

Next Generation ACO Model



*Open Door Forum:
Next Generation ACO
Application Overview*

March 14, 2017

Agenda

- Model Overview
- Application and Selection Timeline
- Letter of Intent
- Application Overview

Next Generation ACO Model Overview

- The Next Generation ACO Model (NGACO or the Model) is an initiative developed by the CMS Innovation Center for ACOs experienced in managing the health of populations of patients.
- The Model seeks to test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for original Medicare beneficiaries.
- The Model offers more predictable financial targets and greater opportunities to coordinate care coupled with tools to help ACOs better engage beneficiaries.

Model Principles

There are six basic principles of the Model:

- Protect Medicare Fee-for-Service (FFS) beneficiaries' freedom of choice;
- Allow beneficiaries a choice in their alignment with the ACO;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care; and
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.

Current Model Status

- NGACO is a five year initiative that began on January 1, 2016 and will end on December 31, 2020.
- The Model is structured as an initial agreement period and two option years.
- ACOs that enter the Model on January 1, 2018 will have an initial agreement period of one year before the two option years.
- There are 45 Next Generation ACOs (NGACOs) participating in the Model as of the start of calendar year (CY) 2017.

Additional Information

Additional information about the Model can be found on the website:
<https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

General Model Information

- Model Benchmark Methodology
- Model Factsheet
- Benefit Enhancement Information

Application Resources

- Request for Applications (RFA)
- Letter of Intent (LOI) & Checklist
- Open Door Forum Presentations

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- Model Overview
- Application and Selection Timeline
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- Application Overview

Preliminary 2018

Application and Selection Timeline

Milestone	Date
LOI Due Date	May 4, 2017
Application* Due	May 18, 2017
Next Generation Participant List Due	June 9, 2017
Finalists Identified	August 2017
Agreements Signed	Late Fall 2017
Start of Performance Year	January 1, 2018

**The text of the application is currently available in Appendix G of the RFA. The application is available via <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.*

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Letter of Intent

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Next Generation ACO Model Letter of Intent



Organizations interested in applying to the Next Generation ACO Model must submit a Letter of Intent (LOI). LOIs will be used only for planning purposes, and the content of the LOI will not be binding. CMS will not consider applications from organizations that do not submit a timely LOI.

⚠ DO NOT use your browser's back page function or navigate away from this page while completing your LOI. Doing so will cause you to lose information that you have entered into your LOI. If you navigate away from this page, all information that you entered will be lost.

Questions about the LOI should be directed to NextGenerationACOModel@cms.hhs.gov.

All applicants, including those who completed the 2017 application process but were not selected, must submit an LOI and application if they wish to apply to participate in the Next Generation ACO Model beginning in 2018.

- In order to apply for the Next Generation ACO Model, interested organizations must first submit a [Letter of Intent](#) (LOI).
- The LOI will take about 10-15 minutes to complete.
- Contents of the LOI are not binding and will only be used for planning purposes.

Letter of Intent

- The LOI cannot be saved while in progress—do not press the back button or navigate away from a page.
 - Have all information and supporting documents ready before starting the LOI.
 - Download the [Signature Certification PDF](#) prior to beginning the LOI.
- Once the LOI has been submitted, the primary contact will receive a confirmation e-mail with a unique LOI number.
- The LOI number is needed to access the full application.

Sections of the LOI

- Section A. Organization and Contact Information
- Section B. Letter of Intent
- Section C. Supplemental Survey (Optional)
- Section D. [Signature Certification](#) and Submission

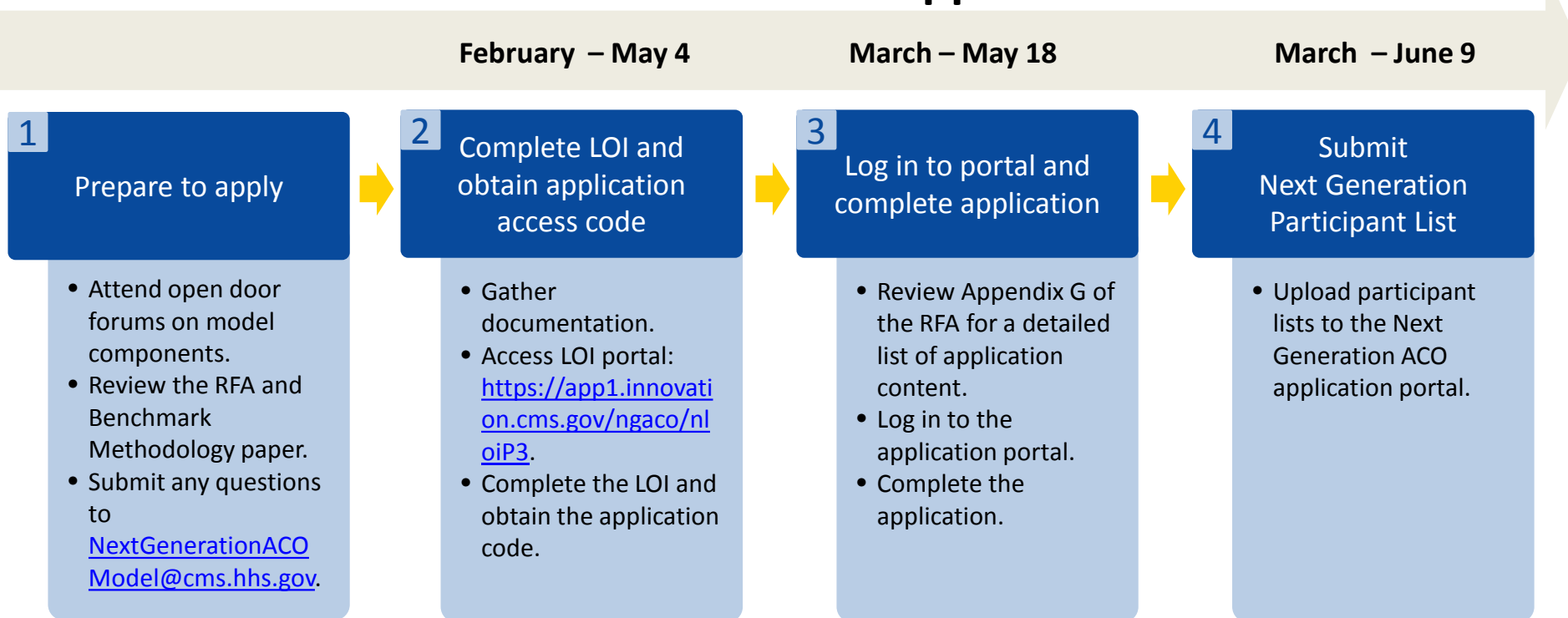
For a more detailed description of each LOI section, refer to the [presentation](#) from the ODF held on Tuesday, January 31, 2017.

