$ = the capped operating expense PBPM accrued to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year

$\bar{C}^{c}_{i,a,e,o}$ = the capped operating expense PBPM accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$M_{i,a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

B.11.1 Operating expenditure incurred by a beneficiary

The (uncapped) operating expenditure incurred by a beneficiary is given by:

$$C^{u}_{i,a,e,o} = C^{pay}_{i,a,e,o} + C^{seq}_{i,a,e,o} + C^{pbp}_{i,a,e,o} - C^{dsh}_{i,a,e,o} - C^{ime}_{i,a,e,o} - C^{ucc}_{i,a,e,o}$$

where

$C^{u}_{i,a,e,o}$ = the uncapped operating expense accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{pay}_{i,a,e,o}$ = the provider payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{seq}_{i,a,e,o}$ = the budget sequestration reduction accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{pbp}_{i,a,e,o}$ = the PBP (population-based payment) reduction accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{ime}_{i,a,e,o}$ = the IME (indirect medical education) payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{dsh}_{i,a,e,o}$ = the DSH (disproportionate share hospital) payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{ucc}_{i,a,e,o}$ = the UCC (uncompensated care) payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

B.11.2 Capped base-year operating expenditure for a beneficiary

The capped base-year operating accrued to an entitlement category by a beneficiary is given by:

$$C^{c}_{i,a,e,0} = \begin{cases} C^{u}_{i,a,e,0}, & C^{u}_{i,a,e,0} \leq M_{i,a,e,0} \times C^{99}_{e,0} \\ M_{i,a,e,0} \times C^{99}_{e,0}, & C^{u}_{i,a,e,0} > M_{i,a,e,0} \times C^{99}_{e,0} \end{cases}$$

where

$C^{c}_{i,a,e,0}$ = Capped operating expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$C^{u}_{i,a,e,0}$ = Uncapped (incurred) operating expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$C^{99}_{e,0}$ = 99th percentile of the PBPM operating expenditure accrued by all alignment-eligible (reference) beneficiaries in the base year

$M_{i,a,e,0}$ = Alignment-eligible months accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

B.12 Terms used in the formal statement of the NGACO benchmarking methods

$\bar{B}^{c}_{a,e,t}$ = the capped benchmark expenditure PBPM of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{C}^{c}_{a,e,o}$ = the average capped operating expense PBPM accrued to entitlement category *e* by beneficiaries aligned with NGACO *a*

$\bar{C}^{c}_{i,a,e,o}$ = the capped operating expense PBPM accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C^{99}_{e,0}$ = 99th percentile of the PBPM operating expenditure accrued by all alignment-eligible (reference) beneficiaries in the base year

$C^{c}_{i,a,e,0}$ = Capped operating expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$C^{u}_{i,a,e,0}$ = Uncapped (incurred) operating expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$C^{dsh}_{i,a,e,o}$ = the DSH (disproportionate share hospital) payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C_{i,a,e,o}^{ime}$ = the IME (indirect medical education) payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C_{i,a,e,o}^{pay}$ = the provider payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C_{i,a,e,o}^{pbp}$ = the PBP (population-based payment) reduction accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C_{i,a,e,o}^{seq}$ = the budget sequestration reduction accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C_{i,a,e,o}^{u}$ = the uncapped operating expense accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$C_{i,a,e,o}^{ucc}$ = the UCC (uncompensated care) payment accrued to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

D_t = Standard discount that applies to the trended risk-adjusted baseline in Performance-Year *t* (equal to 0.03 (3%))

$E_{e,0}^{99}$ = 99th percentile of the PBPM expenditure accrued by all alignment-eligible (reference) beneficiaries in the base year

$E_{e,t}^{99}$ = 99th percentile of the PBPM expenditure accrued by all alignment-eligible (reference) beneficiaries in Performance-Year *t*

$E_{i,a,e,0}^{c}$= Capped expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$E_{i,a,e,0}^{u}$ = Uncapped (incurred) expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in the base year

$E_{i,a,e,t}^{c}$ = Capped expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in Performance-Year *t*

$E_{i,a,e,t}^{u}$ = Uncapped (incurred) expenditure accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in Performance-Year *t*

$\bar{E}_{a,e,t}^{c}$ = the capped baseline expenditure PBPM of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{G}_{a,e,t}^{r}$ = the average regional GAF baseline adjustment of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$\bar{H}_{a,e,0}$ = the average base-year HCC risk score of beneficiaries aligned NGACO *a* in months accruing to entitlement category *e*

$\bar{H}_{a,e,\mathrm{t}}$ = the average HCC risk score of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{H}^{n}_{e,0}$ = the average base-year HCC risk score of all alignment-eligible beneficiaries in months accruing to entitlement category *e* in the base-year

$\bar{H}^{n}_{e,t}$ = the average HCC risk score of all alignment-eligible beneficiaries for entitlement category *e* in Performance Year *t*

$H_{i,a,e,0}$ = the average base-year HCC risk score of the *i*th beneficiary aligned with NGACO *a* in months accruing to entitlement category *e*

$H_{i,a,e,\mathrm{t}}$ = the average Performance Year *t* HCC risk score of the *i*th beneficiary aligned with NGACO *a* in months accruing to entitlement category *e*

$H_{i,m,a,\mathrm{e},0}$ = the HCC risk score of the *i*th beneficiary aligned with NGACO *a* in each month *m* of the base year that accrues to entitlement category *e*

$H_{i,m,a,\mathrm{e},t}$ = the HCC risk score of the *i*th beneficiary aligned with NGACO *a* in each month *m* of Performance Year *t* that accrues to entitlement category *e*

$\bar{L}^{r}_{a,e,t}$ = the average Performance Year *t* regional GAF trend adjustment factor of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$\bar{L}^{r}_{e,t}$ = the Performance Year *t* regional GAF trend adjustment factor of base-year alignment-eligible beneficiaries residing in region (county) *r* who accrue experience to entitlement category *e*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year

$M_{a,\mathrm{e},t}$ = the number of eligible months accrued during Performance Year *t* to entitlement category *e* by beneficiaries aligned with NGACO *a*

$M^{r}_{a,e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M^{n}_{e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by all alignment-eligible beneficiaries

$M^{r}_{e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M^{n}_{e,t}$ = the number of eligible months accrued during Performance Year *t* to entitlement category *e* by all alignment-eligible beneficiaries

$M_{i,a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by the *i*th beneficiary aligned with NGACO *a* in the base year

$M_{i,a,\mathrm{e},t}$ = the number of eligible months accrued to entitlement category *e* during Performance Year *t* by the *i*th beneficiary aligned with NGACO *a*

$M_{i,a,e,t}$ = Alignment-eligible months accrued to entitlement category *e* by the *i*th aligned beneficiary of NGACO *a* in Performance-Year *t*

$O^{n}_{a,e.0}$ = the national baseline operating efficiency ratio of NGACO *a* for entitlement category *e*

$O^{r}_{a,e.0}$ = the regional baseline operating efficiency ratio of NGACO *a* for entitlement category *e*

$Q_{a,t-1}$ = the quality score attained by NGACO *a* in the year prior to the Performance-Year

$Q_{a,t-2}$ = the quality score attained by NGACO *a* in the 2nd year prior to the Performance-Year

$\bar{R}_{a,e,0}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in the base-year

$\bar{R}_{a,e,\mathrm{t}}$ = the re-normalized average risk score of NGACO *a* for entitlement category *e* in Performance Year *t*

$\bar{S}_{a,e,0}$ = the GAF- and risk-standardized average expenditure PBPM of NGACO *a* for entitlement category *e* in the base-year

$\bar{S}^{n}_{a,e,0}$ = the national GAF- and risk-standardized average expenditure PBPM for entitlement category *e* in the base-year

$\bar{S}^{r}_{a,e,0}$ = the average base-year regional GAF- and risk-standardized average operating expenditure PBPM of NGACO *a* for entitlement category *e*

$\bar{S}^{n}_{e,0}$ = the base-year GAF- and risk-standardized average operating expenditure PBPM accrued in the base-year to entitlement category *e* of all alignment eligible-beneficiaries

$\bar{S}^{r}_{e,0}$ = the regional GAF- and risk-standardized average operating expenditure PBPM accrued in the base-year to entitlement category *e* by beneficiaries who reside in county *r*

$\hat{T}^{n}_{e,t}$ = the national projected trend for entitlement category *e* in Performance Year *t*

$\mathfrak{B}^{c}_{a,t}$ = the capped aggregate benchmark expenditure of NGACO *a* in Performance Year *t*

$\mathfrak{B}^{c}_{a,t}$= Capped aggregate benchmark expenditure of NGACO *a* in Performance-Year *t*

$\mathfrak{E}^{c}_{a,e,0}$= Capped aggregate expenditure incurred of all beneficiaries aligned with NGACO *a* in the base year

$\mathfrak{E}^{c}_{a,t}$= Capped aggregate expenditure incurred of all beneficiaries aligned with NGACO *a* in Performance-Year *t*

$\mathfrak{P}^{c}_{a,t}$= Aggregate savings (loss) incurred by NGACO *a* in Performance-Year *t*

$\gamma(\dots)$= the quality adjustment to the standard discount

$\delta(\dots)$= the adjusted discount applied to the risk-adjusted trended baseline for eligibility category *e*

$\lambda(\dots)$= the risk adjustment to the trended baseline

$\nu(\dots)$= the national efficiency adjustment to the standard discount

$\rho(\dots)$= the regional efficiency adjustment to the standard discount

Appendix C. Technical description of the GAF trend adjustment

Provider payments under most Medicare fee-for-service (FFS) payment systems reflect an adjustment for the cost-of-doing business in the local geographic area in which the provider is located.[15] These geographic adjustment factors (GAFs) are updated annually. The purpose of the GAF trend adjustment in the NGACO Model is to prevent the benchmark from being unfairly understated (or overstated) because of differences between the GAFs that Medicare used to calculate provider payments in the base-year (CY2014) and the Performance-Year.

C.1 Overview of the GAF trend adjustment

The GAF trend adjustment factor is a county-level adjustment. The GAF trend adjustment factor for a county is an estimate of the impact of the Performance Year Medicare GAFs on the base-year provider payments for services provided to reference beneficiaries residing in the county. That is, the GAF trend adjustment is an estimate of the amount by which the base-year expenditure of residents of a county would have increased or decreased if the Performance-Year GAFs had been used to calculate provider payments.

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

3. The base year expenditure[16] incurred by residents of a county adjusted to reflect the impact on provider payments of the geographic pricing factors that Medicare will use in the Performance Year; to,
4. The actual expenditure incurred by residents of a county, which reflects the geographic pricing factors that Medicare used to calculate provider payments in the base year.

The GAF-trend adjustment factor will be calculated prospectively for alignment-eligible beneficiaries in each county in the base year and will have no impact on the national FFS trend.[17]

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

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[15] Examples of these Geographic Adjustment Factors (GAFs) are the Medicare area wage index (AWI) and the geographic practice cost index (GPCI).

[16] The GAF adjustment is the ratio of: (1) the aggregate normalized or budget-neutral GAF-adjusted provider payment; to (2) the aggregate unadjusted provider payment. It is not necessary to convert the aggregate provider payment to a PBPM amount.

[17] The GAF-trend adjustment will be calculated on a budget-neutral basis so that the regional trend adjustments neither increase nor decrease the total expenditure of the reference population nationally. That is the adjusted claim amount for the reference population will equal the incurred claim amount.

C.1.1 GAF-adjustable claims

All claims will be included in the calculation of the GAF trend-trend adjustment. Only the following classes of claims will be adjusted to reflect the impact of the Performance-Year GAFs on base-year expenditures:

1. Claims paid under the Inpatient Prospective Payment System (IPPS);
2. Claims paid under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS);
3. Claims paid under the Long-term Care Hospital Prospective Payment System (LTCH PPS);
4. Claims paid under the Skilled Nursing Facility Prospective Payment System (SNF PPS);
5. Claims paid under the Home Health Prospective Payment System (HH PPS);
6. Claims paid under the Hospice Per-diem Payment System (Hospice PDPS);
7. Claims paid under the Hospital Outpatient Prospective Payment System (OPPS);
8. Claims paid under the ESRD Prospective Payment System (ESRD PPS); and,
9. Claims paid under the Physician Fee Schedule (PFS).

For claims that do not belong to these classes, the "GAF-adjusted" payment amount will be equal to the incurred (actual) payment amount.

C.1.2 Attribution of expenditures to counties

The GAF trend-adjusted base-year expenditure for a county is an estimate of the expenditure that would have been incurred in the base-year for claims that are subject to the GAF trend-adjustment and for which the GAF trend-adjustment can be calculated by beneficiaries residing in the county in January of the base-year[18] if provider payment had been calculated using the GAFs that were used in the Performance-Year.

C.2 Regional GAF trend adjustment factor for an NGACO

An NGACO's regional GAF trend adjustment to the national trend for an entitlement category is given by:

$$\bar{L}^{r}_{a,e,t} = \frac{\sum_r \left(M^{r}_{a,e,0} \times L^{r}_{e,t}\right)}{\sum_r \left(M_{a,\mathrm{e},0}\right)} = \frac{\sum_r \left(M^{r}_{a,e,0} \times L^{r}_{e,t}\right)}{M_{a,\mathrm{e},0}}$$

where

$\bar{L}^{r}_{a,e,t}$ = the average Performance Year *t* regional GAF trend adjustment factor of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$\bar{L}^{r}_{e,t}$ = the Performance Year *t* regional GAF trend adjustment factor of base-year alignment-eligible beneficiaries residing in region (county) *r* who accrue experience to entitlement category *e*

[18] Expenditures accrue to the county in which the beneficiary resided in January of the base-year.

$M^{r}_{a,e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year[19]

C.3 County-level GAF trend adjustment factor

Conceptually, the county-level GAF trend adjustment factor represents the amount by which provider payments[20] in the base-year for services received by alignment-eligible beneficiaries who reside in a county would have increased (or decreased) if payments had been calculated using the Geographic Adjustment Factors (GAFs) that will be applied in the Performance-Year.

Computationally, the GAF trend adjustment factor is the ratio of:

- The average GAF-adjusted expend[21] in the base-year of all alignment-eligible beneficiaries residing in a county; to,
- The average incurred expenditure PBPM in the base-year of all alignment-eligible beneficiaries residing in a county.

Note that a beneficiary residing in a given county may obtain services from providers located in other counties. A beneficiary living in San Diego may, for example, receive care from hospitals located in Los Angeles. The county-level adjustment would reflect the patterns of care of beneficiaries living in the county, wherever they happened to obtain care. It is, therefore, similar to the locality adjustment that OACT applies to the Medicare Advantage ratebook.

C.3.1 Formal statement of county-level GAF trend-adjustment factor

Formally:

[19] The total months accruing to entitlement category *e* in the base year equals the sum across counties of the months accruing to the entitlement category by beneficiaries residing in the county equals in the base year ($M_{a,\mathrm{e},0} = \sum_{r}\left(M^{r}_{a,e,0}\right)$).

[20] The provider payment that is used in the GAF trend-adjustment includes Indirect Medical Education and Disproportionate Share Hospital payments and exclude Uncompensated Care payments.