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Overall Application Process

Next Generation ACO Model Application Process



Application Landing Page



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Welcome Clark K. ▾

Application for the Next Generation ACO Model

Welcome to the Next Generation ACO Model online application. The Next Generation ACO Model application is due in two parts: The first part, the narrative portion, must be submitted electronically no later than 5 pm ET on Thursday, May 18, 2017. The second part, a provider list identifying the proposed Next Generation participants, must be submitted electronically no later than 5 pm ET on Friday, June 9, 2017.

To enter your responses, please select the "Start Application" link within the table below. You may enter responses into the application, save your answers, and come back to complete it at a later date. While the provider list is not due until a later date, you must upload a sample file in order to successfully submit the narrative portion of the application. Once an application has been submitted you will not be allowed to change your narrative responses. However, you will have the ability to replace the sample files with valid files that satisfy the corresponding question, until the deadline indicated above expires. Upon submission of the application you will receive a confirmation e-mail with reminder instructions to replace your files by 5 pm ET on Friday, June 9, 2017.

In the table below, please use the links in the Action column to start, edit or view your application. To begin your application, click "Start Application". To edit an application, click "Edit". To view an application PDF, click "View PDF".


LOI/RFA #	Organization Name	Status	Special Access	Action
NG-XXX	ACO Name	Not Started		Start Application

- The landing page includes instructions along with current application status.
- Applicants can enter and save responses, and return to complete the application at a later date.
- The 'Action' column is used to start, edit, or view your application.
- The application is not considered complete until it is submitted. Once submitted, applicants may not make additional changes to the application.

Accessing the Application

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Next Generation ACO Model Login



Username

Password

Login

[Forgot Password?](#)


Request for Application Access

- Access the application portal via the Next Generation ACO Model's [website](#).
- Select 'Request for Application Access' if it is the first time logging in.

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Next Generation ACO Model Login

Request for Application



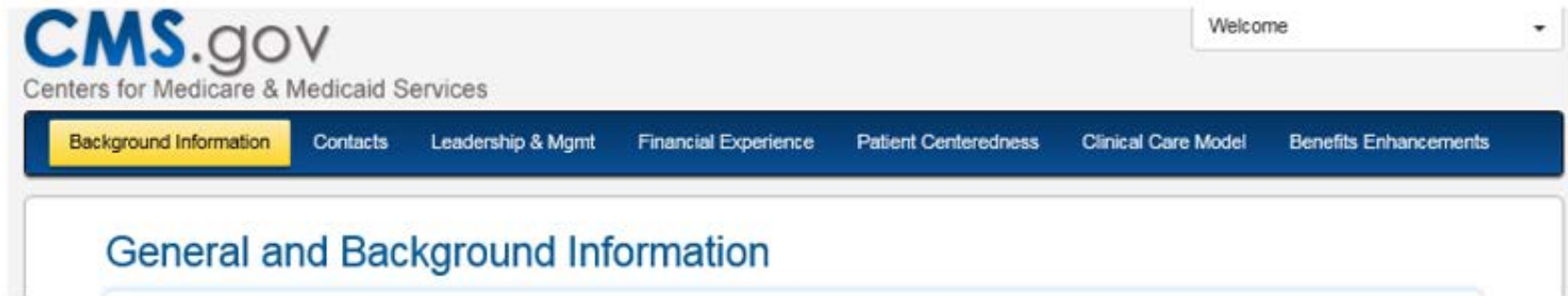
LOI Confirmation #

Email

Submit

- Enter the LOI confirmation number and the primary contact's email address used to submit the LOI.
- The primary POC should have received a LOI submission confirmation email.
- Create a unique username and password.

Navigating Through the Application



- Applicants can toggle between the seven application sections using the navigation banner at the top of the screen.



- At the end of each section, responses can be saved.
- These actions are available at the end of each section.

General Background Information



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Background Information | Contacts | Leadership & Mgmt | Financial Experience | Patient Centeredness | Clinical Care Model | Benefits Enhancements

General and Background Information

A. ACO Organization Information

All fields are required unless noted as optional

1. Organization Name

sdjkl

2. Organization TIN/EIN

388738393

3. Street Address

sdfi

4. City

io

5. State

Alabama

6. Zip Code

87898

7. Website, if applicable (Optional)

B. ACO Organization Profile

All fields are required unless noted as optional

1. Type of Applicant ACO. Please select one:

Please Select One

2. Does the Applicant ACO include any of the following providers or facilities? Please select all that apply.

Available:

Cancer or specialty hospitals
Psychiatric hospital or other mental or behavioral health facility
Hospital(s) receiving disproportionate share (DSH) payments or uncompensated care payments from Medicare or Medicaid
Critical Access Hospital (CAH)
Other rural hospital
Federally Qualified Health Center (FQHC)
Other community health centers
Skilled nursing facility (SNF)
Inpatient rehabilitation facility (IRF)
Home Health Agency (HHA)
Other post-acute care facility



Chosen:

3. Is the Applicant ACO or any of its proposed Next Generation Participants currently participating in a Medicare shared savings initiative?

Please select all that apply. Available:

Care Management for High-Cost Beneficiaries Demonstration
Comprehensive ESRD Care Initiative (CECI)
Comprehensive Primary Care Initiative (CPCI)
Independence at Home Medical Practice Demonstration (IAH)
Medicare Health Care Quality Demonstration Programs (including Indiana Health Information Exchange and North Carolina Community Care Network)
Multi-payer Advanced Primary Care Practice Demonstration with a shared savings arrangement (MAPCP)
Physician Group Practice Transition Demonstration (PGP)
Pioneer ACO Model
Medicare Shared Savings Program (MSSP)

Provide the following information:

- Organization address and contact information.
- Type of ACO.
- Types of participating providers and facilities.
 - If not applicable, select “Other” and write “N/A” in the text box below.
- Participation in other CMS Medicare shared savings initiatives.
- Participation in the Bundled Payments for Care Improvements (BPCI) Model.
- Description of organizational composition.
- Certificate of incorporation.
- Service area information.
- Signed data request and attestation form.