[21] The numerator and denominator of the GAF trend adjustment can be expressed either as a PBPM or simply as the aggregate of all alignment-eligible beneficiaries. When expressed as a PBPM the numerator (adjusted expenditure) and denominator (incurred claims) are both divided by the number of eligible months accrued to the entitlement category by beneficiaries residing in the county.

$$L_{e,t}^{r} = \frac{\sum_k \left(\left[A_{k,e,0}^{cc,r,t} \times N_{k,e,0}^{cc,t} \right] + \left[A_{k,e,0}^{nc,r,t} \times N_{k,e,0}^{nc,t} \right] + \left[A_{k,e,0}^{na,r,t} \times N_{k,e,0}^{na,t} \right] \right)}{\sum_k \left(E_{k,e,0}^{cc,r,t} + E_{k,e,0}^{nc,r,t} + E_{k,e,0}^{na,r,t} \right)}$$

which can also be stated:

$$L_{e,t}^{r} = \frac{\sum_k \left[A_{k,e,0}^{cc,r,t} \times N_{k,e,0}^{cc,t} \right] + \sum_k \left[A_{k,e,0}^{nc,r,t} \times N_{k,e,0}^{nc,t} \right] + \sum_k \left[A_{k,e,0}^{na,r,t} \times N_{k,e,0}^{na,t} \right]}{\sum_k \left(E_{k,e,0}^{cc,r} \right) + \sum_k \left(E_{k,e,0}^{nc,r} \right) + \sum_k \left(E_{k,e,0}^{na,r} \right)}$$

where

$L_{e,t}^{r}$ = the GAF trend-adjustment factor of county *r* entitlement category *e* in Performance-Year *t*

$A_{k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$N_{k,e,0}^{cc.t}$ = the national Performance-Year *t* budget-neutrality factor for claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{cc.r}$ = the expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{k,e,0}^{nc.r,t}$ = the expenditure on claims of type *k* to which a GAF trend-adjustment applies but cannot be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{nc.r}$ = the expenditure on claims of type *k* to which a GAF trend-adjustment applies but cannot be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{k,e,0}^{na.r,t}$ = the expenditure on claims of type *k* to which a GAF trend-adjustment does not apply that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{na.r}$ = the expenditure on claims of type *k* to which a GAF trend-adjustment does not apply that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

For claims that are not subject to GAF-adjustment or for which the GAF-adjustment cannot be calculated, the adjusted expenditure is the same as the incurred expenditure (i.e., $A_{k,e,0}^{nc.r,t} = E_{k,e,0}^{nc.r}$ and

$A_{k,e,0}^{na.r,t} = E_{k,e,0}^{na.r}$). Consequently, the budget neutrality factors for these two sub-classes of claims are both equal to 1.0, and the county-level GAF trend-adjustment factor can be stated as:

$$L_{e,t}^{r} = \frac{\sum_k \left(A_{k,e,0}^{cc,r,t} \times N_{k,e,0}^{cc,t}\right) + \sum_k \left(E_{k,e,0}^{nc,r}\right) + \sum_k \left(E_{k,e,0}^{na,r}\right)}{\sum_k \left(E_{k,e,0}^{cc,r}\right) + \sum_k \left(E_{k,e,0}^{nc,r}\right) + \sum_k \left(E_{k,e,0}^{na,r}\right)}$$

C.3.2 Budget-neutrality factor for class of GAF-adjustable claims

Because the application of Performance-Year GAFs to base-year claims may cause the GAF-adjusted payment across all adjusted claims to be to be higher or lower than the actual incurred expenditure, a "budget-neutrality" adjustment is applied to the adjusted payment. The budget-neutrality factor is the same for all claims within an adjustment class. A separate budget-neutrality factors is calculated for each class of GAF-adjusted claims (e.g., separate budget-neutrality factors are calculated for acute inpatient claims paid under the IPPS, for SNF claims paid under the SNF PPS, for physician claims paid under the PFS, etc.).

For a class of GAF-adjustable claims, the GAF trend-adjusted expenditure before the application of the budget neutrality factor is the sum across all beneficiaries residing in the county of the locality adjusted expenditure for that type of claim during months that accrue to the entitlement category during the base year. The budget-neutrality factor for a class of GAF-adjustable claims is the ratio of:

1. The total GAF trend-adjusted expenditure for that class of claims across all counties (or, equivalently, across all alignment-eligible beneficiaries); to
2. The total incurred (actual) expenditure for that class of claims across all counties.

Formally:

$$N_{\mathrm{k},e,0}^{cc,t} = \frac{A_{k,e,0}^{cc,n,t}}{E_{k,e,0}^{cc,n}} = \frac{\sum_r \left(A_{k,e,0}^{cc,r,t}\right)}{\sum_r \left(E_{k,e,0}^{cc,r}\right)} = \frac{\sum_r \sum_i \left(A_{i,k,e,0}^{cc,r,t}\right)}{\sum_r \sum_i \left(E_{i,k,e,0}^{cc,r}\right)}$$

where

$N_{k,e,0}^{cc.t}$ = the national Performance-Year *t* budget-neutrality factor for claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{k,e,0}^{cc.n,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by all alignment-eligible beneficiaries (nationally) that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{cc.n}$ = the actual payment on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by all alignment-eligible beneficiaries (nationally) that accrues to entitlement category *e* in the base-year

$A_{k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{cc.r}$ = the actual payment on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{i,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{i,k,e,0}^{cc.r}$ = the incurred (actual) payment on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

C.3.3 County-level GAF trend-adjusted base-year expenditure (before budget neutrality)

For a category of claims, the GAF trend-adjusted expenditure that accrues to a county is simply the sum of the locality adjusted expenditure in months that accrue to the entitlement category by all beneficiaries who reside in the county in the base year:

$$A_{\mathrm{k},e,0}^{cc,r,t} = \sum_{i} A_{i,\mathrm{k},\mathrm{e},0}^{cc,r,t}$$

where

$A_{k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{i,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

C.3.4 Beneficiary-level GAF trend-adjusted base-year expenditure

For a category of claims, the GAF trend-adjusted expenditure that accrues to a beneficiary is simply the sum of the locality adjusted expenditure on claims incurred by the beneficiary in months that accrue to the entitlement category in the base year:

$$A_{\mathrm{i,k},e,0}^{cc,r,t} = \sum_{j} A_{i,\mathrm{j,k,e},0}^{cc,r,t}$$

where

$A_{i,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted expenditure on claims of type *k* to which a GAF trend-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the *j*th claim of type *k* to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

C.3.5 GAF trend-adjusted base-year payment amount (expenditure)

The GAF trend-adjusted (repriced) payment amount for an individual claim within a class of GAF-adjustable claims is given generally by:

$$A_{i,j,k,e,0}^{cc,r,t} = E_{i,j,k.e,0}^{cc,r} \times \left(\frac{P_{i,j,k,t}^{cc,r}}{P_{i,j,k,0}^{r}} \right)$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the *j*th claim of type *k* to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the *j*th claim of type *k* to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{cc,r}$ = the geographic (price) adjustment factor that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the geographic (price) adjustment factor that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

When used to calculate provider payment, the GAFs are generally weighted by a factor (e.g., the labor-share or the relative value unit). Consequently, a more complete statement of the trend-adjusted (repriced) payment amount for an individual claim within a class of GAF-adjustable claims is given generally by:

$$A_{i,j,k,e,0}^{cc,r,t} = E_{i,j,k.e,0}^{cc,r} \times \left(\frac{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,t}^{cc,r} \right] + \left[1 - W_{i,j,k,0}^{cc,r} \right]}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r} \right] + \left[1 - W_{i,j,k,0}^{cc,r} \right]} \right)$$

where

$W_{i,j,k,0}^{cc,r}$ = the weight that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The specific methods used to calculate the GAF-adjusted payment amount vary by class of GAF-adjustable claim. For example, the GAF-adjusted payment amount for acute inpatient care is also corrected to reflect the Part A deductible. The specific methods are described in sections C.4 through C.12.

C.4 Adjustment of Inpatient Prospective Payment System (IPPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (IPPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0} \right) \times \left(\frac{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,t}^{cc,r} \right] + \left[1 - W_{i,j,k,0}^{cc,r} \right]}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r} \right] + \left[1 - W_{i,j,k,0}^{cc,r} \right]} \right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (IPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type *k* (IPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{cc,r}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the j^{th} claim of type *k* (IPPS) to which a GAF trend-adjustment both applies

and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (IPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (IPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the j^{th} claim of type *k* (IPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it must be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount.

C.5 Adjustment of Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (IRF PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,t}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (IRF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type *k* (IRF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{cc,r}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* (IRF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (IRF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (IRF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the *j*th claim of type *k* (IRF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it must be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount.

C.6 Adjustment of Long-term Care Hospital Prospective Payment System (LTCH PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (LTCH PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,t}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the *j*th claim of type *k* (LTCH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-

eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{cc,r}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the *j*th claim of type *k* (LTCH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it must be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount.

C.7 Adjustment of Skilled Nursing Facility Prospective Payment System (SNF PPS) claims

Using the OACT method the 'adjusted' claim amount for SNF claims that are paid under the inpatient prospective payment system (SNF PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,t}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the *j*th claim of type *k* (SNF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E^{cc.r}_{i,j,k,e,0}$ = the incurred (actual) payment on the j^{th} claim of type *k* (SNF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,t}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the j^{th} claim of type *k* (SNF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,0}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (SNF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W^{cc,r}_{i,j,k,0}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (SNF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the j^{th} claim of type *k* (SNF PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P^{cc,r}_{i,j,k,0}$, $P^{cc,r}_{i,j,k,t}$) and labor proportion ($W^{cc,r}_{i,j,k,0}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it should be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount. However, the data available to calculate the adjusted claim amount may not include the deductible amounts.

C.8 Adjustment of Home Health Prospective Payment System (HH PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (HH PPS) is calculated as follows:

$$A^{cc,r,t}_{i,j,k,e,0} = \left(E^{cc,r}_{i,j,k.e,0} - D_{i,j,k,e,0}\right) \times \left(\frac{\left[W^{cc,r}_{i,j,k,0} \times P^{cc,r}_{i,j,k,t}\right] + \left[1 - W^{cc,r}_{i,j,k,0}\right]}{\left[W^{cc,r}_{i,j,k,0} \times P^{cc,r}_{i,j,k,0}\right] + \left[1 - W^{cc,r}_{i,j,k,0}\right]}\right) + D_{i,j,k,e,0}$$

where

$A^{cc.r,t}_{i,j,k,e,0}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (HH PPS) to which a GAF trend-adjustment both applies and can be calculated

that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E^{cc,r}_{i,j,k,e,0}$ = the incurred (actual) payment on the j^{th} claim of type *k* (HH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,t}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the j^{th} claim of type *k* (HH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,0}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (HH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W^{cc,r}_{i,j,k,0}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (HH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = payments for durable medical equipment paid on the j^{th} claim of type *k* (HH PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P^{cc,r}_{i,j,k,0}$, $P^{cc,r}_{i,j,k,t}$) and labor proportion ($W^{cc,r}_{i,j,k,0}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Durable medical equipment payments are made outside of the HH PPS and are not subject to the HH area wage adjustment. They are therefore deducted from the home health payment before application of the GAF-adjustment and are then added to the adjusted payment amount.

C.9 Adjustment of Hospice Per-diem Payment System (Hospice PDPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (HOSPICE PPS) is calculated as follows:

$$A^{cc,r,t}_{i,j,k,e,0} = \left(E^{cc,r}_{i,j,k.e,0}\right) \times \left(\frac{\left[W^{cc,r}_{i,j,k,0} \times P^{cc,r}_{i,j,k,t}\right] + \left[1 - W^{cc,r}_{i,j,k,0}\right]}{\left[W^{cc,r}_{i,j,k,0} \times P^{cc,r}_{i,j,k,0}\right] + \left[1 - W^{cc,r}_{i,j,k,0}\right]} \right)$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the *j*th claim of type *k* (HOSPICE PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the *j*th claim of type *k* (HOSPICE PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{cc,r}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* (HOSPICE PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (HOSPICE PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (HOSPICE PPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment.

C.10 Adjustment of Hospital Outpatient Prospective Payment System (OPPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (OPPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r}\right) \times \left(\frac{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,t}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]} \right)$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the *j*th claim of type *k* (OPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E^{cc.r}_{i,j,k,e,0}$ = the incurred (actual) payment on the j^{th} claim of type *k* (OPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,t}$ = the area wage index that applies in Performance-Year *t* to calculate the provider payment on the j^{th} claim of type *k* (OPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,0}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (OPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W^{cc,r}_{i,j,k,0}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (OPPS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P^{cc,r}_{i,j,k,0}$, $P^{cc,r}_{i,j,k,t}$) and labor proportion ($W^{cc,r}_{i,j,k,0}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment.

C.11 Adjustment of ESRD Prospective Payment System (ESRD PPS) claims

C.12 Adjustment of Physician Fee Schedule (PFS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (PFS) is calculated as follows:

$$A^{cc,r,t}_{i,j,k,e,0} = \left(E^{cc,r}_{i,j,k.e,0}\right) \times \left(\frac{\left[W^{w,cc,r}_{i,j,k,0} \times P^{w,cc,r}_{i,j,k,t}\right] + \left[W^{pe,cc,r}_{i,j,k,0} \times P^{pe,cc,r}_{i,j,k,t}\right] + \left[W^{mp,cc,r}_{i,j,k,0} \times P^{mp,cc,r}_{i,j,k,t}\right]}{\left[W^{w,cc,r}_{i,j,k,0} \times P^{w,cc,r}_{i,j,k,0}\right] + \left[W^{pe,cc,r}_{i,j,k,0} \times P^{pe,cc,r}_{i,j,k,0}\right] + \left[W^{mp,cc,r}_{i,j,k,0} \times P^{mp,cc,r}_{i,j,k,0}\right]} \right)$$

where

$A^{cc.r,t}_{i,j,k,e,0}$ = the Performance-Year *t* trend-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E^{cc.r}_{i,j,k,e,0}$ = the incurred (actual) payment on the j^{th} claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{w,cc,r}$ = the "work" GPCI that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{w,cc,r}$ = the "work" GPCI that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{w,cc,r}$ = the "work" RVU that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{pe,cc,r}$ = the "practice expense" GPCI that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{pe,cc,r}$ = the "practice expense" GPCI that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{pe,cc,r}$ = the "practice expense" RVU that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,t}^{mp,cc,r}$ = the "malpractice" GPCI that applies in Performance-Year *t* to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{mp,cc,r}$ = the "malpractice" GPCI that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{mp,cc,r}$ = the "malpractice" RVU that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (PFS) to which a GAF trend-adjustment both applies and can be calculated that is incurred by the *i*th

alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The GPCIs ($P^{w,cc,r}_{i,j,k,0}$, $P^{w,cc,r}_{i,j,k,t}$, *etc.*) and relative value units ($W^{w,cc,r}_{i,j,k,0}$)will be determined based on the "pricing locality" to which the claim is assigned for purposes of pricing. The pricing locality is based on the MAC and PFS locality within a state.