Organization Points of Contact

Applicants should include information for three main points of contact:

- Primary/secondary POC
- ACO executive contact
- IT/technical Contact

For each individual, please provide:

- Name and title
- Phone number
- Email
- Address

If any edits are necessary to the pre-populated fields, please email Technical Support: CMMIForceSupport@cms.hhs.gov

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Background Information **Contacts** Leadership & Mgmt Financial Experience Patient Centeredness Clinical Care Model Benefits Enhancements

Contact Information

A. Application Contact(s)
All fields are required unless noted as optional

1. First Name: sdk
2. Last Name: jkl
3. Title/Position (Optional): sdf
4. Business Phone Number: 3139303738
5. Business Phone Number Ext (Optional):
6. Alternative Phone Number (Optional):
7. E-mail Address: ahsfde+testngfda@gmail.com
8. Street Address: sdfl
9. City: io
10. State: Alabama ☒
11. Zip Code: 87898

Secondary Contact? ☒ Yes
All fields are required unless noted as optional

1. First Name: sdijk
2. Last Name: jkl
3. Title/Position (Optional): jkl
4. Business Phone Number: 3233839383
5. Business Phone Number Ext (Optional):
6. Alternative Phone Number (Optional):
7. E-mail Address: i@test.com
8. Street Address: sdfl
9. City: io
10. State: Alabama ☒
11. Zip Code: 87898

B. ACO Executive Contact
All fields are required unless noted as optional

1. First Name:
2. Last Name:
3. Title/Position (Optional):
4. Business Phone Number:
5. Business Phone Number Ext (Optional):
6. Alternative Phone Number (Optional):

Leadership and Management Leadership Team

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Background Information Contacts **Leadership & Mgmt** Financial Experience Patient Centeredness Clinical Care Model Benefits Enhancements

Leadership and Management

A. Leadership Team

All fields are required unless noted as optional

1. Please provide a proposed organizational chart for the Applicant ACO. The proposed organizational chart should depict the legal structure, the proposed composition of the ACO (e.g., all of the TINs and organizations composing the ACO), and any relevant committees.

Upload File

2. Please describe the contractual and/or employment relationships between and among the Applicant ACO and proposed Next Generation Participants, as well as any contractual and/or employment relationships with other partners or entities that will provide services to the ACO.

3. Please upload:

i. A sample contract or an amendment or addendum to a current contract between the ACO and proposed Next Generation Participants; and

Upload File

ii. A sample contract or an amendment or addendum to a current contract between the ACO and any other partners or entities that will provide services to the ACO (if applicable).

Upload File

4. For providers participating in your ACO, please report the following. The term "primary employer" below refers to the employer for whom the physician delivers health services (not just Medicare patients) and that the physician considers to be their primary place of employment (e.g. accounts for the majority of the physician's income).

i. The total number of physicians participating in your ACO:

ii. The total number of ACO participating physicians for whom the ACO is their primary employer. Physicians whose primary employer is a hospital or group practice directly owned by the ACO or one of its subsidiaries should be treated as physicians whose primary employer is the ACO.

iii. The total number of ACO participating physicians for whom a non-ACO hospital (e.g. hospital that is not directly owned by the ACO or one of its subsidiaries) is their primary employer.

iv. The total number of ACO participating physicians whose primary employer is a non-ACO group practice (e.g. group practice that is not directly owned by the ACO or one of its subsidiaries) with 10 or more physicians.

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

Provide the following information:

- Organizational chart with legal structure and ACO composition.
- Sample contractual agreement for ACO participants and partners.
- Description of contractual and employment relationships with participants.
- Information about the number of physicians participating in the ACO.
- Description of ACO history and its major organizations (relationships and collaboration).
- Exclusivity of ACO leadership team.

Leadership and Management Governing Body

B. Legal Entity and Governing Body

All fields are required unless noted as optional

1. For Next Generation ACOs that are formed by two or more Next Generation Participants, the ACO shall be a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers. If, however, the Next Generation ACO was a Pioneer ACO pursuant to Pioneer ACO Model Innovation Agreement or was a Medicare Shared Savings Program ACO, then the ACO legal entity may be the same as that of the existing legal entity, provided all other requirements are met.

Please select one:

Please Select One

2. Please complete the table below with information specific to the Applicant ACO's proposed governing body.

Add Governing Body

No Data Found.

3. Please describe how responsibilities and accountability will be shared across the leadership team and governing body structures in the Applicant ACO.

4. Please describe how the governing body will ensure that the interests of beneficiaries and providers will be represented adequately. Specifically, explain the following:

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

5. Please provide a narrative explanation of why the Applicant ACO wishes to participate in the Next Generation Model and how participation in the Model will help CMS and the Applicant ACO's proposed Next Generation Participants achieve the goals of better health and better care for Medicare beneficiaries.

6. Please upload the compliance plan intended for use by the Applicant ACO.

Upload File

7. CMMI model applications require all applicants to disclose any sanctions, investigations, probations, actions or corrective action plans that the applicant, its physicians/practitioners, its owners or managers, and/or other participating organizations, entities, or individuals, including the applicant's Next Generation Participants, are currently undergoing or have undergone in the last five years. Please provide this information using the table below.

Add Corrective Action

Provide the following information:

- If the governing body is different from the MSSP or Pioneer governing body.
- Description of the responsibilities and accountability of the governing body and leadership team.
- Description of how beneficiary interests will be represented.
- Explanation of why the applicant wants to participate in the Next Generation ACO Model.
- The compliance plan intended for use by the applicant ACO.
- Disclosure of any sanctions, investigations, probations, actions, or corrective action plans the applicant has undergone within the last five years.

Financial and Risk Sharing Experience

Provide the following information:

- Distribution of clinical revenues across Medicare FFS, Medicare Advantage, Medicaid, self-pay, etc.
- Description of performance under performance based contracts.
- Percent of clinical revenues from outcomes based contracts, and methodology for calculating.
- Description of business model and process to transition from FFS to outcomes based contracts.
- Description of relationship to other health care entities in the same area.
- Description of history of collaboration among major stakeholders and communities being served.

The screenshot shows the CMS.gov website with the "Financial Experience" tab selected in the navigation bar. The form is titled "Financial Experience and Information" and contains two main sections: "A. Financial Experience and Information" and "B. Risk Sharing Experience".

A. Financial Experience and Information
All fields are required unless noted as optional

1. What percentage of the Applicant ACO's total clinical revenues in the last fiscal year was derived from the following sources? Applicants may approximate this through summation of the revenue received by all proposed Next Generation Participants for clinical services (e.g., fee-for-service, per-member per-year, per-member per-month, per-episode).

- i. Medicare fee-for-service:
- ii. Medicare Advantage:
- iii. Other Medicare health plans (e.g., PACE plans, Medicare cost plans):
- iv. Commercial health plans:
- v. Medicaid:
- vi. Self-pay patients:
- vii. Patients who are dually eligible for Medicare and Medicaid:
- viii. Other (e.g., local uncompensated care funds):
- ix. Please describe any additional sources of funding:

B. Risk Sharing Experience
All fields are required unless noted as optional

1. Please describe the Applicant ACO's performance under prior or current outcomes-based contracts, if any. Outcomes-based contracts must include: (1) financial accountability; (2) evaluation of patient experiences of care; and (3) substantial quality performance incentives. If applicable, please include performance under CMS programs and demonstrations that meet the definition of outcomes-based contracts. Check N/A if no prior or current risk sharing arrangements. Please also indicate the number of covered lives in outcomes-based contracts with any of the Applicant ACO's proposed Next Generation Participants.

Financial Plan

Provide the following information:

- Attestation that the ACO has been licensed by the state in which it is located and a copy of the license if applicable.
- Description of how the applicant intends to fund ACO activity specifically how it will ensure payments to Medicare.
- Description of how the applicant plans to manage Part D utilization expenditures.
- Risk arrangement and payment mechanisms.

C. Financial Plan if Selected for Next Generation ACO Model

All fields are required unless noted as optional

1. Please attest that the Applicant ACO has been licensed by the state(s) in which it is located as a risk-bearing entity or that it is exempt from such licensure and/or other such requirements.

Please Select One

2. Funding Ongoing ACO Activity:

- Please describe how the Applicant ACO intends to fund ongoing ACO activity. Indicate how the funding plan supports the three-part aim of better health, better health care, and lower per-capita costs and how it ties individual providers into the overall outcomes-based revenue strategy. To the extent applicable, please describe how savings or losses will be distributed among participants and eligible affiliates.
- Please describe how the Applicant ACO plans to ensure payment to Medicare of its share of losses relative to the benchmark.

3. Please explain any plans the Applicant ACO has to better manage Part D utilization and expenditures. Please include any plans the ACO has to partner with Part D Plans while preserving beneficiary choice. Please include information on the types of activities that would fall under a Part D partnership, such as data sharing or medication reconciliation.

4. Please indicate the intended risk arrangement:

Please Select One

5. Please indicate the intended payment mechanism. Payment mechanism is separate from risk arrangement. It dictates the method of payment for proposed Next Generation Participant claims and affords the ACO the option of receiving monthly payments. Please select one.

- Normal FFS [No changes to FFS claims payment.]
- Normal FFS with monthly infrastructure payments [ACO participants and all other Medicare providers that care for ACO beneficiaries will have claims reimbursed by CMS through FFS. The ACO may elect to receive monthly payments at an amount no greater than \$6 PBPM. Monthly payments are reconciled and recouped (against both savings and losses) in the final financial reconciliation calculation.]
- Population-based payments (PBP) [If an ACO elects population-based payments (PBP), ACO participants will have FFS claims payments reduced by an agreed upon percentage. The ACO will receive a monthly payment commensurate with percentage taken out of participants' FFS payments.]
- All Inclusive Population Based Payments (AIPBP) [If an ACO elects AIPBP, ACO participants that participate in AIPBP will have their FFS claims for aligned beneficiaries reduced by 100%. The ACO will receive a monthly payment commensurate with the fee reductions and will be responsible for paying providers in accordance with their written agreements and the Model's Participation Agreement.]

Patient Centeredness Beneficiary Engagement

Provide the following information:

- Description of ability to accomplish goals and objectives related to beneficiary engagement as outlined in the RFA.
- Description of existing or planned beneficiary outreach approach.
- Description of existing or planned approach for evaluating beneficiary satisfaction.

The screenshot shows the CMS.gov website with the "Patient Centeredness and Beneficiary Engagement" application form. The form is titled "Patient Centeredness and Beneficiary Engagement" and includes a navigation bar with links: Background Information, Contacts, Leadership & Mgmt, Financial Experience, Patient Centeredness (selected), Clinical Care Model, and Benefits Enhancements. The form is divided into two main sections: A. Goals and Objectives and B. Beneficiary Engagement. Section A includes a list of goals and objectives related to patient centeredness, such as promoting evidence-based medicine, ensuring patient/caregiver engagement, and providing access to medical records. Section B includes a list of beneficiary engagement activities, such as describing the existing or planned approach to conduct beneficiary outreach and evaluating beneficiary satisfaction. The form includes a "Save" button, a "Save & Continue" button, a "Submit Application" button, and a "Print PDF" button.

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Background Information | Contacts | Leadership & Mgmt | Financial Experience | **Patient Centeredness** | Clinical Care Model | Benefits Enhancements

Patient Centeredness and Beneficiary Engagement

A. Goals and Objectives
All fields are required unless noted as optional

1. Please describe the Applicant ACO's ability to accomplish the items below. The narrative should include the ability to achieve the goals and objectives of the Next Generation ACO Model as it relates to patient centeredness:

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

B. Beneficiary Engagement
All fields are required unless noted as optional

1. Please describe the existing or planned approach that the Applicant ACO will use to conduct beneficiary outreach.

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

Save | Save & Continue | Submit Application | Print PDF

Clinical Care Model

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Background Information Contacts Leadership & Mgmt Financial Experience Patient Centeredness **Clinical Care Model** Benefits Enhancements

Clinical Care Model

A. Care Coordination and Health IT Capability

All fields are required unless noted as optional

1. Please describe the Applicant ACO's plan to achieve better health, better care, and lower costs through integrated and coordinated care interventions. Please address the following in your narrative:

- The Applicant ACO's use of interdisciplinary care teams to coordinate care for patients.
- The Applicant ACO's methods and processes to coordinate care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care between providers (both inside and outside the ACO).
- The Applicant ACO's use of health information technology.
- The Applicant ACO's strategies for improving beneficiary access to care.
- The Applicant ACO's development and use of population health management tools.
- The Applicant ACO's plan to incorporate medication management into its care coordination approach; and,
- Additional specific care interventions and tools.