Technical Note C-1:

The NGACO's regional trend can be calculated as either the product of the national prospective trend and a person-month weighted average of the county-level GAF trend-adjustment factors:

$$\bar{T}^r_{a,e,t} = \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{a,e,t} - 1$$

or as a person-month weighted average of county-level adjusted trends:

$$\bar{T}^r_{a,e,t} = \frac{\sum_r \left(M^r_{a,e,0} \times \hat{T}^r_{e,t}\right)}{\sum_r \left(M_{a,\mathrm{e},0}\right)} = \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{a,e,t} - 1$$

where

$$\hat{T}^r_{e,t} = \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{e,t} - 1$$

Proof:

$$\bar{T}^r_{a,e,t} = \frac{\sum_r \left(\left[M^r_{a,e,0} \times \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{e,t} - M^r_{a,e,0}\right]\right)}{\sum_r \left(M_{a,\mathrm{e},0}\right)}$$

$$\bar{T}^r_{a,e,t} = \frac{\sum_r \left(\left[M^r_{a,e,0} \times \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{e,t}\right]\right) - \sum_r M^r_{a,e,0}}{\sum_r \left(M_{a,\mathrm{e},0}\right)}$$

$$\bar{T}^r_{a,e,t} = \frac{\sum_r \left(\left[M^r_{a,e,0} \times \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{e,t}\right]\right)}{\sum_r \left(M_{a,\mathrm{e},0}\right)} - 1$$

$$\bar{T}^r_{a,e,t} = \left(1 + \hat{T}^n_{e,t}\right) \times \left[\frac{\sum_r \left(M^r_{a,e,0} \times \bar{L}^r_{e,t}\right)}{\sum_r \left(M_{a,\mathrm{e},0}\right)}\right] - 1$$

$$\bar{T}^r_{a,e,t} = \left(1 + \hat{T}^n_{e,t}\right) \times \bar{L}^r_{a,e,t} - 1$$

where

$\bar{T}^r_{a,e,t}$ = the average Performance Year *t* regional trend of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e* in Performance Year *t*

$\hat{T}^{r}_{e,t}$ = the national projected trend for entitlement category *e* in Performance Year *t*

$\hat{T}^{n}_{e,t}$ = the national projected trend for entitlement category *e* in Performance Year *t*

$\bar{L}^{r}_{a,e,t}$ = the average Performance Year *t* regional GAF trend adjustment factor of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$\bar{L}^{r}_{e,t}$ = the Performance Year *t* regional GAF trend adjustment factor of base-year alignment-eligible beneficiaries residing in region (county) *r* who accrue experience to entitlement category *e*

$M^{r}_{a,e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year[22]

[22] The total months accruing to entitlement category *e* in the base year equals the sum across counties of the months accruing to the entitlement category by beneficiaries residing in the county equals in the base year ($M_{a,\mathrm{e},0} = \sum_{r}(M^{r}_{a,e,0})$).

Appendix D. Technical description of the GAF baseline-adjustment

Provider payments under most Medicare fee-for-service (FFS) payment systems reflect an adjustment for the cost-of-doing business in the local geographic area in which the provider is located.[23] These geographic adjustment factors can cause differences of up to ±10% or more in the payments that are made for the same services in different regions. The purpose of the GAF baseline adjustment in the NGACO Model is to prevent the efficiency adjustment (particularly the national efficiency adjustment) to the standard discount, and therefore the benchmark, from being unfairly understated (or overstated) because of differences between the GAFs that Medicare used to calculate provider payments in the base-year (CY2014).

D.1 Overview of the GAF baseline-adjustment

The GAF baseline-adjustment factor is a county-level adjustment. The GAF baseline-adjustment factor for a county is an estimate of the impact of the base-year Medicare GAFs on the base-year provider payments for services provided to reference beneficiaries residing in the county. That is, the GAF baseline-adjustment is an estimate of the amount by which the base-year expenditure of residents of a county was increased or decreased relative to the national average based solely on the base-year GAFs that were used to calculate provider payments.

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

1. The base-year expenditure[24] incurred by residents of a county adjusted to remove the impact on provider payments of the geographic pricing factors that Medicare used in the base-year; to,
2. The actual expenditure incurred by residents of a county, which reflects the geographic pricing factors that Medicare used to calculate provider payments in the base year.

The GAF baseline-adjustment factor will be calculated prospectively for alignment-eligible beneficiaries in each county in the base year and will have no impact on the national baseline reference-population expenditure.[25]

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

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[23] Examples of these Geographic Adjustment Factors (GAFs) are the Medicare area wage index (AWI) and the geographic practice cost index (GPCI).

[24] The GAF adjustment is the ratio of: (1) the aggregate normalized or budget-neutral GAF-adjusted provider payment; to (2) the aggregate unadjusted provider payment. It is not necessary to convert the aggregate provider payment to a PBPM amount.

[25] The GAF-trend adjustment will be calculated on a budget-neutral basis so that the regional GAF baseline-adjustments neither increase nor decrease the total expenditure of the reference population nationally. That is the baseline GAF-adjusted claim amount for the reference population will equal the incurred claim amount.

D.1.1 GAF-adjustable claims

All claims will be included in the calculation of the GAF baseline-adjustment. Only the following classes of claims will be adjusted to reflect the impact of the base-year GAFs on base-year expenditures:

10. Claims paid under the Inpatient Prospective Payment System (IPPS);
11. Claims paid under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS);
12. Claims paid under the Long-term Care Hospital Prospective Payment System (LTCH PPS);
13. Claims paid under the Skilled Nursing Facility Prospective Payment System (SNF PPS);
14. Claims paid under the Home Health Prospective Payment System (HH PPS);
15. Claims paid under the Hospice Per-diem Payment System (Hospice PDPS);
16. Claims paid under the Hospital Outpatient Prospective Payment System (OPPS);
17. Claims paid under the ESRD Prospective Payment System (ESRD PPS); and,
18. Claims paid under the Physician Fee Schedule (PFS).

For claims that do not belong to these classes, the "GAF-adjusted" payment amount will be equal to the incurred (actual) payment amount.

D.1.2 Attribution of expenditures to counties

The GAF baseline-adjusted base-year expenditure for a county is an estimate of the expenditure that would have been incurred in the base-year for claims that are subject to the GAF baseline-adjustment and for which the GAF baseline-adjustment can be calculated by beneficiaries residing in the county in January of the base-year[26] if provider payment had been calculated without applying the GAFs that were used in the base-year.

D.2 GAF baseline-adjustment factor for an NGACO

An NGACO's GAF baseline-adjustment for an entitlement category is given by:

$$\bar{G}^{r}_{a,e,0} = \frac{\sum_r \left(M^{r}_{a,e,0} \times G^{r}_{e,0}\right)}{\sum_r \left(M_{a,\mathrm{e},0}\right)} = \frac{\sum_r \left(M^{r}_{a,e,0} \times G^{r}_{e,0}\right)}{M_{a,\mathrm{e},0}}$$

where

$\bar{G}^{r}_{a,e,0}$ = the average performance year *t* regional GAF baseline-adjustment factor of beneficiaries aligned with NGACO *a* in the base-year for experience accrued to entitlement category *e*

$G^{r}_{e,0}$ = the performance year *t* GAF baseline-adjustment factor of base-year alignment-eligible beneficiaries residing in region (county) *r* who accrue experience to entitlement category *e*

[26] Expenditures accrue to the county in which the beneficiary resided in January of the base-year.

$M^{r}_{a,e,0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* who reside in county *r*

$M_{a,\mathrm{e},0}$ = the number of eligible months accrued during the base year to entitlement category *e* by beneficiaries aligned with NGACO *a* in the base year[27]

D.3 County-level GAF trend adjustment factor

Conceptually, the county-level GAF baseline-adjustment factor represents the amount by which the GAFs used in the base-year increased or decreased base-year provider payments[28] for services received by alignment-eligible beneficiaries who reside in a county relative to the national average payment.

Computationally, the GAF baseline-adjustment factor is the ratio of:

- The average GAF baseline-adjusted expend[29] in the base-year of all alignment-eligible beneficiaries residing in a county; to,
- The average incurred expenditure PBPM in the base-year of all alignment-eligible beneficiaries residing in a county.

Note that a beneficiary residing in a given county may obtain services from providers located in other counties. A beneficiary living in San Diego may, for example, receive care from hospitals located in Los Angeles. The county-level adjustment would reflect the patterns of care of beneficiaries living in the county, wherever they happened to obtain care. It is, therefore, similar to the locality adjustment that OACT applies to the Medicare Advantage ratebook.

D.3.1 Formal statement of county-level GAF baseline-adjustment factor

Formally:

$$L^{r}_{e,t} = \frac{\sum_{k}\left(\left[A^{cc,r,t}_{k,e,0} \times N^{cc,t}_{k,e,0}\right] + \left[A^{nc,r,t}_{k,e,0} \times N^{nc,t}_{k,e,0}\right] + \left[A^{na,r,t}_{k,e,0} \times N^{na,t}_{k,e,0}\right]\right)}{\sum_{k}\left(E^{cc,r,t}_{k,e,0} + E^{nc,r,t}_{k,e,0} + E^{na,r,t}_{k,e,0}\right)}$$

[27] The total months accruing to entitlement category *e* in the base year equals the sum across counties of the months accruing to the entitlement category by beneficiaries residing in the county equals in the base year ($M_{a,\mathrm{e},0} = \sum_{r}\left(M^{r}_{a,e,0}\right)$).

[28] The provider payment that is used in the GAF baseline-adjustment excludes Indirect Medical Education and Disproportionate Share Hospital payments as well as Uncompensated Care payments.

[29] The numerator and denominator of the GAF baseline-adjustment can be expressed either as a PBPM or simply as the aggregate of all alignment-eligible beneficiaries. When expressed as a PBPM the numerator (adjusted expenditure) and denominator (incurred claims) are both divided by the number of eligible months accrued to the entitlement category by beneficiaries residing in the county.

which can also be stated:

$$L_{e,t}^{r} = \frac{\sum_k \left[A_{k,e,0}^{cc,r,t} \times N_{k,e,0}^{cc,t}\right] + \sum_k \left[A_{k,e,0}^{nc,r,t} \times N_{k,e,0}^{nc,t}\right] + \sum_k \left[A_{k,e,0}^{na,r,t} \times N_{k,e,0}^{na,t}\right]}{\sum_k \left(E_{k,e,0}^{cc,r}\right) + \sum_k \left(E_{k,e,0}^{nc,r}\right) + \sum_k \left(E_{k,e,0}^{na,r}\right)}$$

where

$L_{e,t}^{r}$ = the GAF baseline-adjustment factor of county *r* entitlement category *e* in the base-year

$A_{k,e,0}^{cc.r,t}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$N_{k,e,0}^{cc.t}$ = the national base-year budget-neutrality factor for claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{cc.r}$ = the expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{k,e,0}^{nc.r,t}$ = the expenditure on claims of type *k* to which a GAF baseline-adjustment applies but cannot be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{nc.r}$ = the expenditure on claims of type *k* to which a GAF baseline-adjustment applies but cannot be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{k,e,0}^{na.r,t}$ = the expenditure on claims of type *k* to which a GAF baseline-adjustment does not apply that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{na.r}$ = the expenditure on claims of type *k* to which a GAF baseline-adjustment does not apply that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

For claims that are not subject to GAF-adjustment or for which the GAF-adjustment cannot be calculated, the adjusted expenditure is the same as the incurred expenditure (i.e., $A_{k,e,0}^{nc.r,t} = E_{k,e,0}^{nc.r}$ and $A_{k,e,0}^{na.r,t} = E_{k,e,0}^{na.r}$). Consequently, the budget neutrality factors for these two sub-classes of claims are both equal to 1.0, and the county-level GAF baseline-adjustment factor can be stated as:

$$L_{e,t}^{r} = \frac{\sum_k \left(A_{k,e,0}^{cc,r,t} \times N_{k,e,0}^{cc,t}\right) + \sum_k \left(E_{k,e,0}^{nc,r}\right) + \sum_k \left(E_{k,e,0}^{na,r}\right)}{\sum_k \left(E_{k,e,0}^{cc,r}\right) + \sum_k \left(E_{k,e,0}^{nc,r}\right) + \sum_k \left(E_{k,e,0}^{na,r}\right)}$$

D.3.2 Budget-neutrality factor for class of GAF-adjustable claims

Because the application of base-year GAFs to base-year claims may cause the GAF-adjusted payment across all adjusted claims to be to be higher or lower than the actual incurred expenditure, a "budget-neutrality" adjustment is applied to the adjusted payment. The budget-neutrality factor is the same for all claims within an adjustment class. A separate budget-neutrality factor is calculated for each class of GAF-adjusted claims (e.g., separate budget-neutrality factors are calculated for acute inpatient claims paid under the IPPS, for SNF claims paid under the SNF PPS, for physician claims paid under the PFS, etD.).

For a class of GAF-adjustable claims, the GAF baseline-adjusted expenditure before the application of the budget neutrality factor is the sum across all beneficiaries residing in the county of the locality adjusted expenditure for that type of claim during months that accrue to the entitlement category during the base year. The budget-neutrality factor for a class of GAF-adjustable claims is the ratio of:

3. The total GAF baseline-adjusted expenditure for that class of claims across all counties (or, equivalently, across all alignment-eligible beneficiaries); to
4. The total incurred (actual) expenditure for that class of claims across all counties.

Formally:

$$N_{\mathrm{k},e,0}^{cc,t} = \frac{A_{k,e,0}^{cc,n,t}}{E_{k,e,0}^{cc,n}} = \frac{\sum_r \left(A_{k,e,0}^{cc,r,t}\right)}{\sum_r \left(E_{k,e,0}^{cc,r}\right)} = \frac{\sum_r \sum_i \left(A_{i,k,e,0}^{cc,r,t}\right)}{\sum_r \sum_i \left(E_{i,k,e,0}^{cc,r}\right)}$$

where

$N_{k,e,0}^{cc.t}$ = the national budget-neutrality factor for claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A_{k,e,0}^{cc.n,t}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by all alignment-eligible beneficiaries (nationally) that accrue to entitlement category *e* in the base-year

$E_{k,e,0}^{cc.n}$ = the actual payment on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by all alignment-eligible beneficiaries (nationally) that accrues to entitlement category *e* in the base-year

$A_{k,e,0}^{cc.r,t}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible

beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$E^{cc.r}_{k,e,0}$ = the actual payment on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A^{cc.r,t}_{i,k,e,0}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

$E^{cc.r}_{i,k,e,0}$ = the incurred (actual) payment on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

D.3.3 County-level GAF trend-adjusted base-year expenditure (before budget neutrality)

For a category of claims, the GAF baseline-adjusted expenditure that accrues to a county is simply the sum of the baseline-adjusted expenditure in months that accrue to the entitlement category by all beneficiaries who reside in the county in the base year:

$$A^{cc,r,t}_{\mathrm{k},e,0} = \sum_{i} A^{cc,r,t}_{i,\mathrm{k},\mathrm{e},0}$$

where

$A^{cc.r,t}_{k,e,0}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by alignment-eligible beneficiaries residing in county *r* and that accrue to entitlement category *e* in the base-year

$A^{cc.r,t}_{i,k,e,0}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

D.3.4 Beneficiary-level GAF trend-adjusted base-year expenditure

For a category of claims, the GAF trend-adjusted expenditure that accrues to a beneficiary is simply the sum of the locality adjusted expenditure on claims incurred by the beneficiary in months that accrue to the entitlement category in the base year:

$$A^{cc,r,t}_{\mathrm{i,k},e,0} = \sum_{j} A^{cc,r,t}_{i,\mathrm{j},\mathrm{k},\mathrm{e},0}$$

where

$A^{cc.r,t}_{i,k,e,0}$ = the baseline-adjusted expenditure on claims of type *k* to which a GAF baseline-adjustment both applies and can be calculated that are incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrue to entitlement category *e* in the base-year

$A^{cc.r,t}_{i,j,k,e,0}$ = the baseline-adjusted payment amount (expenditure) on the *j*th claim of type *k* to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

D.3.5 GAF trend-adjusted base-year payment amount (expenditure)

The GAF baseline-adjusted (repriced) payment amount for an individual claim within a class of GAF-adjustable claims is given generally by:

$$A^{cc,r,t}_{i,j,k,e,0} = E^{cc,r}_{i,j,k.e,0} \times \left(\frac{1}{P^{r}_{i,j,k,0}} \right)$$

where

$A^{cc.r,t}_{i,j,k,e,0}$ = the baseline-adjusted payment amount (expenditure) on the *j*th claim of type *k* to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E^{cc.r}_{i,j,k,e,0}$ = the incurred (actual) payment on the *j*th claim of type *k* to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P^{cc,r}_{i,j,k,0}$ = the geographic (price) adjustment factor that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

When used to calculate provider payment, the GAFs are generally weighted by a factor (e.g., the labor-share or the relative value unit). Consequently, a more complete statement of the trend-adjusted (repriced) payment amount for an individual claim within a class of GAF-adjustable claims is given generally by:

$$A^{cc,r,t}_{i,j,k,e,0} = E^{cc,r}_{i,j,k.e,0} \times \left(\frac{1}{\left[W^{cc,r}_{i,j,k,0} \times P^{cc,r}_{i,j,k,0} \right] + \left[1 - W^{cc,r}_{i,j,k,0} \right]} \right)$$

where

$W_{i,j,k,0}^{cc,r}$ = the weight that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type k to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county r and that accrues to entitlement category e in the base-year

The specific methods used to calculate the GAF-adjusted payment amount vary by class of GAF-adjustable claim. For example, the GAF-adjusted payment amount for acute inpatient care is also corrected to reflect the Part A deductible. The specific methods are described in sections D.4 through D.12.

D.4 Adjustment of Inpatient Prospective Payment System (IPPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (IPPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the j^{th} claim of type k (IPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county r and that accrues to entitlement category e in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type k (IPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county r and that accrues to entitlement category e in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type k (IPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county r and that accrues to entitlement category e in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type k (IPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county r and that accrues to entitlement category e in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the *j*th claim of type *k* (IPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it must be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount.

D.5 Adjustment of Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (IRF PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the *j*th claim of type *k* (IRF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the *j*th claim of type *k* (IRF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (IRF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (IRF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the *j*th claim of type *k* (IRF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-

eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it must be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount.

D.6 Adjustment of Long-term Care Hospital Prospective Payment System (LTCH PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (LTCH PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the *j*th claim of type *k* (LTCH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (LTCH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the *j*th claim of type *k* (LTCH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage index ($P_{i,j,k,0}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it must be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the adjusted amount.

D.7 Adjustment of Skilled Nursing Facility Prospective Payment System (SNF PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (SNF PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} + D_{i,j,k,e,0}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) - D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the *j*th claim of type *k* (SNF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the *j*th claim of type *k* (SNF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the *j*th claim of type *k* (SNF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the *j*th claim of type *k* (SNF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = the inpatient deductible paid on the *j*th claim of type *k* (SNF PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the *i*th alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Because the deductible amount is the same in all payment localities, it should be added to the paid amount before calculating the GAF trend-adjusted payment and then must be deduced from the

adjusted amount. However, deductible amounts may not be available in the data used to calculate the adjusted payment amount.

D.8 Adjustment of Home Health Prospective Payment System (HH PPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (HH PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r} - D_{i,j,k,e,0}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right) + D_{i,j,k,e,0}$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (HH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type *k* (HH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (HH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (HH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$D_{i,j,k,e,0}$ = payments for durable medical equipment paid on the j^{th} claim of type *k* (HH PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment. Durable medical equipment payments are made outside of the HH PPS and are not subject to the HH area wage adjustment. They are therefore deducted from the home health payment before application of the GAF-adjustment and are then added to the adjusted payment amount.

D.9 Adjustment of Hospice Per-diem Payment System (Hospice PDPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (HOSPICE PPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right)$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (HOSPICE PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type *k* (HOSPICE PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (HOSPICE PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (HOSPICE PPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment.

D.10 Adjustment of Hospital Outpatient Prospective Payment System (OPPS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (OPPS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r}\right) \times \left(\frac{1}{\left[W_{i,j,k,0}^{cc,r} \times P_{i,j,k,0}^{cc,r}\right] + \left[1 - W_{i,j,k,0}^{cc,r}\right]}\right)$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (OPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type *k* (OPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{cc,r}$ = the area wage index that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (OPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{cc,r}$ = the labor proportion that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (OPPS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The area wage indices ($P_{i,j,k,0}^{cc,r}$, $P_{i,j,k,t}^{cc,r}$) and labor proportion ($W_{i,j,k,0}^{cc,r}$)will be determined based on the "payment locality" to which the provider is assigned for purposes of making the wage adjustment.

D.11 Adjustment of ESRD Prospective Payment System (ESRD PPS) claims

D.12 Adjustment of Physician Fee Schedule (PFS) claims

Using the OACT method the 'adjusted' claim amount for acute inpatient services claims that are paid under the inpatient prospective payment system (PFS) is calculated as follows:

$$A_{i,j,k,e,0}^{cc,r,t} = \left(E_{i,j,k.e,0}^{cc,r}\right) \times \left(\frac{\left[W_{i,j,k,0}^{w,cc,r}\right] + \left[W_{i,j,k,0}^{pe,cc,r}\right] + \left[W_{i,j,k,0}^{mp,cc,r}\right]}{\left[W_{i,j,k,0}^{w,cc,r} \times P_{i,j,k,0}^{w,cc,r}\right] + \left[W_{i,j,k,0}^{pe,cc,r} \times P_{i,j,k,0}^{pe,cc,r}\right] + \left[W_{i,j,k,0}^{mp,cc,r} \times P_{i,j,k,0}^{mp,cc,r}\right]} \right)$$

where

$A_{i,j,k,e,0}^{cc.r,t}$ = the baseline-adjusted payment amount (expenditure) on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$E_{i,j,k,e,0}^{cc.r}$ = the incurred (actual) payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{w,cc,r}$ = the "work" GPCI that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{w,cc,r}$ = the "work" RVU that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{pe,cc,r}$ = the "practice expense" GPCI that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{pe,cc,r}$ = the "practice expense" RVU that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$P_{i,j,k,0}^{mp,cc,r}$ = the "malpractice" GPCI that applies in the base-year to calculate the provider payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

$W_{i,j,k,0}^{mp,cc,r}$ = the "malpractice" RVU that applies to the geographic (price) adjustment factor in the base-year to calculate the provider payment on the j^{th} claim of type *k* (PFS) to which a GAF baseline-adjustment both applies and can be calculated that is incurred by the i^{th} alignment-eligible beneficiary residing in county *r* and that accrues to entitlement category *e* in the base-year

The GPCIs ($P_{i,j,k,0}^{w,cc,r}$, $P_{i,j,k,t}^{w,cc,r}$, *etc.*) and relative value units ($W_{i,j,k,0}^{w,cc,r}$)will be determined based on the "pricing locality" to which the claim is assigned for purposes of pricing. The pricing locality is based on the MAC and PFS locality within a state.

Next Generation ACO Model Participation Agreement

Appendix C

Voluntary Alignment

I. General

A. This Appendix C will apply only if the ACO selects participation in Voluntary Alignment pursuant to Section X of the Agreement.

B. If the ACO selects participation in Voluntary Alignment, CMS shall conduct beneficiary alignment in accordance with Appendix B, except that CMS shall also align to the ACO any Medicare beneficiary eligible for voluntary alignment under Section V of this Appendix C.

II. Voluntary Alignment Forms

A. The ACO shall submit the following to CMS for approval by a time and in a manner specified by CMS:

1. A preliminary list identifying the Medicare Beneficiaries whom the ACO will contact regarding voluntary alignment; and

2. The criteria used by the ACO to identify such Medicare beneficiaries.

B. CMS will conduct a sample audit to verify that the beneficiaries on the preliminary list satisfy the voluntary alignment eligibility requirement under Section V.A of this Appendix C.

C. CMS will determine which beneficiaries on the preliminary list the ACO may contact regarding voluntary alignment and return to the ACO the final list ("**Voluntary Alignment Beneficiary List**") identifying the Medicare beneficiaries that the ACO may contact regarding voluntary alignment.

D. During a period starting on or after a date determined by CMS, the ACO shall provide a form ("**Voluntary Alignment Form**") and instructions to all Medicare beneficiaries that are included on the Voluntary Alignment Beneficiary List.

E. CMS shall determine the content of the Voluntary Alignment Forms and instructions. CMS shall provide templates for both the Voluntary Alignment Forms and instructions to the ACO.

F. The ACO shall make no changes to the template forms and instructions, except for making necessary changes solely for the purpose of formatting for electronic distribution

and/or receipt of submissions and for the insertion of the following information where indicated on such forms:

1. The name of the Medicare beneficiary's main doctor, main provider, and/or the main place the beneficiary receives care;

2. The logo of the ACO or Next Generation Participant;

3. Information about unique care coordination and preventive services offered by the ACO as included in the beneficiary notification or as approved by CMS in accordance with Section V.E of the Agreement;

4. The ACO's contact information for answering Medicare beneficiaries' questions;

5. Instructions for how the Medicare beneficiary can submit the Voluntary Alignment Form to the ACO; and

6. Such other fields on the Voluntary Alignment form that CMS may identify.

G. The ACO may choose to provide Voluntary Alignment Forms at the point of care only in the offices of Next Generation Participants. The ACO shall notify CMS by a date specified by CMS if the ACO elects to provide Voluntary Alignment Forms at the point of care.

H. Form Requests

1. The ACO shall permit any Medicare beneficiary who is a patient of a Next Generation Participant to receive a Voluntary Alignment Form upon request. The ACO shall permit a beneficiary to request a form in person at the office of such Next Generation Participant or by calling the ACO.

2. The ACO shall permit any Medicare beneficiary who has received a Voluntary Alignment Form to request another Voluntary Alignment Form that identifies a different Next Generation Participant as the beneficiary's main doctor, main provider, or main place of care or otherwise reverses his or her voluntary alignment or that identifies a physician or other individual or entity that is not a Next Generation Participant as his or her main doctor, main provider, or main place of care or otherwise reverses his or her voluntary alignment. The ACO shall permit such requests to be made by calling the ACO.

3. The ACO shall permit any Medicare beneficiary that has received a Voluntary Alignment Form to request another form that allows signature by an appointed

representative. Instructions on how to make this request will be included on the Voluntary Alignment Form. The ACO shall permit such requests to be made by calling the ACO.

I. Maintenance of Records

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

III. Beneficiary-Next Generation Participant Communications

A. The ACO, Next Generation Participants and other individuals or entities performing functions or services related to ACO Activities, may directly communicate orally with Medicare beneficiaries regarding voluntary alignment and the Voluntary Alignment Forms.

B. The ACO shall require personnel at the offices of Next Generation Participants to instruct Medicare beneficiaries to call the ACO for questions about how to make changes to a Voluntary Alignment Form.

C. The ACO may instruct Next Generation Participants to answer questions from beneficiaries regarding the Voluntary Alignment Form, but must prohibit them from completing the form on behalf of any beneficiary.

IV. Voluntary Alignment Process

A. By a date specified by CMS, the ACO shall submit to CMS a list ("Voluntary Alignment List"). The Voluntary Alignment List must contain the following:

1. The name and other required identifying information of each Medicare Beneficiary who returned one or more valid Voluntary Alignment Forms to the ACO or a Next Generation Participant (For purposes of this Appendix, a Voluntary Alignment Form is valid only if it has been signed and dated by the Medicare beneficiary or his or her appointed representative, was received by the ACO on or before the date on which the ACO submits its Voluntary Alignment List to CMS);

2. For each valid Voluntary Alignment Form submitted by a beneficiary, the date on which the beneficiary executed the Voluntary Alignment Form, and the identity of the Next Generation Participant that the beneficiary has identified as his or her main doctor, main provider, or main place of care; and

3. A certification by an executive of the ACO that, to the best of his or her knowledge, information, and belief, the information contained on the Voluntary Alignment List is true, accurate, and complete and identifies only those Medicare beneficiaries who have submitted a valid Voluntary Alignment Form to the ACO.

B. CMS will use the Voluntary Alignment List submitted by the ACO to conduct alignment of Medicare beneficiaries for the subsequent Performance Year.

1. CMS will align Medicare beneficiaries that were included on the ACO's Voluntary Alignment List to the ACO in accordance with the criteria set forth in Section V of this Appendix.

2. If a Medicare beneficiary returns more than one Voluntary Alignment Form to an ACO or returns such forms to multiple ACOs, CMS will honor the Voluntary Alignment Form with the latest execution date.

C. CMS will audit the ACO's Voluntary Alignment List for accuracy in accordance with Section XVII of this Agreement.

D. For each Performance Year in which the ACO participates in voluntary alignment, CMS may survey Next Generation Beneficiaries as a part of the voluntary alignment audit process.

V. Voluntary Alignment Eligibility Criteria

CMS shall align a Medicare beneficiary to the ACO for a Performance Year if the following conditions are satisfied:

A. The Medicare beneficiary has at least one paid claim for a Qualified Evaluation and Management service, as defined in Appendix B of this Agreement, furnished by a Next Generation Participant on or after a date specified by CMS.

B. On or before a deadline specified by CMS, the Pioneer ACO received a valid Voluntary Alignment Form from the Medicare beneficiary identifying a Next Generation Participant as his or her main doctor, main provider, or main place of care.

C. The Medicare beneficiary has not, on or before such deadline specified by CMS, subsequently identified a physician or other individual or entity that is not a Next

Generation Participant as his or her main doctor, main provider, or main place of care or otherwise reversed his or her voluntary alignment.

D. At the time the ACO's beneficiary alignment is conducted, the Medicare beneficiary meets the eligibility criteria set forth in Appendix B of this Agreement.

E. At the time CMS conducts beneficiary alignment, CMS has not aligned the Medicare beneficiary to another model or demonstration including, but not limited to, the Independence at Home Demonstration, the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP), or the Duals Demonstrations.

VI. Transitioning Voluntary Alignment Decisions from Other ACO Initiatives

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

INSTRUCTIONS FOR COMPLETING THE DATA USE AGREEMENT (DUA) FORM CMS-R-0235

(AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL IDENTIFIERS)

This agreement must be executed prior to the disclosure of data from CMS' Systems of Records to ensure that the disclosure will comply with the requirements of the Privacy Act, the Privacy Rule and CMS data release policies. It must be completed prior to the release of, or access to, specified data files containing protected health information and individual identifiers.