2. Please provide the anticipated percentage of eligible professionals in the Applicant ACO that will have attested to Electronic Health Record (EHR) Stage 2 Meaningful Use Criteria by December 31, 2015:

i. Please provide any additional information regarding the Applicant ACO's ability to meet the Meaningful Use requirements.

Please answer the following questions which describe the proposed providers/suppliers ability to electronically conduct the following activities using the currently implemented EHR or platform planned to be implemented.

3. Is the ACO a physician-based organization (e.g., convening entity is either a physician independent practice association (IPA), a physician practice management association, an individual physician group, or collection of physician groups)?

Please Select One

4. Is the ACO hospital-based (e.g., convening entity is a physician hospital organizations (PHO) or management service organizations (MSO) that includes hospitals)?

Please Select One

5. Please describe the ability of the Applicant ACO and proposed Next Generation Participants to use EHR data and electronic tools to understand patient risk, risk stratify, and use this information for decision making.

Provide the following information:

- Description of applicant's ability to achieve better health, care, and lower cost through integrated and coordinated care interventions.
- Percent of eligible professionals that attest to EHR Stage 2 Meaningful Use Criteria and the applicant's ability to meet these requirements.
- Whether the ACO is physician-based or hospital-based.
- Description of how participants will use EHR for better, more coordinated care.
- Description of experience establishing and reporting clinical and patient satisfaction quality measures.
- Description of experience designing, implementing, and assessing specific care improvement interventions.

Benefit Enhancements

Provide the following information:

- Interest in different benefit enhancements: SNF3-Day Rule Waiver, Post-Discharge Home Visits, and Telehealth.
- Description of how coordinated care reward payments will help improve care integration, quality assurance, and patient safety while reducing total Medicare expenditures.
- Description of how the network of preferred providers using selected benefit enhancements will be identified.

The screenshot shows the CMS.gov website with the 'Benefit Enhancements' tab selected in the navigation bar. The page title is 'Benefit Enhancements Implementation'. Below the title, there is a paragraph explaining that the section asks for information on proposed implementation of various benefit enhancements, noting that acceptance into the Next Generation ACO Model is not contingent upon implementing any particular enhancement. The form is divided into four sections: A. 3-Day SNF Rule, B. Post-Discharge Home Visits, C. Telehealth, and D. Beneficiary Coordinated Care Reward. Each section has a heading, a note that all fields are required unless noted as optional, and a numbered list of questions. Sections A, B, and C each have a dropdown menu with 'Please Select One' and a checkmark icon. Section D has a large text area for the first question and a smaller one for the second question.

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Background Information | Contacts | Leadership & Mgmt | Financial Experience | Patient Centeredness | Clinical Care Model | **Benefit Enhancements**

Benefit Enhancements Implementation

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

A. 3-Day SNF Rule
All fields are required unless noted as optional

1. Please indicate if the Applicant ACO would be interested in implementing a waiver of the policy requiring a three-day inpatient stay prior to SNF admission.

Please Select One ☒

B. Post-Discharge Home Visits
All fields are required unless noted as optional

1. Please indicate if Applicant ACO would be interested in billing for post-discharge home visits

Please Select One ☒

C. Telehealth
All fields are required unless noted as optional

1. Please indicate if the Applicant ACO would be interested in greater flexibility in performing telehealth services:

Please Select One ☒

D. Beneficiary Coordinated Care Reward
All fields are required unless noted as optional

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

2. Please describe how the Applicant ACO will identify a network of Preferred Providers for using the benefit enhancements above. Specifically, what data and information will the Applicant ACO offer to determine which providers are eligible for the coordinated care reward?

Review and Submit

- At the bottom of the Benefit Enhancements Page there are three options:

By checking “I Agree” below and clicking submit, I acknowledge that my application is final and that it has been completed to the best of my knowledge.

☐ I Agree

Save

Submit Application

Print PDF

- Save, Submit Application, and Print PDF
- CMS recommends you save, review, and print your application before submitting.
- You must submit your application before 4:59 PM ET on May 18, 2017.
- You will not be able to make any additional changes after the application is submitted. You will only be able to upload the Next Generation Participant Lists required in the ‘Background Information’ section, which is due before 5:00 PM ET June 9, 2017. Consider saving your login and password information.
- After you submit your application, you will still be able to print the final application.

Questions?

Upcoming Open Door Forums

Open Door Forum Topic	Date and Time
Next Generation ACO Model Benefit Enhancements Overview	March 28, 2017
Overview of Population-Based Payments and All-Inclusive Population-Based Payment	April 11, 2017
Deep Dive: Completing Your Next Generation ACO Model Participant List	April 25, 2017

Next Generation ACO Model Webpage:

<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

E-mail: NextGenerationACOModel@cms.hhs.gov

Technical Support: CMMIForceSupport@cms.hhs.gov

Next Generation ACO Model Open Door Forum



*Submission of Initial CY
2018 Next Generation
Participant Lists by 2018
NGACO Applicants*

*March 14, 2017
4:00-5:00pm ET*

Disclaimer

The comments made on this call are offered only for general informational and educational purposes. As always, the agency's position on matters may be subject to change. CMS' comments are not offered as, and do not constitute legal advice or legal opinions, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules and regulations. ACOs are responsible for ensuring that their actions fully comply with applicable laws and regulations, and we encourage you to consult with your own legal counsel to ensure such compliance. Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. CMS is not seeking group advice.

Housekeeping

Slides will be made
available online!

Agenda

- Review:
 - Provider definitions (CMMI)
 - Provider overlap rules (CMMI)
- Policies & Procedures: Changes after initial submission, accuracy of data, Legacy TINs, CCNs (CMMI)
- PLST Demo (RTI)
- PLST Tips (RTI)
- Provider list processing timeline (CMMI)
- Q&A Session (CMMI & RTI)

Definition: Next Generation Participant

A “**Next Generation Participant**” is defined as an individual or entity that:

- is a Medicare-enrolled provider or supplier,
- is identified on the Participant List,
- bills for items and services it furnishes to beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations,
- is not a Preferred Provider,
- is not a Prohibited Participant, and
- 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 pursuant to a written agreement with the ACO.

Definition: Next Generation Professional

“Next Generation Professional” is defined as 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 dietitian or nutrition professional (as defined at 42 CFR § 410.134).