Directions for the completion of the agreement follow:

Before completing the DUA, please note the language contained in this agreement cannot be altered in any form.

- First paragraph, enter the Requestor's Organization Name.
- Section #1, enter the Requestor's Organization Name.
- Section #4 enter the Study and/or Project Name and CMS contract number if applicable for which the file(s) will be used.
- Section #5 should delineate the files and years the Requestor is requesting. Specific file names should be completed. If these are unknown, you may contact a CMS representative to obtain the correct names The System of Record (SOR) should be completed by the CMS contact or Project Officer. The SOR is the source system the data came from.
- Section #6, complete by entering the Study/Project's anticipated date of completion.
- Section #12 will be completed by the User.
- Section #16 is to be completed by Requestor.
- Section #17, enter the Custodian Name, Company/Organization, Address, Phone Number (including area code), and E-Mail Address (if applicable). The Custodian of files is defined as that person who will have actual possession of and responsibility for the data files. **This section should be completed even if the Custodian and Requestor are the same.** This section will be completed by Custodian.
- Section #18 will be completed by a CMS representative.
- Section #19 should be completed if your study is funded by one or more other Federal Agencies. The Federal Agency name (other than CMS) should be entered in the blank. The Federal Project Officer should complete and sign the remaining portions of this section. If this does not apply, leave blank.
- Sections #20a AND 20b will be completed by a CMS representative.
- Addendum, CMS-R-0235A, should be completed when additional custodians outside the requesting organization will be accessing CMS identifiable data.

Once the DUA is received and reviewed for privacy and policy issues, a completed and signed copy will be sent to the Requestor and CMS Project Officer, if applicable, for their files.

DATA USE AGREEMENT

DUA # _____

(AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL IDENTIFIERS)

CMS agrees to provide the User with data that reside in a CMS Privacy Act System of Records as identified in this Agreement. In exchange, the User agrees to pay any applicable fees; the User agrees to use the data only for purposes that support the User's study, research or project referenced in this Agreement, which has been determined by CMS to provide assistance to CMS in monitoring, managing and improving the Medicare and Medicaid programs or the services provided to beneficiaries; and the User agrees to ensure the integrity, security, and confidentiality of the data by complying with the terms of this Agreement and applicable law, including the Privacy Act and the Health Insurance Portability and Accountability Act. In order to secure data that reside in a CMS Privacy Act System of Records; in order to ensure the integrity, security, and confidentiality of information maintained by the CMS; and to permit appropriate disclosure and use of such data as permitted by law, CMS and _____ enter into this agreement to comply with the following specific paragraphs.
(Requestor)

1. This Agreement is by and between the Centers for Medicare & Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services (HHS), and _____, hereinafter termed "User."
(Requestor)

2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain, use, reuse and disclose the CMS data file(s) specified in section 5 and/or any derivative file(s) that contain direct individual identifiers or elements that can be used in concert with other information to identify individuals. This Agreement supersedes any and all agreements between the parties with respect to the use of data from the files specified in section 5 and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any grant award or other prior communication from the Department of Health and Human Services or any of its components with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact or the CMS signatory to this Agreement shown in section 20.

3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.

4. The User represents, and in furnishing the data file(s) specified in section 5 CMS relies upon such representation, that such data file(s) will be used solely for the following purpose(s).

Name of Study/Project
CMS Next Generation Accountable Care Organization (ACO) Model

CMS Contract No. *(If applicable)*

The User represents further that the facts and statements made in any study or research protocol or project plan submitted to CMS for each purpose are complete and accurate. Further, the User represents that said study protocol(s) or project plans, that have been approved by CMS or other appropriate entity as CMS may determine, represent the total use(s) to which the data file(s) specified in section 5 will be put.

The User agrees not to disclose, use or reuse the data covered by this agreement except as specified in an Attachment to this Agreement or except as CMS shall authorize in writing or as otherwise required by law, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement. The User affirms that the requested data is the minimum necessary to achieve the purposes stated in this section. The User agrees that, within the User organization and the organizations of its agents, access to the data covered by this Agreement shall be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in this section (i.e., individual's access to the data will be on a need-to-know basis).

5. The following CMS data files are covered under this Agreement.

File	Years(s)	System of Record
HIGLAS - Payment Data	2012-2015	N/A
NLR - Meaningful Use Data	2012-2015	NCH
RAS - Risk Adjustment Data	2012-2015	IDR
CAHPS - Beneficiary Survey Data	2012-2015	IDR
GPRO - Quality Measurement Data	2012-2015	NCH
NPICS - NPI Crosswalk	2012-2015	NPESS
PECOS - Provider Enrollment Data	2012-2015	PECOS
CME - Beneficiary Enrollment Data	2012-2015	CME
IDR - Parts A, B, and D Claims	2012-2015	IDR

6. Except as provided in this paragraph, the undersigned parties mutually agree that the aforesaid CMS data files(s) (and/or any derivative data file(s)), including, but not limited to those files that directly identify individuals or that directly identify bidding firms and/or such firms' proprietary, or confidential information, may be retained by the User until _____, hereinafter known as the "retention date". They further agree that any individually identifiable health information from such CMS data files or derivative data files may be retained after the completion of the purpose specified in section 4 and past the retention date if the data is maintained in a HIPAA-covered designated record set by a covered entity or a business associate of a covered entity as those terms are used in 45 CFR Parts 160 and 164. Other than for data described in the preceding sentence, the User agrees to destroy and send written certification of the destruction of the CMS data files and/or any derivative data files to CMS within 30 days of the retention date, or the completion date (the date on which the work described in paragraph 4 is completed or abandoned), whichever is earlier. User agrees to notify CMS in writing within 30 days of the completion date, and in so doing, shall ask CMS to close the data use agreement within 30 days of their completion date notice.

   The Agreement may be terminated by either party at any time for any reason upon 30 days written notice or upon material breach of the program agreement or the applicable DUA(s) governing access to CMS data under that agreement, unilaterally by CMS. Upon notice of termination by User, CMS will cease releasing data from the file(s) to the User under this Agreement. CMS will also notify the User to destroy such data file(s) except for individually identifiable health information from such data file(s) or derivative data file(s) that is maintained in a HIPAA-covered designated record set by a covered entity or a business associate of a covered entity as those terms are used in 45 CFR Parts 160 and 164. Sections 3, 4, 6, 8, 9, 10, 11, 13, 14 and 15 shall survive termination of this Agreement.

7. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it.The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems **(http://www.whitehouse.gov/omb/circulars/a130/a130.html)** as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" **(http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf);** and, Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" **(http://csrc.nist.gov/publications/nistpubs/800-53-Rev2/sp800-53-rev2-final.pdf)**. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified in section 5 is prohibited. Further, the User agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in section 17 without written approval from CMS unless such movement, transmission or disclosure is required by a law.

8. The User agrees to grant access to the data to the authorized representatives of CMS or DHHS Office of the Inspector General at the site indicated in section 17 for the purpose of inspecting to confirm compliance with the terms of this agreement.

9. The User agrees not to disclose direct findings, listings, or information derived from the file(s) specified in section 5, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

   The User agrees that any use of CMS data in the creation of any document (manuscript, table, chart, study, report, etc.) concerning the purpose specified in section 4 (regardless of whether the report or other writing expressly refers to such purpose, to CMS, or to the files specified in section 5 or any data derived from such files) must adhere to CMS' current cell size suppression policy. **This policy stipulates that no cell (eg. admittances, discharges, patients, services) 10 or less may be displayed.** Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less. By signing this Agreement you hereby agree to abide by these rules and, therefore, will not be required to submit any written documents for CMS review. If you are unsure if you meet the above criteria, you may submit your written products for CMS review. CMS agrees to make a determination about approval and to notify the user within 4 to 6 weeks after receipt of findings. CMS may withhold approval for publication only if it determines that the format in which data are presented may result in identification of individual beneficiaries

10. The User agrees that, absent express written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement to do so, the User shall not attempt to link records included in the file(s) specified in section 5 to any other individually identifiable source of information. This includes attempts to link the data to other CMS data file(s). A protocol that includes the linkage of specific files that has been approved in accordance with section 4 constitutes express authorization from CMS to link files as described in the protocol.

11. The User understands and agrees that they may not reuse original or derivative data file(s) without prior written approval from the appropriate System Manager or the person designated in section 20 of this Agreement.

12. The parties mutually agree that the following specified Attachments are part of this Agreement:
    See Attachment A.

13. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made a use, reuse or disclosure of the aforesaid file(s) that is not authorized by this Agreement or another written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement, CMS, at its sole discretion, may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized use, reuse or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal response to an allegation of unauthorized use, reuse or disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses or disclosures; and (e) if requested by CMS, return data files to CMS or destroy the data files it received from CMS under this agreement. The User understands that as a result of CMS's determination or reasonable belief that unauthorized uses, reuses or disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.

    The User agrees to report any breach of personally identifiable information (PII) from the CMS data file(s), loss of these data or disclosure to any unauthorized persons to the CMS Action Desk by telephone at (410) 786-2850 or by e-mail notification at **cms_it_service_desk@cms.hhs.gov** within one hour and to cooperate fully in the federal security incident process. While CMS retains all ownership rights to the data file(s), as outlined above, the User shall bear the cost and liability for any breaches of PII from the data file(s) while they are entrusted to the User. Furthermore, if CMS determines that the risk of harm requires notification of affected individual persons of the security breach and/or other remedies, the User agrees to carry out these remedies without cost to CMS.

14. The User hereby acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding $10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The User further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the Requestor or Custodian, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses. Any person found to have violated sec. (i)(3) of the Privacy Act shall be guilty of a misdemeanor and fined not more than $5,000. Finally, the User acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that the User, or any individual employed or affiliated therewith, has taken or converted to his own use data file(s), or received the file(s) knowing that they were stolen or converted. Under such circumstances, they shall be fined under Title 18 or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $1,000, they shall be fined under Title 18 or imprisoned not more than 1 year, or both.

15. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement and acknowledges having received notice of potential criminal or administrative penalties for violation of the terms of the Agreement.

16. On behalf of the User the undersigned individual hereby attests that he or she is authorized to legally bind the User to the terms of this Agreement and agrees to all the terms specified herein.

Name and Title of User *(typed or printed)*		
Company/Organization		
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature	Date	

17. The parties mutually agree that the following named individual is designated as Custodian of the file(s) on behalf of the User and will be the person responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

    The Custodian hereby acknowledges his/her appointment as Custodian of the aforesaid file(s) on behalf of the User, and agrees to comply with all of the provisions of this Agreement on behalf of the User.

Name of Custodian *(typed or printed)*		
Company/Organization		
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature	Date	

18. The disclosure provision(s) that allows the discretionary release of CMS data for the purpose(s) stated in section 4 follow(s). (To be completed by CMS staff.) _____

19. On behalf of _____ the undersigned individual hereby acknowledges that the aforesaid Federal agency sponsors or otherwise supports the User's request for and use of CMS data, agrees to support CMS in ensuring that the User maintains and uses CMS's data in accordance with the terms of this Agreement, and agrees further to make no statement to the User concerning the interpretation of the terms of this Agreement and to refer all questions of such interpretation or compliance with the terms of this Agreement to the CMS official named in section 20 (or to his or her successor).

Typed or Printed Name	Title of Federal Representative
Signature	Date
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*

20. The parties mutually agree that the following named individual will be designated as point-of-contact for the Agreement on behalf of CMS.

    On behalf of CMS the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

Name of CMS Representative *(typed or printed)*		
Title/Component		
Street Address		Mail Stop
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
A. Signature of CMS Representative		Date
B. Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date

ATTACHMENT A

This Attachment supplements the Data Use Agreement between the Centers for Medicare & Medicaid Services ("CMS") and the Users. To the extent that this Attachment is inconsistent with any terms in the Data Use Agreement, this Attachment modifies and overrides the Data Use Agreement.

USE OF THE INFORMATION

A-1. The ACO (the "User") intends to use the requested information as a tool to deliver seamless, coordinated care for patients with Original Medicare (that is, who are not in Medicare Advantage private health plans) to promote better care, better health, and lower growth in expenditures. Information derived from the files specified in Section 5 of the Data Use Agreement may be shared and used within the legal confines of the ACO and its Next Generation Participants in a manner consistent with Section A-2 to enable the ACO to improve care integration and be a patient-centered organization.

A-2. User may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation, but shall not disseminate original or derived information from the files specified in Section 5 of the Data Use Agreement, with or without direct identifiers, to anyone who is not a Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule "Covered Entity" Next Generation Participant, a HIPAA Privacy Rule "Business Associate" of a "Covered Entity" Next Generation Participant or a "Covered Entity" in a treatment relationship with a Next Generation Beneficiary. User may disseminate and link information derived from the files specified in Section 5 of the Data Use Agreement to other sources of individually-identifiable (patient-specific) health information, such as medical records, available to the ACO and its Next Generation Participants unless expressly prohibited by the Medicare beneficiary. When using or disclosing protected health information (PHI) or personally identifiable information (PII), obtained under the Data Use Agreement, Users must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. Users shall limit disclosure of information to the established Privacy Act "routine uses," which are categories established by the Privacy Act which dictate the types of uses under which data can be disclosed.

A-3. Nothing in the Data Use Agreement, including but not limited to Section 9, prohibits Users from discussing or reporting on specific individuals or incidents in a manner consistent with Section A-2.

A-4. Nothing in the Data Use Agreement, including but not limited to Section 9, prohibits the Users from obtaining and disseminating any information whatsoever that is obtained independent of the Data Use Agreement, whether or not the information also could be derived from the files specified in Section 5 of the Data Use Agreement.

A-5. Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in Section 5 in a manner consistent with Section A-2. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in Section 5 to other files.

A-6. Nothing in the Data Use Agreement grants CMS, or any other person or entity, any authority to review or restrain any report or communication by a User before its dissemination to a "Business Associate" of User or to a Next Generation Participant in the same CMS-approved ACO.

A-7. Notwithstanding any contrary provision in the DUA or any prior Addenda, User is permitted to retain any CMS-provided beneficiary data that it has received/receives under DUA [DUA Number: _____] if the User is a HIPAA covered entity, and the data has been incorporated into the subject beneficiaries' medical records. Furthermore, regardless of whether User is a HIPAA covered entity, any HIPAA covered entity to whom User provides such data in the course of carrying out the Model initiative may also retain such data if such entity is a HIPAA covered entity and the data is incorporated into the subject beneficiaries' medical records. The provisions of this paragraph apply equally to the business associates of such covered entities, should those covered entities task their business associate(s) with the maintenance of such covered entities' medical records. These permissions survive termination of the Agreement and this DUA so long as the records continue to be protected under the HIPAA privacy and security rules (i.e., so long as the records are maintained in the medical records of a HIPAA covered entity or its business associate). User shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph.

POTENTIAL PENALTIES

A-8. Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement and this attachment.

_____

For: Centers for Medicare & Medicaid Services

_____

For: Accountable Care Organization

Next Generation ACO Model Participation Agreement

Appendix E

Data Sharing and Reports

Pursuant to Section VI of the Agreement and Appendix D, CMS shall provide the following data and reports to the ACO upon request:

I. Next Generation Beneficiary Data

These files will include individually identifiable demographic and Medicare eligibility status information and various summary reports with data relevant to ACO operations and performance in the Model.

II. Detailed Claims Data

These files will include individually identifiable claim and claim line data for services furnished by Medicare-enrolled providers and suppliers (both Next Generation Participants and non-Next Generation Participants) to Next Generation Beneficiaries. The data will not include claims for Next Generation Beneficiaries who have opted out of sharing data pursuant to Section VI.C of this Agreement. The data will not include any information about substance abuse services protected under Substance Abuse and Mental Health Services Administration (SAMHSA) regulations for any Next Generation Beneficiaries who have not opted out in to sharing data pursuant to Section VI.D of this Agreement. Files for a Next Generation Beneficiary consist of an initial file containing historical data for the preceding three years and monthly files thereafter.

III. Monthly Financial Reports

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

IV. Quarterly Baseline Benchmark Reports

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

Next Generation ACO Model Participation Agreement

Appendix F

Quality Measures

The following quality measures are the measures for use in establishing quality performance standards in the first Performance Year of the Model.

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance PY1
AIM: Better Care for Individuals				
Patient/Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	R
	ACO - 2	CAHPS: How Well Your Doctors Communicate	Survey	R
	ACO - 3	CAHPS: Patients' Rating of Doctor	Survey	R
	ACO - 4	CAHPS: Access to Specialists	Survey	R
	ACO - 5	CAHPS: Health Promotion and Education	Survey	R
	ACO - 6	CAHPS: Shared Decision Making	Survey	R
	ACO - 7	CAHPS: Health Status/Functional Status	Survey	R
	ACO - 34	CAHPS: Stewardship of Patient Resources	Survey	R
Care Coordination/Patient Safety	ACO - 8	Risk-Standardized, All Condition Readmission	Claims	R
	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Claims	R
	ACO - 36	All-Cause Unplanned Admissions for Patients with Diabetes	Claims	R
	ACO - 37	All-Cause Unplanned Admissions for Patients with Heart Failure	Claims	R
	ACO - 38	All-Cause Unplanned Admissions for Patients with	Claims	R

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance PY1
		Multiple Chronic Conditions		
	ACO - 9	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)	Claims	R
	ACO - 10	Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	Claims	R
	ACO 39	Documentation of Current Medications in the Medical Record	CMS Web Interface	R
	ACO 13	Falls: Screening for Future Fall Risk	CMS Web Interface	R
AIM: Better Care for Populations				
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	R
	ACO - 15	Pneumonia Vaccination Status for Older Adults	CMS Web Interface	R
	ACO - 16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	CMS Web Interface	R
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	R
	ACO - 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	CMS Web Interface	R
	ACO - 19	Colorectal Cancer Screening	CMS Web Interface	R
	ACO - 20	Breast Cancer Screening	CMS Web Interface	R
	ACO - 21	Preventive Care and	CMS Web	R

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance PY1
		Screening: Screening for High Blood Pressure and Follow-up Documented	Interface	
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	R
Clinical Care for At Risk Population - Depression	ACO – 40	Depression Remission at Twelve Months	CMS Web Interface	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Composite (All or Nothing Scoring): ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control ACO - 41: Diabetes: Eye Exam	CMS Web Interface	R
	ACO - 41			
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure	CMS Web Interface	R
Clinical Care for At Risk Population - Ischemic Vascular Disease	ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	CMS Web Interface	R
Clinical Care for At Risk Population - Heart Failure	ACO - 31	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	CMS Web Interface	R
Clinical Care for At Risk Population – Coronary Artery Disease	ACO - 33	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)	CMS Web Interface	R

Next Generation ACO Model Participation Agreement

Appendix G

Alternative Payment Mechanism - Infrastructure Payments

I. Eligibility Criteria

In its sole discretion, CMS may reject the ACO's election to participate in Infrastructure Payments for a performance year if CMS has imposed any remedial actions pursuant to Section XIX of this Agreement during the two performance years prior to the applicable performance year.

II. Calculation

A. Determining Aligned Population

CMS will calculate the amount of the ACO's Infrastructure Payments using the aligned population, as determined according to Appendix B prior to the start of the applicable performance year.

B. PBPM Payment

1. If the ACO elects to participate in Infrastructure Payments through the annual selections process under Section X of this Agreement, the ACO must select the dollar amount of the per-beneficiary per-month ("**PBPM**") payment.

2. The PBPM amount may not exceed $6.00 PBPM.

C. Monthly Payment

1. The amount of the monthly Infrastructure Payment:

   (a) Is the product of the number of aligned beneficiaries in II.A and the selected PBPM amount in II.B;

   (b) Will be calculated by CMS prior to the start of each performance year in which the ACO has elected to participate in Infrastructure Payments; and

   (c) Will not be updated during the Performance Year.

2. CMS will make Infrastructure Payments as a monthly lump sum payment to the ACO.

3. Infrastructure Payments may be subject to budget sequestration.

D. Claims Payment

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

E. Reconciliation of Infrastructure Payments

1. The ACO shall repay CMS all Infrastructure Payments amounts received during a Performance Year as Other Monies Owed at the Performance Year settlement or through settlement reports issued at such other times as may be required under this Agreement under Section XIV.

2. Infrastructure Payments do not affect the calculation of Shared Savings/Losses, which will continue to be based on total FFS expenditures during the Performance Year for Next Generation Beneficiaries (see Appendix B for more detail).

3. The reconciliation of Infrastructure Payments does not affect and is not affected by the ACO's selected risk arrangement or savings/losses cap.

4. Infrastructure Payments will be reconciled as Other Monies Owed during the Performance Year financial settlement or through a settlement report at such other time as may be required under this Agreement.

5. To reduce the number of transactions between the ACO and CMS, the amount of Infrastructure Payments owed will be added to any Shared Losses to be paid to CMS or deducted from any Shared Savings to be paid to the ACO, such that the ACO may owe CMS a payment despite earning Shared Savings.

6. Settlement and repayment of Infrastructure Payments will occur in accordance with Section XIV of this Agreement.

Next Generation ACO Model

Appendix H

Alternative Payment Mechanism - Population-Based Payments

I. Eligibility Criteria

In its sole discretion, CMS may reject the ACO's election to participate in PBP for a performance year if CMS has imposed any remedial actions pursuant to Section XIX of this Agreement during the two performance years prior to the applicable performance year.

II. Reduced FFS Payments

A. If the ACO has elected to participate in PBP for a Performance Year, the ACO shall notify and educate all Next Generation Participants of the ACO's participation in PBP and the associated Reduced FFS Payments by a date determined by CMS. Providing a copy of the Fee Reduction Agreement shall not constitute notification and education for purposes of this requirement.

B. Not all Next Generation Participants must agree to receive Reduced FFS Payments for the ACO to participate in PBP.

C. Not all Next Generation Participants billing under a TIN must agree to receive Reduced FFS Payments for the TIN to participate in PBP.

D. CMS will make Reduced FFS Payments only to those Next Generation Participants that agree to receive Reduced FFS Payments.

E. CMS will not make Reduced FFS Payments for items and services billed by a Next Generation Participant using a Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers (DMEPOS) supplier billing number.

F. Written Consent

1. The ACO shall obtain written confirmation of consent to receive Reduced FFS Payments in a Performance Year from each Next Generation Participant that has agreed to receive Reduced FFS Payments. Such written consent must be in the form of a completed Fee Reduction Agreement signed by an executive of the applicable TIN.

2. Such written consent must include verification of which Next Generation Participants billing under that TIN have affirmatively consented to receive Reduced FFS Payments.

3. For Next Generation Professionals, the ACO shall identify which individual NPIs billing under that TIN have affirmatively consented to receive Reduced FFS Payments. For all other Next Generation Participants, the ACO shall identify which organizational NPIs billing under that TIN have affirmatively consented to receive Reduced FFS Payments.

4. Such consent will apply for the full Performance Year and must be renewed annually in order for a Next Generation Participant to continue to receive Reduced FFS Payments.

G. PBP Fee Reduction List

1. At a time and in a manner determined by CMS, the ACO shall submit to CMS a list ("**PBP Fee Reduction List**") identifying all Next Generation Participants that have agreed to accept Reduced FFS Payments.

2. With such submission, the ACO shall certify that it has received signed Fee Reduction Agreements from all TINs included on the PBP Fee Reduction List.

3. The ACO shall certify that prior to execution of each Fee Reduction Agreement, the executive of the applicable TIN reviewed and consented to the inclusion of the listed Next Generation Participants that bill through such TIN on the PBP Fee Reduction List.

4. For each Performance Year in which the ACO participates in PBPs, the ACO shall submit a scanned file containing copies of the signed Fee Reduction Agreements for each participating TIN, by a date and in a manner determined by CMS.

5. CMS will make Reduced FFS Payments to the Next Generation Participants on the PBP Fee Reduction List.

III. Calculation of the Population-Based Payment

A. Overview

The Population-Based Payment (PBP) is an estimate of the total amount by which FFS payments will be reduced for Medicare Part A and B services rendered by PBP-participating Next Generation Participants who agree to accept Reduced FFS Payments when providing care to Next Generation Beneficiaries during the upcoming Performance Year. This estimate will be based on available data on payments to Next Generation Participants participating in PBP for the applicable performance year for services that were provided to aligned beneficiaries during the 12-month period immediately prior to the performance year.

B. Detailed Description of PBP Calculation

1. The calculation of the annual PBP payment to the ACO is the product of: the estimated PBP reduction for the 12-month period ending prior to the performance year, in aggregate, and the ratio of the number of performance year aligned beneficiaries to the number of aligned beneficiaries for the previous calendar year. The annual PBP payment will be paid to the ACO in 12 equal monthly installments.

2. PBPM Expenditures

    a. Use of Prior Years' Expenditures

        The PBP payment to the ACO will be calculated before the beginning of the applicable performance year. The PBP payment will be calculated using the prior calendar years' expenditures. For example: CY 2015 expenditures will be used to calculate the PBP payment for PY1 (CY 2016).

    b. Experience of Previous Calendar Year Aligned Beneficiaries

        i. The PBP payment amount will be calculated using the experience of beneficiaries aligned in the previous calendar year. For example: The PY1 (CY 2016) PBP amount will be calculating using beneficiaries aligned in CY 2015.

        ii. Aligned beneficiaries who would have been excluded prior to the start of the previous calendar year will not be used in the PBP payment amount because PBP would not affect claims. This includes beneficiaries who:

            - died before January 1 of the previous calendar year;
            - enrolled in MA during January of the previous calendar year (most of whom enroll during the open enrollment period).

        iii. Beneficiaries who would be excluded because they become ineligible during the performance year for other reasons, or who are excluded at the end of the year by the service-area eligibility requirements, will be used in these calculations as the claims of such beneficiaries will be subject to PBP during the performance year.

    c. Claims of Performance Year PBP Participating Next Generation Participants

        i. The monthly PBP calculation will be calculated using claims/expenditures in the previous calendar year for *services provided to aligned beneficiaries by performance year PBP participating Next Generation Participants* that are incurred between January 1 and October 31 of the previous calendar year and paid prior to November 1 of the previous calendar year. For example: In PY1 (CY 2016), the PBP calculation is based on CY 2015 claims/expenditures for *services provided to aligned beneficiaries by PY1 PBP participating Next*

Generation Participants that are incurred between 1/1/2015 and 10/31/2015 and paid prior to 11/1/2015.

ii. Claims for services provided to an aligned beneficiary by a PBP participating Next Generation Participant will be reduced. CMS will use the *pre-PBP reduction payment amount* (i.e. what otherwise would have been paid in the absence of PBP) in expenditure calculations.

iii. Year-end reconciliation of monthly PBP payments to PBP payment reductions will compare the amount that would have been paid to the PBP participating Next Generation Participants, after sequestration, to the amount of reduced FFS payments to these Next Generation Participants and the amount of monthly PBP payments made to the ACO.

iv. The monthly PBP payment to the ACO will be subject to budget sequestration. In contrast, the calculation of the monthly PBP payments to the ACO will use estimated claims payments to PBP participating Next Generation Providers/Suppliers prior to any PBP reduction and before sequestration.

d. Calculation of Completion Factor

i. In order to estimate the PBP payment amount prior to the start of the performance year, the most recent data available for the calculation are claims incurred in October of the previous calendar year. A completion factor will be applied to estimate incurred but not paid claims for the previous calendar year.

ii. The completion factor will be developed by comparing claims incurred and paid during the first 10 months of the previous calendar year to the claims experience of beneficiaries aligned to the ACO two calendar years previously (after removing beneficiaries who died before the start of that year or that are enrolled in Medicare Advantage in January of that calendar year).

For example: For PY 1 (CY 2016), the completion factor is the ratio of:

- Total claims incurred during the 10-month time period of January 2015-October 2015, and paid by October 31st 2015; to,
- Total claims incurred during CY2014, and paid by March 31st 2015.
- The completion factor is based on total expenditures, not just the claims incurred by PY1 PBP participating Next Generation Participants.

3. Size of Aligned Population

a. Calculation of the performance year PBP payment to the ACO requires an estimate of the number of person-months that will accrue during the performance

year. Specifically, the performance year PBP population will consist of performance year aligned beneficiaries excluding beneficiaries who:

- are expected to die before the start of the performance year; or
- are expected to enroll in MA during January of the performance year.

b. Because decedent information for the previous calendar year is incomplete, and because data from the performance year Medicare open enrollment is not available prior to January of the performance year, CMS will use the proportion of beneficiaries that was excluded from the previous year's aligned population to make these adjustments.

c. The estimated performance year PBP reduction will be multiplied by the ratio of the estimated number of performance year aligned beneficiaries to the number of previous calendar year aligned beneficiaries to arrive at an estimate of the total PBP reduction that will be made in the performance year.

4. Calculation of the Monthly Check Amount

a. The estimated PBPM expenditures from section II.B.2 will be multiplied by the estimated performance period person-months from section II.B.3 yielding total expenditures subject to the PBP reduction.

b. The total expenditures subject to the PBP reduction will then be multiplied by the PBP reduction percentage yielding total estimated PBP reduction. If different PBP-participating Next Generation Participants select different reduction percentages, the total expenditures will be calculated for the set of PBP-participating Next Generation Participants at each reduction level and then multiplied by the relevant FFS reduction. The estimated PBP reduction represents the total amount of payment withheld from performance year PBP-participating Next Generation Participants for services provided to aligned beneficiaries, during the performance period.

c. This amount will be divided by twelve yielding the monthly ACO PBP payment amount prior to sequestration.

d. The monthly PBP payments made to the Next Generation ACO is subject to sequestration.

IV. Reconciliation of the PBP

A. The reductions to FFS payments do not affect the calculation of Shared Savings/Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the fee reduction. The reconciliation of PBP payments and reductions in FFS payments does not affect and is not affected by the sharing rate or savings/loss cap. The PBP payments will be reconciled with the Shared Savings/Losses

payment during the annual financial settlement such that the settlement report will show the amount of net earned Shared Savings or Losses, as well as 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 FFS reduction for PBP participating Next Generation Provider/Suppliers for eligible services rendered to the Next Generation Beneficiaries ("**PBP Reconciliation**"). Also included in PBP Reconciliation are reductions in FFS payments to PBP participating Next Generation Participants for services provided to Next Generation Beneficiaries who were excluded from the aligned population during the Performance Year because they did not meet alignment-eligibility requirements.