Definition: Prohibited Participant

- A “**Prohibited Participant**” is defined as 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.

Definition: Preferred Provider

“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.

Participant Overlap Rules: ACO Overlap

An NGACO may not simultaneously participate in any other Medicare shared savings initiatives (e.g., Medicare Shared Savings Program (MSSP), Comprehensive ESRD Care (CEC) Initiative).

Participant Overlap Rules: Next Generation

Participant and Preferred Provider Overlap

- 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 Medicare Shared Savings Program.
- A Next Generation Professional who is a primary care specialist 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.

Participant Overlap Rules: Next Generation

Participant and Preferred Provider Overlap

In the NGACO model a Next Generation Professional who is a primary care specialist is defined as a physician or non-physician practitioner whose principal specialty code is one of the following:

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

Participant Overlap Rules: Next Generation Participant and Preferred Provider Overlap

A Next Generation Participant who is a non-primary care specialist may be a Next Generation Participant in another NGACO or serve in an equivalent role in any other model or program in which such non-primary care specialists are not required to be exclusive to one participating entity.

Provider Overlap Rules: SSP & Full-TIN Exclusivity

- The NGACO Model does not require full TIN participation. In other words, the NGACO Model does not require that all individuals/organizations in an NGACO-participating TIN be a part of the NGACO.
- MSSP requires that all eligible professionals in ACO-participating TIN be part of the MSSP ACO.
- If one individual or entity under a TIN is an approved Next Generation Participant, then all individuals/entities who bill under that TIN are precluded from participating as an ACO participant, ACO provider/supplier and/or ACO professional in the MSSP ACO Model.

Policies & Procedures: Changes after Initial Participant Submission

- After submission of your proposed/initial CY 2018 Next Generation Participant lists on June 9, 2017, 2018 NGACO Applicants are not permitted, at any time prior to the Performance Year, to:
 - A) Add new proposed Next Generation Participants, and/or
 - B) Change/correct/amend identifiers associated with previously-submitted proposed Next Generation Participants
- NGACOs will be able to remove proposed Next Generation Participants from their lists, prior to the PY, at a designated time
- It is incumbent upon the ACO to ensure accurate data & provider identifiers are submitted

[Provider Identifiers for Provider Types]

Provider Type	Taxpayer ID Number	Individual NPI	Organization NPI	CMS Certification Number
Practitioner at a Solo Practice	Required	Required	Optional	Prohibited
Practitioner at a Group Practice	Required	Required	Optional	Prohibited
Practitioner at an FQHC, RHC, or CAH2	Required	Required	Required	Required
Facility or Institution	Required	Prohibited	Required	Required

Policies & Procedures: Accuracy of Provider Data

- CMMI does not verify the accuracy of provider identifiers (CCNs, TINs, individual NPIs, organizational NPIs, individual provider names, organizational names) submitted by NGACOs.
- CMMI does not verify that a TIN submitted by an NGACO on behalf of a proposed provider is the actual, correct and/or accurate TIN through which the individual provider bills Medicare for services rendered to beneficiaries.
- CMMI verifies ONLY if the format of certain provider identifiers is/are correct.
- It is incumbent upon the applicant NGACO to ensure all provider identifiers are accurate BEFORE submitting their proposed/initial Next Generation Participant lists to CMMI.
- It is incumbent upon the NGACO to verify that the correct TIN (the TIN the provider uses/has authorized to bill Medicare) is submitted on behalf of providers. It is incumbent upon the NGACO to verify that an individual provider has reassigned their billing rights to whichever TIN they submit. This information is stored in PECOS (Provider Enrollment Chain and Ownership System).
 - <https://pecos.cms.hhs.gov/pecos/login.do>
 - “Who should I call?” CMS Provider Enrollment Assistance Guide: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads//CMSProviderEnrollmentAssistanceGuide.pdf>

[Provider Identifiers]

- Providers (individual or organizations) should update their information in the National Plan and Provider Enumeration System (NPPES)
 - National Provider Identifier (NPI)
 - Specialist designation
- Program Integrity Checks (CPI)
 - Ensures that individual suppliers can bill Medicare and are not sanctioned

Definition: Legacy TIN

- A Legacy TIN is defined as a taxpayer identification number that was used by a proposed Next Generation Participant when billing for primary care services during the 24-month Alignment Period but will not be used by that Next Generation Participant to bill for primary care services during the Performance Year.
- The Alignment Period is the 24-month period that is used when identifying whether Next Generation Participants were the principal source of primary care services received by a beneficiary.
- The 2-year alignment period for CY2018/PY3 is July 1, 2015 through June 30, 2017.

Legacy TINs: Types & Purpose

- Two types of Legacy TINs: “sunsetted” Legacy TINs and “active” Legacy TINs.
- Sunsetted Legacy TIN= a TIN that was used by a Next Generation Participant to bill for services during the Alignment Period but is no longer used by any Medicare providers/suppliers.
- Active Legacy TIN= a TIN that was used by a Next Generation Participant to bill for services during the Alignment Period but will no longer be used by that same Next Generation Participant to bill for services during the PY. However, that TIN is still used by other Medicare providers/suppliers to bill for services.
 - For example, in the past, a Next Generation Participant billed using TIN 123. The Next Generation Participant now bills under TIN 456, but TIN 123 is still used by a group of Medicare providers and suppliers that are not Next Generation Participants. This Legacy TIN would be considered an “active Legacy TIN.”

Submitting Legacy TINs on Initial Next Generation Participant List

- If applicable to a given ACO provider, you can and should submit both types of Legacy TINs on behalf of proposed Next Generation Participants to ensure that the services provided by those providers during the Alignment Period are accurately captured and reflected in the execution of the beneficiary alignment algorithm.
- When completing your Initial Next Generation Participants list, you must indicate if a provider record submitted contains a legacy TIN.
- If an ACO submits an active or sunsetted legacy TIN on behalf of a Next Generation Participant on its initial 2018 Next Generation Participant list for alignment purposes, the ACO must submit *two* records for that provider on the list according to the example in the table on the next slide. One record contains the provider's non-legacy, current TIN that will be used for billing during 2018 while the second record contains the active/sunsetted Legacy TIN.