B. Under PBP, annual financial settlement will involve two steps:

1. Calculation of the shared savings or loss for which the Next Generation ACO is at risk based on the current Agreement.

2. The reconciliation of the Shared Savings/Losses with the difference between the reduction in FFS payment and the monthly PBP payments made to the Next Generation ACO in accordance with XIV.A.3 of the Agreement.

C. If the reduction in FFS payments exceeds the amount paid to the Next Generation ACO in monthly PBPs, the difference shall:

1. In the case of Shared Savings, be added to the amount paid to the Next Generation ACO; or

2. In the case of Shared Losses, be subtracted from the amount of Shared Losses paid to CMS by the Next Generation ACO; or

3. If no Savings or Losses are earned/owed, be paid to the Next Generation ACO by CMS.

D. If the amount of monthly PBP payments made to the Next Generation ACO exceeds the reduction in FFS payments, the difference shall:

1. In the case of Shared Savings, be subtracted from the amount paid to the Next Generation ACO; or

2. In the case of Shared Losses, be added to the amount paid to CMS by the Next Generation ACO; or

3. If no Savings or Losses are earned/owed, be paid to CMS by the Next Generation ACO.

E. Adjusted Settlement

1. For each Performance Year in which the ACO participates in PBP, CMS shall conduct a second PBP Reconciliation at the same time that CMS issues the settlement report for the subsequent Performance Year.

2. If, as a result of the second PBP Reconciliation, CMS determines that:

    a. The reduction in FFS payments exceeds the amount paid to the Next Generation ACO in monthly PBPs, the difference shall be deemed Other Monies Owed and payable to the ACO by CMS in the settlement for the subsequent Performance Year;

    b. The amount of monthly PBP payments made to the Next Generation ACO exceeds the reduction in FFS payments, the difference shall be deemed Other Monies Owed and payable to CMS by the ACO in the settlement for the subsequent Performance Year;

3. In the case of the final year of the Agreement Term or termination of the Agreement after the date determined under Section XIX.D.3:

    a. CMS will make reasonable efforts to conduct the second PBP Reconciliation within 12 months after the issuance of the original settlement report for that Performance Year;

    b. CMS shall issue an adjusted settlement report to the ACO setting forth the results of the second PBP Reconciliation and identifying any payments due by the ACO to CMS, or CMS to the ACO, as a result of this second PBP Reconciliation.

    c. Any payments due by the ACO to CMS, or CMS to the ACO, as a result of this second PBP Reconciliation shall be payable in accordance with XIV.B.5 of the Agreement.

Next Generation ACO Model Participation Agreement

Appendix I

3-Day SNF Rule Waiver Benefit Enhancement

This appendix will apply for a Performance Year only if the ACO has selected the use of this Benefit Enhancement in accordance with Section X and submitted an Implementation Plan to CMS in accordance with Section XI of the Agreement.

I. Waiver

CMS waives the requirement in section 1861(i) for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services furnished by an Eligible SNF to an Eligible Next Generation Beneficiary and in such other circumstances as provided in this Appendix ("**3-Day SNF Rule Waiver**"). All other provisions of the statute and regulations regarding Medicare Part A post-hospital extended care services ("**SNF Services**") shall continue to apply. Thus, SNF Services furnished by Eligible SNFs will be covered under Medicare Part A for Eligible Next Generation Beneficiaries who are admitted to the Eligible SNF without a prior inpatient hospital stay ("**Direct SNF Admission**") or who are discharged from a hospital to an Eligible SNF after an inpatient hospital stay of fewer than three days, as long as all other coverage requirements for such services are satisfied.

II. Eligible SNFs

A. For purposes of this waiver, an "**Eligible SNF**" is a SNF or swing bed hospital that is a Next Generation Participant or Preferred Provider that has been approved by CMS to participate under this waiver following a review of the qualifications of the SNF to accept Direct SNF Admissions or admissions after an inpatient stay of fewer than three days. This review may include a consideration of the program integrity history of the SNF and any other factors that CMS, at its sole discretion, determines may affect the qualifications of the SNF to provide SNF Services.

B. At the time of CMS approval of the Eligible SNF to participate under this waiver, a SNF must have a quality rating of three or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website.

C. Eligibility of SNFs and swing bed hospitals under this 3-Day SNF Rule Waiver will be reassessed annually, prior to the start of each Performance Year.

D. The ACO shall maintain and provide to its Next Generation Participants and Preferred Providers an accurate and complete list of Eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF eligibility. The ACO shall also furnish these lists to a Next Generation Beneficiary, upon request.

III. Eligible Next Generation Beneficiaries

For purposes of this waiver, an "**Eligible Next Generation Beneficiary**" is a Medicare beneficiary who is:

A. A Next Generation Beneficiary at the time of SNF admission under this waiver;

B. Aligned to the ACO at the time of SNF admission under this waiver; and

C. Not residing in a SNF or long-term care setting at the time of SNF admission under this waiver.

IV. Eligible SNF Admissions

A. A Direct SNF Admission will be covered only if, at the time of admission, the Eligible Next Generation Beneficiary:

1. Is medically stable;

2. Has confirmed diagnoses;

3. Has been evaluated by a physician within three days prior to SNF admission;

4. Does not require inpatient hospital evaluation or treatment; and

5. Has a skilled nursing or rehabilitation need that is identified by the evaluating physician and cannot be provided as an outpatient.

B. A SNF admission will be covered for an Eligible Next Generation Beneficiary who is discharged to an Eligible SNF after fewer than three days of inpatient hospitalization only if at the time of admission the Eligible Next Generation Beneficiary:

1. Is medically stable;

2. Has confirmed diagnoses;

3. Does not require further inpatient hospital evaluation or treatment; and

4. Has a skilled nursing or rehabilitation need that has been identified by a physician during the inpatient hospitalization and that cannot be provided on an outpatient basis.

V. Beneficiary Exclusion

In the case of a beneficiary who was a Next Generation Beneficiary at the beginning of the Performance Year but is later excluded from alignment to the ACO, the following provisions apply for all SNF services for which CMS would have made payment to the Eligible SNF due to the SNF's participation in the 3-Day SNF Rule Waiver during the period in which the beneficiary was aligned to the ACO:

A. For SNF and swing bed hospital admissions that occur within 90 days following the date of such exclusion (the "**Grace Period**"), CMS shall make payment for such SNF services furnished to the beneficiary under the terms of the 3-Day SNF Rule Waiver.

B. If the Grace Period ends prior to the end of the Performance Year in which the date of exclusion occurred, CMS shall continue to make payment for such services furnished to the beneficiary through the end of the Performance Year under the terms of the 3-Day SNF Rule Waiver, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year.

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

In the event that an Eligible SNF provides SNF Services under this 3-Day SNF Rule Waiver to a Next Generation Beneficiary who is not eligible to receive services under the waiver, as defined in Section III, above, the following rules shall apply:

A. CMS shall make no payment to the Eligible SNF for such services;

B. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Next Generation Beneficiary for the expenses incurred for such services;

C. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Next Generation Beneficiary any monies collected from the Next Generation Beneficiary; and

D. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

VII. Responsibility for Denied Claims

A. In the event that a claim for any SNF Services furnished to a Next Generation Beneficiary by an Eligible SNF is denied as a result of a CMS error and the Eligible SNF did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such SNF Services (and for such period of time as CMS finds will carry out the objectives of Title XVIII) under the terms of this 3-Day SNF Rule Waiver as though the coverage denial had not occurred.

B. In the event that a claim for any SNF Services furnished to a Next Generation Beneficiary by an Eligible SNF is denied for any reason other than a CMS error and the Eligible SNF did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. Payment shall, notwithstanding such determination, be made by CMS for such SNF Services (and for such period of time as CMS finds will carry out the objectives of Title XVIII) under the terms of this 3-Day SNF Rule Waiver as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

C. In the event that a claim for any SNF Services furnished to a Next Generation Beneficiary by an Eligible SNF is denied and the Eligible SNF knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. CMS shall make no payment to the Eligible SNF for such services;

2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

D. In the event that a Next Generation Participant or Preferred Provider that is not an Eligible SNF submits a claim for SNF Services, as defined in Section II, above, furnished to a Next Generation Beneficiary for which CMS only would have made payment if the Next Generation Participant or Preferred Provider had been an Eligible SNF participating in the 3-Day SNF Rule Waiver at the time of service:

1. CMS shall make no payment to the Next Generation Participant or Preferred Provider for such services;

2. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the SNF Services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the SNF Services returns to the beneficiary any moniescollected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

VIII. Compliance and Enforcement

A. CMS may, at its sole discretion, remove a Next Generation Participant or Preferred Provider from the list of Next Generation Participants or Preferred Providers that have been approved by CMS to participate as Eligible SNFs under the 3-Day SNF Rule Waiver.

B. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Next Generation Beneficiary alignment to the ACO.

C. CMS will monitor the ACO's use of this waiver to ensure that admissions of Eligible Next Generation Beneficiaries to Eligible SNFs under this waiver are medically appropriate and consistent with the terms of the 3-Day SNF Rule Waiver.

D. As a condition of this waiver, the ACO is required to submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of this waiver and to provide CMS with supplemental information upon request regarding its use of the 3-Day SNF Rule Waiver.

E. Pursuant to Section XIX of the Agreement, CMS may terminate or suspend this waiver or take other remedial action, as appropriate, if the ACO fails to comply with the terms and conditions of the 3-Day SNF Rule Waiver.

F. Notwithstanding Section XXI.D of the Agreement, CMS may amend this Appendix I without the ACO's consent. To the extent practicable, CMS shall provide the ACO with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

Next Generation ACO Model Participation Agreement

Appendix J

Telehealth Expansion Benefit Enhancement

This appendix will apply for a Performance Year only if the ACO has selected this Benefit Enhancement pursuant to Section X of the Agreement and submitted an Implementation Plan for the Benefit Enhancement in accordance with Section XI of the Agreement.

I. Eligible Telehealth Providers

For purposes of this Telehealth Expansion Benefit Enhancement, an "**Eligible Telehealth Provider**" is a Next Generation Professional or Preferred Provider who is:

A. A physician or other practitioner listed at 42 C.F.R. § 410.78(b)(2);

B. Licensed under applicable State law to furnish telehealth services;

C. Designated on the Participant List or Preferred Provider List as participating in the Telehealth Expansion Benefit Enhancement; and

D. Approved by CMS according to the criteria described in Section IV of the Agreement.

II. Waiver

Subject to the applicable provisions of the Agreement and this Appendix K, CMS waives the following provisions with respect to otherwise covered telehealth services furnished to a Next Generation Beneficiary by an Eligible Telehealth Provider and in such other circumstances as provided in this Appendix.

A. Waiver of Originating Site Requirements: CMS waives the requirements in section 1834(m)(4)(C) of the Social Security Act and 42 C.F.R. § 410.78(b)(3)–(4) with respect to telehealth services furnished in accordance with this Agreement.

B. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement that telehealth services be "furnished at an originating site" from section 1834(m)(4)(B) of the Social Security Act when furnished in accordance with this Agreement.

C. Waiver of Originating Site Facility Fee provision: CMS waives section 1834(m)(2)(B) and 42 C.F.R. § 414.65(b) with respect to telehealth services furnished to a beneficiary at his/her home or place of residence when furnished in accordance with this Agreement .

III. Eligibility Requirements

A. To be eligible for reimbursement under the terms of the waiver under Section II of this Appendix the beneficiary must be located at an originating site that is either:

1. One of the sites listed in section 1834(m)(4)(C)(ii) of the Social Security Act; or
2. The beneficiary's home or place of residence.

B. Claims will be denied for the following telehealth services furnished to a beneficiary located at his/her home or place residence:
   1. Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. HCPCS codes G0406 - G0408;
   2. Subsequent hospital care services, with the limitation of one telehealth visits every three days. CPT codes 99231 – 99233; and
   3. Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days. CPT codes 99307 - 99310.

C. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Eligible Telehealth Provider shall not submit a claim for such telehealth services.

D. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining portions of section 1834(m) of the Social Security Act and 42 C.F.R. §§ 410.78 and 414.65.

E. An Eligible Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Next Generation Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider knows or should know in person services are medically necessary.

IV. Beneficiary Exclusion

In the event that a Next Generation Beneficiary who had been aligned with the ACO is later excluded from alignment to the ACO, the following provisions apply for all services for which CMS would have made payment to the Eligible Telehealth Provider under the terms of the waiver in Section II of this Appendix, due to the provider's participation in the Telehealth Expansion Benefit Enhancement during the period in which the Next Generation Beneficiary was aligned to the ACO:

A. For a period of 90 days following the date of such exclusion (the "**Grace Period**"), CMS shall make payment for such services furnished to the beneficiary.

B. If the Grace Period ends prior to the end of the Performance Year in which the date of exclusion occurred, CMS shall continue to make payment for such services furnished to the beneficiary through the end of the Performance Year, but will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year.

V. Responsibility for Denied Claims

A. In the event that a claim for any telehealth services furnished to a Next Generation Beneficiary by an Eligible Telehealth Provider is denied as a result of a CMS error and the Eligible Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such telehealth services (and for such period of time as CMS finds will carry out the objectives of Title XVIII) under the terms of the waiver in Section II of this Appendix as though the coverage denial had not occurred.

B. In the event that a claim for any telehealth services furnished to a Next Generation Beneficiary by an Eligible Telehealth Provider is denied for any reason other than a CMS error and the Eligible Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. Payment shall, notwithstanding such determination, be made by CMS for such telehealth services (and for such period of time as CMS finds will carry out the objectives of Title XVIII) under the terms of the waiver in Section II of this Appendix as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Eligible Telehealth Provider that provided the telehealth services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Eligible Telehealth Provider that provided the telehealth services returns to the Next Generation Beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

C. In the event that a claim for any telehealth services furnished to a Next Generation Beneficiary by an Eligible Telehealth Provider is denied and the Eligible Telehealth Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. CMS shall make no payment to the Eligible Telehealth Provider for such services;

2. The ACO shall ensure that the Eligible Telehealth Provider that provided the telehealth services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Eligible Telehealth Provider that provided the telehealth services returns to the beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

D. In the event that a Next Generation Participant or Preferred Provider that is not an Eligible Telehealth Provider submits claims for telehealth services under this Telehealth Expansion Benefit Enhancement above, furnishes services to a Next Generation Beneficiary for which CMS only would have made payment if the Next Generation Participant or Preferred Provider had been an Eligible Telehealth Provider participating in the this Telehealth Expansion Benefit Enhancement at the time of service:

1. CMS shall make no payment to the Next Generation Participant or Preferred Provider for such services;

2. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the telehealth services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the telehealth returns to the Next Generation Beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

V. Enforcement

A. CMS may, at its sole discretion, remove a Next Generation Participant or Preferred Provider from the list of Next Generation Participants or Preferred Providers that have been approved by CMS to participate as Eligible Telehealth Providers under the waiver.

B. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Next Generation Beneficiary alignment to the ACO.

C. As a condition of this waiver, the ACO is required to submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of this waiver and to provide CMS with supplemental information upon request regarding its use of the waiver.

D. CMS will monitor the ACO's use of the waiver under Section II of this Appendix to ensure that telehealth services furnished by Eligible Telehealth Providers under this waiver are medically appropriate and consistent with the terms of this waiver.

E. In accordance with Section XIX of this Agreement, CMS may terminate or suspend this waiver or take other remedial action if the ACO fails to comply with the terms and conditions of the waiver.

F. Notwithstanding Section XXI.D of the Agreement, CMS may amend this Appendix J without the ACO's consent. To the extent practicable, CMS shall provide the ACO with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

Next Generation ACO Model Participation Agreement

Appendix K

Post-Discharge Home Visits Benefit Enhancement

This appendix will apply for a Performance Year only if the ACO selects this Benefit Enhancement pursuant to Section X of the Agreement and submits an Implementation plan for the Benefit Enhancement in accordance with Section XI of the Agreement. This Post-Discharge Home Visits Benefit Enhancement increases the availability to beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits under certain conditions.

I. Definition

Licensed Clinical Staff means auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1), licensed or otherwise appropriately certified under applicable state law to perform the services ordered by the supervising physician or other practitioner under this Appendix.

II. Waiver and Terms

CMS waives the requirement in 42 C.F.R. § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) ("incident to" services) must be furnished under the direct supervision of the physician (or other practitioner)[1], provided that such services are furnished as follows:

A. The services are furnished to a Next Generation Beneficiary who either does not qualify for Medicare coverage of home health services under 42 C.F.R. § 409.42 or who qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as provided in Medicare Benefit Policy Manual, Chapter 15 § 60.4;

B. The services are furnished in the Next Generation Beneficiary's home after the beneficiary has been discharged from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility;

C. The services are furnished by Licensed Clinical Staff under the general supervision, as defined in 42 C.F.R. § 410.32(b)(3)(i), of a Next Generation Professional or Preferred Provider who is a physician or other practitioner;

D. The claims for such services are billed by the supervising Next Generation Professional or Preferred Provider who is a physician or other practitioner;

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

E. The services are furnished not more than twice: one time in the first ten days following discharge and one additional time in the first 30 days following discharge; and
F. The services are furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b).

CMS also waives the direct supervision requirement in 42 C.F.R. § 410.26(b)(5) under such other circumstances as provided in this Appendix.

III. Beneficiary Exclusion

In the event that a Next Generation Beneficiary who had been aligned with the ACO is later excluded from alignment to the ACO, the following provisions apply for all services for which CMS would have made payment to the Next Generation Professional or Preferred Provider under the terms of the waiver in Section II of this Appendix, due to the provider's participation in the Post-Discharge Home Visits Benefit Enhancement during the period in which the Next Generation Beneficiary was aligned to the ACO:

1. For a period of 90 days following the date of such exclusion (the "**Grace Period**"), CMS shall make payment for such services furnished to the beneficiary.

2. If the Grace Period ends prior to the end of the Performance Year in which the date of exclusion occurred, CMS shall continue to make payment for such services furnished to the beneficiary through the end of the Performance Year, but will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year.

IV. Responsibility for Denied Claims

A. In the event that a claim for any "incident to" services furnished to a Next Generation Beneficiary by a Next Generation Professional or Preferred Provider that had been identified as a provider participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied as a result of a CMS error and the Next Generation Professional or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such "incident to" services (and for such period of time as CMS finds will carry out the objectives of Title XVIII) under the terms of the waiver in Section II of this Appendix as though the coverage denial had not occurred.

B. In the event that a claim for any "incident to" services furnished to a Next Generation Beneficiary by a Next Generation Professional or Preferred Provider that had been identified as provider participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied for any reason other than a CMS error and the Next Generation Professional or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. Payment shall, notwithstanding such determination, be made by CMS for such "incident to" services (and for such period of time as CMS finds will carry out the objectives of Title XVIII) under the terms of the waiver in Section II of this Appendix as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

2. The ACO shall ensure that the Next Generation Professional or Preferred Provider that provided the "incident to" services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Next Generation Professional or Preferred Provider that provided the "incident to" services returns to the Next Generation Beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

C. In the event that a claim for any "incident to" services furnished to a Next Generation Beneficiary by a Next Generation Professional or Preferred Provider that had been identified as provider participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Next Generation Professional or Preferred Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

1. CMS shall make no payment to the Next Generation Professional or Preferred Provider for such services;

2. The ACO shall ensure that the Next Generation Professional or Preferred Provider that provided the "incident to" services does not charge the Next Generation Beneficiary for the expenses incurred by such services;

3. The ACO shall ensure that the Next Generation Professional or Preferred Provider that provided the "incident to" services returns to the Next Generation Beneficiary any monies collected from the beneficiary; and

4. The ACO shall indemnify and hold the Next Generation Beneficiary harmless for payment of any such services provided to the Next Generation Beneficiary.

V. Enforcement

A. The ACO shall ensure, through its contract with each Next Generation Participant and Preferred Provider that will be participating in the Post-Discharge Home Visit Benefit Enhancement, that each Next Generation Participant and Preferred shall be accountable for auxiliary personnel's compliance with the terms of this Agreement and appendix.

B. CMS may, at its sole discretion, remove a Next Generation Participant or Preferred Provider from the list of Next Generation Participants or Preferred Providers that have been approved by CMS to participate in this Post-Discharge Home Visits Benefit Enhancement.

C. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Next Generation Beneficiary alignment to the ACO.

D. As a condition of this waiver, the ACO is required to submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of this waiver and to provide CMS with supplemental information upon request regarding its use of the waiver.

E. CMS will monitor the ACO's use of the waiver under Section II of this Appendix to ensure that services furnished under the waiver are medically appropriate and consistent with the terms of this waiver.

F. In accordance with Section XIX of this Agreement, CMS may terminate or suspend this waiver or take other remedial action if the ACO fails to comply with the terms and conditions of the waiver.

G. Notwithstanding Section XXI.D of the Agreement, CMS may amend this Appendix K without the ACO's consent. To the extent practicable, CMS shall provide the ACO with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

Next Generation ACO Model Participation Agreement

Appendix L

Financial Guarantee

This Appendix provides requirements regarding the ACO's financial guarantee for repayment of amounts owed to CMS as Shared Losses and/or Other Monies Owed, as required under Section XIV.D of this Agreement.

1. Form of Financial Guarantee

1.1. The financial guarantee must be in one or more of the following forms:
   (a) Funds placed in escrow;
   (b) A line of credit as evidenced by a letter of credit upon which CMS may draw;
   (c) Surety bond.

1.2. CMS may reject any financial guarantee that does not comply with the terms of this Appendix L.

2. Amount of the Financial Guarantee

2.1. For each Performance Year, the ACO shall obtain a financial guarantee in an amount equal to two percent of its total capped Medicare Parts A and B fee-for-service expenditures for beneficiaries, which represents the ACO's baseline expenditures for the relevant Performance Year.

2.2. CMS shall provide written notice to the ACO of the amount that must be funded by the financial guarantee. The amount will be calculated by CMS using a financial report that will be provided to the ACO prior to the start of Performance Year.

2.3. For each Performance Year during which the ACO participates in the Model, the ACO shall increase the amount of its financial guarantee to include the amount specified by CMS in the annual written notice furnished to the ACO under paragraph 2.2. Within 60 days of the date of the annual written notice furnished to the ACO under paragraph 2.2, the ACO shall submit to CMS documentation of the financial guarantee.

3. Duration of the Financial Guarantee

3.1. Except as set forth in paragraph 3.2, the financial guarantee for each Performance Year must remain in effect (or the amount funded for a Performance Year in a financial guarantee that funds multiple Performance Years must remain available to CMS) until the earliest of the earliest of the following:
   (a) The ACO has fully repaid CMS any Shared Losses and/or Other Monies Owed for the Performance Year;
   (b) CMS has exhausted the amount funded by the financial guarantee for the Performance Year and CMS determines that the ACO does not need to replenish the financial guarantee in accordance with paragraph 3.3; or
   (c) CMS determines that the ACO does not owe any Shared Losses and/or Other Monies Owed under the Model for the Performance Year.

3.2. The ACO shall maintain its financial guarantee until the earlier of the following with respect to the final Performance Year:

(a) The date on which the settlement report for the final Performance Year is deemed final, if such settlement report indicates that the ACO does not owe any Shared Losses or Other Monies Owed for any Performance Year; or

(b) The date on which the ACO makes payment in full for all Shared Losses or Other Monies Owed for any Performance Year.

3.3. If any portion of the financial guarantee is used to repay Shared Losses or Other Monies Owed to CMS, the ACO must, within 90 days of the data that CMS draws on the financial guarantee: (1) replenish the amount of its financial guarantee or establish another financial guarantee to ensure it maintains coverage equal to the amount required under paragraph 2.1; and (2) submit to CMS documentation demonstrating that it has complied with this provision.

4. Other requirements

4.1. **Beneficiary/Obligee**: The ACO shall designate CMS as the sole beneficiary or obligee. CMS's address is 7500 Security Boulevard, Baltimore, MD 21244.

4.2. **Condition for calling funds**: The financial guarantee should indicate that the ACO is obligated to repay money it owes to CMS as a result of participation in the Next Generation ACO Model, citing the Next Generation ACO Participation Agreement. Example:

> The ACO is obligated to repay money it owes to CMS under the Next Generation ACO Model, as required by the Next Generation ACO Participation Agreement. The amount of Shared Losses and/or Other Monies Owed will be noted in a demand letter to the ACO from CMS.

4.3. **Demand letter**: The financial guarantee must allow for payment to CMS in response to a demand letter from CMS.

4.4. **Account fees**: Account fees or other fees associated with establishing, maintaining, or cancelling a financial guarantee are the responsibility of the ACO and must not be paid out of the principal for the financial guarantee.

5. Requirements for specific financial guarantee mechanisms

5.1. Funds placed in Escrow

CMS and U.S. Bank National Association ("U.S. Bank") have a standard escrow account agreement available for use between U.S. Bank, CMS, and third parties, where CMS is the recipient of funds held in escrow if payment is due to CMS. The ACO should contact the Next Generation ACO Model (as specified below) to open a U.S. Bank escrow account.

If the ACO wants to establish an escrow account at a different institution, CMS must approve the escrow agreement and the instructions for disbursement of the assets. Generally, CMS will accept an escrow agreement with a different institution under the following conditions:

(a) The funds are invested in Treasury-backed securities or a money market fund;

(b) The instructions for disbursement of the assets are consistent with CMS' standard escrow instructions (see Escrow Instructions of Depositor below);

(c) The costs, fees, and expenses associated with the escrow account, including any legal expenses incurred by the escrow agent or the ACO, are not borne by CMS and such costs are not charged to principal;
(d) The principal cannot be encumbered for any purpose other than repaying Shared Losses and/or Other Monies Owed by the ACO to CMS;
(e) CMS is not required to indemnify any person or entity against any loss, claim, damages, liabilities, or expenses, including the costs of litigation arising from the escrow agreement or the subject of the agreement;
(f) CMS will receive advance notice of early termination of the escrow account and any change in the amount of funds held in escrow.

5.2. Letter of Credit

(a) CMS will generally accept a Letter of Credit under the following conditions:
   i. The letter of credit is irrevocable;
   ii. CMS is designated as the sole beneficiary;
   iii. The appropriate credit amount is specified;
   iv. The terms allow an authorized official of CMS to draw on the letter of credit upon submission to the issuing bank of the following items: (a) a certification that "The amount of the drawing under this credit represents funds due to CMS from [ACO Name] under the Next Generation ACO Model and which have remained unpaid for at least 30 days"; and (b) a copy of the appropriate written notice to the ACO of the amount owed; and
   v. The letter must show that CMS will receive advance notice if the letter of credit is revoked or if there is any change in the amount of credit.
(b) **Auto renewal clauses**: ACO should not use clauses providing for the automatic renewal of an irrevocable standby letter of credit to establish the required term. The ACO may, however, use these clauses to automatically renew the letter of credit for a period of time beyond the required term. If the ACO uses an auto renewal clause, it should state that the lender will notify CMS and the ACO at least 90 days in advance if electing not to renew.
(c) **Sanctioned entity clauses**: The bank issuing the letter of credit must omit these clauses entirely, or, if included, exclude entities sanctioned by a federal health care program or by any federal agency.

5.3. Surety Bond

(a) Surety Companies: The surety bond should be issued from a company included on the U.S. Department of Treasury's Listing of Certified (Surety Bond) Companies (https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm). If the ACO uses a bond from a company not included on the Department of Treasury listing, it may be subject to additional scrutiny to make sure appropriate safeguards are in place.
(b) Surety Bond Terms: The bond must contain:
   i. A statement that the surety is liable for assessments that occur during the term of the bond;
   ii. The surety's name, street address or post office box number, city, state, and zip code; and

iii. A statement naming the ACO as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety.

Escrow Instructions of Depositor

1) Immediately upon deposit, all monies ("Assets") held in the Account shall be invested by Agent in Treasury-backed securities. Upon deposit and at such other times as may be requested by Recipient, Agent shall notify Recipient of the date and amount of each deposit and other Account transaction.
2) Agent shall dispose of the Assets only upon written instruction from an authorized representative of Recipient. Such written instructions shall:
   a) Identify the amount, if any, of Shared Losses and/or Other Monies Owed incurred by the Depositor for the relevant performance year, as determined by CMS and set forth in a final settlement report, as revised if applicable, issued by CMS pursuant to Section XIV.C of the Agreement.
   b) Identify the amount of such Shared Losses and/or Other Monies Owed that Depositor has failed to pay (the "Debt") within 30 days of the date of the settlement report.
   c) Instruct Agent to convert the Assets to cash and pay the amount of the Debt to Recipient. If the Assets will be zero after delivering the amount of the Debt to Recipient, Agent shall notify Recipient, and Recipient shall provide further instructions, in consultation with Depositor, for the replenishment of assets or closure of the Account.
   d) If applicable, notify the Agent of the expiration or termination of the Depositor's Next Generation ACO Model Participation Agreement or other circumstances requiring closure of the Account and instruct Agent to convert the Assets to cash and dispose of them as follows:
      i) If the Debt is zero, Agent shall return the full cash value of the Assets to Depositor, less Agent's unpaid fees, costs and expenses.
      ii) If the cash value of the Assets is less than or equal to the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the full cash value of the Assets.
      iii) If the cash value of the Assets exceeds the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the Debt and shall return the remaining Assets to Depositor, less Agent's unpaid fees, costs and expenses.
3) Upon disposition of the Assets as specified in paragraph 2(d), Agent shall close the Account and the Escrow Agreement shall terminate.
4) Unless otherwise specified by written notice of the Parties, the following persons are authorized to provide instructions from Depositor or Recipient, as the case may be, to Agent, consistent with the terms of this Agreement:

Depositor

Name: _____ _____

Specimen Signature

Title: _____

Recipient

Name: _____ _____

Specimen Signature

Title: _____

Next Generation ACO Model Participation Agreement

Appendix M

ACO Proprietary and Confidential Information

The following are specific examples, without limitation, of what the ACO considers proprietary and confidential information currently contained in its program that should not be publicly disclosed:

1)

2)

3)

In accordance with Section XV.D of the Agreement, this information shall remain the sole property of the ACO and, except as required by federal law, shall not be released by CMS without the express written consent of the ACO.