Example

ACO ID	Provider Class	Legacy Record	Billing TIN	Org NPI	CCN	Ind NPI	OrgName	Last Name	First Name	City	State	Zip
V000	PART	Y	012345678			1234567891	Erewhon PC	Chase	Samuel	Boston	MA	02108
V000	PART		012345680			1234567891	Erewhon PC	Chase	Samuel	Boston	MA	02108

Policies & Procedures: CCNs

- A CMS Certification Number (CCN) is a 6 character code issued by CMS when an institutional provider applies to become a Medicare participating provider. The CCN should not be confused with a PTAN or other identifier that may be used by the provider when submitting claims to a Medicare Administrative Contractor.
- Review the CMS State Operations Manual (Chapter 2- Certification Process) for information on how CCNs are assigned. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf>
- <https://www.resdac.org/sites/resdac.umn.edu/files/Provide%20Number%20Table.txt>

Policies & Procedures: CCNs

A CCN is a required identifier for institutional providers/facilities, including but not limited to Federally-Qualified Health Centers (FQHCs), critical access hospitals (CAHs), critical access hospitals that elect payment under Method 2 (CAH2s), home health agencies (HHAs), acute care hospitals (ACHs), skilled nursing facilities (SNFs) and skilled nursing units of acute care hospitals including swing-beds, hospices, rural health clinics (RHCs), inpatient rehabilitation facilities, long-term care hospitals (LTCHs), psychiatric hospitals, etc.

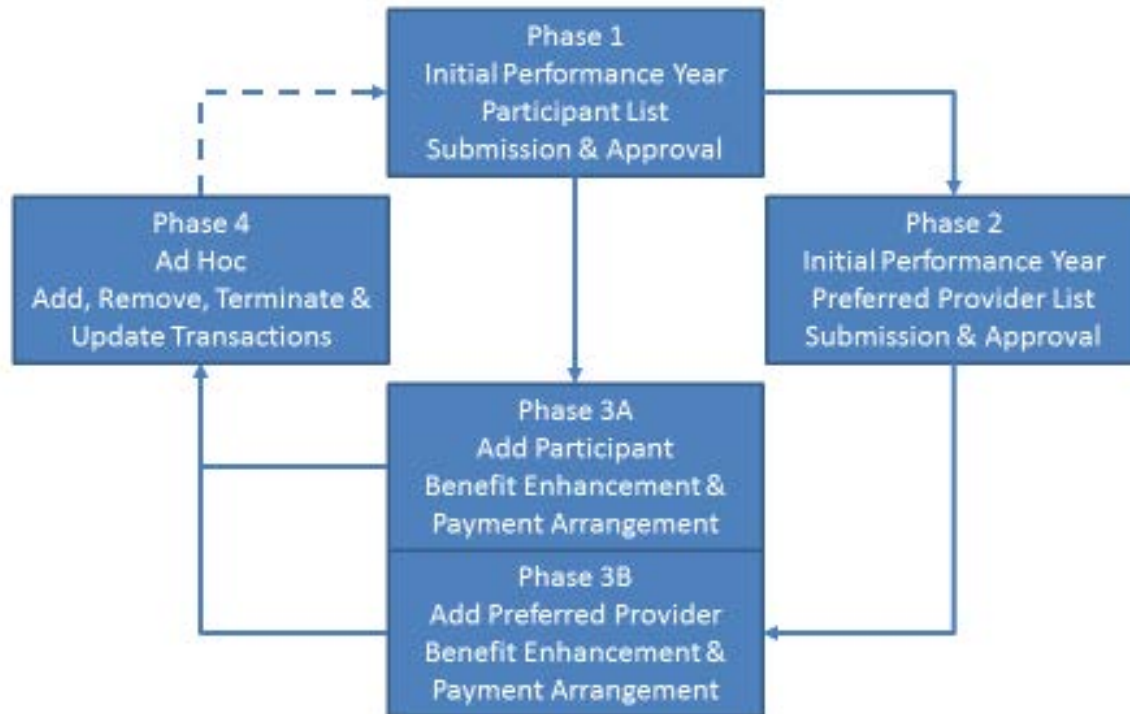
Provider List Submission Tool (PLST)

Demonstration

- The Provider List Submission Tool (PLST) is a macro-enabled Excel workbook with several worksheets
- The PLST is designed to facilitate submission of acceptable provider lists
- It is updated periodically
- Documentation (information packet) is also provided

[Submission Process]

Provider List Management Cycle: Overview



[The Provider List Submission Tool]

CERTIFICATION worksheet

Incomplete certification worksheet

NGACO Participating & Preferred Provider List Submission Certification	
Version 3.02	
PLST Purpose:	
Provider Class:	
Start Date:	01/01/2017
End Date:	12/31/2017
ACO Identifier:	
ACO Name:	
Alt. Payment:	
Validated on:	
Approved by:	
Date approved:	
0	Records will be reviewed by CMMI
0	... Participating provider records
0	... Preferred provider records
0	records will be reviewed by CMMI
0	SNF waiver records will be reviewed by CMMI
0	Telemedicine waiver records will be reviewed by CMMI
0	Post-acute home visit waiver records will be reviewed by CMMI
0	ERROR: No Core Service Area counties identified
Submit	DO NOT SUBMIT DATA UNTIL ALL ERRORS ARE CORRECTED!

Complete certification worksheet

NGACO Participating & Preferred Provider List Submission Certification	
Version 3.02	
PLST Purpose:	Add
Provider Class:	PART
Start Date:	01/01/2018
End Date:	12/31/2018
ACO Identifier:	V000
ACO Name:	NextGeneration ACO
Alt. Payment:	None
Validated on:	February 17, 2017 12:00:00 AM
Approved by:	Benjamin Rush
Date approved:	
1	Records will be reviewed by CMMI
1	... Participating provider records
0	... Preferred provider records
0	None records will be reviewed by CMMI
0	SNF waiver records will be reviewed by CMMI
0	Telemedicine waiver records will be reviewed by CMMI
0	Post-acute home visit waiver records will be reviewed by CMMI
1	Core Service Area county identified
Submit	DATA ARE READY TO SUBMIT FOR CMMI REVIEW

[The Provider List Submission Tool]

LIST_STAGING worksheet: The LIST_STAGING worksheet is a “scratch pad” on which you can prepare records for submission. In general you are advised to copy data first onto the LIST_STAGING worksheet so that you can correct errors as they are identified.

[The Provider List Submission Tool]

ACO_PROVIDER_LIST_VALIDATION worksheet

NGACO Participating & Preferred Provider List Validation	
Import	Transfer
Run Validation	Export
5	Total provider records checked
0	Pass format validation
5	Fail format validation and will not be processed
0	Duplicate records will not be processed
0	Participating provider records checked
0	Participating provider records pass format validation

0	Unique Individual (Professional/Practitioner) NPIs
View List	DATA ARE READY TO SUBMIT FOR CMMI REVIEW

0	Unique Individual (Professional/Practitioner) NPIs
View List	DO NOT SUBMIT DATA UNTIL ALL ERRORS ARE CORRECTED!

[The Provider List Submission Tool]

ACO_PROVIDER_LIST worksheet

- The ACO_PROVIDER_LIST worksheet displays your data. After running the validation algorithm it will also highlight and describe the errors that it encountered and that need to be corrected. Cells containing errors are highlighted in light/bright blue and contain comments describing the error.
- Column T provides “response codes” indicating whether the record passed validation and, if not, the general reason that the record did not pass validation.
- Column W through Z are populated by the PLST validation algorithm with data that are used as part of the validation process or that will be added by CMMI’s contractor after the data have been received and processed.
- Columns AA through AE are populated by the PLST validation algorithm.

[The Provider List Submission Tool]

ACO_SERVICE_AREA worksheet


- The NGACO will use the ACO_SERVICE_AREA worksheet to identify the counties in which its primary care providers maintain office locations. These counties comprise the “core service area” (CSA) of the NGACO. Counties adjacent to the core service area counties are part of the extended service area.
- The ACO_SERVICE_AREA worksheet consists of three fields/columns:
 - State: The postal abbreviation of the state in which the county is located.
 - County Name: The name of the county.
 - NGACO Core Service Area County: An indicator that the county is included in the NGACO’s core service area

[The Provider List Submission Tool]

Data Validation Algorithm

- The algorithm checks for:
 - Formatting errors
 - Duplicate records
- Any records that are submitted with formatting or duplication errors will not be processed.
- To ensure initial processing of all records, run validation on the ACO_PROVIDER_LIST_VALIDATION tab before submitting any provider lists.

[Handling “Errors” Flagged by the PLST]

	A	B	C	D	E	F	G
		Provider	Legacy		Organization		Individual (Practitioner)
1	ACO ID ▾	Class ▾	Record ▾	Billing TIN ▾	NPI ▾	CCN ▾	NPI ▾
2	V000	PART		012345678			1234567890
3	V000	PART		01234567			1234567891
4	V000	PART		012345678			1234567892
5	V000	PART		012345678			1234567893
6	V000	PART		012345678			1234567894

ORG_TIN must be 9 characters

ASK BEFORE YOU SUBMIT DATA CONTAINING ERRORS

PLST Tips

- ALL data should be treated as characters, NOT NUMBERS
- Therefore when cutting and pasting you should “cut and paste values”
 - Do **not** simply cut and paste
 - Excel will treat an identifier (TIN) as a number
- Do NOT include accented characters
 - Maria not María
 - Nunez not Nuñez
- Do NOT include carriage returns or tabs in any cells.
- The validation routine will replace “illegal” characters although it may flag the errors

On the Initial CY 2018 Next Generation Participant PLST due June 9, 2017:

- Do not submit Alternative Payment Arrangements or Benefit Enhancement elections in PLST
- Do NOT change the PLST Purpose, Provider Class, or Alt. Payment settings on the CERTIFICATION worksheet.
- Make sure that:
 - PLST Purpose = Add
 - Provider Class = PART
 - Alt. Payment = None
- Where the PLST asks for ACO ID, NG-301 would use N301
- Applicants MUST specify their core service area on this PLST

PLST Tips Continued..

- The columns in the PLST “as shipped” are all formatted as text.
- 0, 1, 2, 3, 4, 5, 6, 7, 8 and 9 cannot be entered as numbers.
- Excel “treats” anything that looks like a number as a number unless the user/programmer takes steps to prevent that. This is important for identifiers that can begin with a zero.
- For example a valid ORG_TIN is 012345678. The ACO must not omit the initial zero. Similarly a valid ORG_CCN is 010024. The ACO must not omit the initial zero.
- When these data are entered (manually) the initial zero will be preserved.
- If an ACO copies and pastes from another Excel workbook of their own design it is possible that the leading zero will be dropped.

Looking Ahead: Tentative Provider Processing Timeline

- **August 2017:**
 - CMS Selection Decisions Communicated to Applicant NGACOs
 - Proposed CY2018 Next Generation Participant List response files sent to applicants
- **September 2017:**
 - Certification and Submission of Final CY 2018 Participant List due to CMS
 - NGACOs resolve provider overlap issues
 - Selected ACOs and their Proposed Next Generation Participants decide which Medicare shared savings initiative they will participate in for CY 2018
 - Selected NGACOs should begin staging/preparing data for submission of their proposed Preferred Providers, associated Preferred Provider benefit enhancement (BE) and alternative payment mechanism elections, and Participant BE and payment mechanism elections for CY 2018

Looking Ahead: Tentative Provider Processing Timeline

- **October 2017:**
 - CMS sends Final CY2018 Next Generation Participant Response Files to NGACOs who will participate in the NGACO Model for CY2018
- **November 2017:**
 - NGACOs submit proposed CY2018 Preferred Providers & associated benefit enhancement and payment mechanism elections (Population-Based Payments or All-Inclusive Population-Based Payment indicators) to CMS
 - NGACOs submit benefit enhancement and alternative payment elections (Population-Based Payments or All-Inclusive Population-Based Payment indicators) on behalf of their final CY2018 Participants

Looking Ahead: Tentative Provider Processing Timeline

- **December 2017:**
 - CMS sends an updated provider list, in the form of a Response File, to NGACOs reflecting approved/rejected Preferred Providers, approved/rejected benefit enhancement and alternate payment mechanism elections for proposed Preferred Providers, and approved/rejected benefit enhancement and alternate payment mechanism elections for final Next Generation Participants-
 - Certification of Final CY 2018 Preferred Provider List due to CMS
 - NGACOs remove Preferred Providers from its final list before the Performance Year
 - NGACOs remove Next Generation Participants from its final list prior to the PY

Questions?

Next Generation ACO Model Webpage:

<http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

E-mail: NextGenerationACOModel@cms.hhs.gov

Technical Support: CMMIForceSupport@cms.hhs.gov