

Next Generation ACO Model

Calculation of the Performance Year
Benchmark: Performance Year 2021

Acronyms

Acronyms	Acronym Expansions
ACO	Accountable Care Organization
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
NGACO	Next Generation ACO

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1.0 Introduction

1.0 Introduction

This document describes the method of calculating the Performance Year Benchmark and Shared Savings/Losses for a Next Generation Accountable Care Organization (NGACO) in Performance Year 2021 (PY2021).

2.0 Definition of Technical Terms

This section defines technical terms that have a specific meaning in NGACO financial operations.

2.1 Definitions Related to the Performance Year Benchmark

The *Performance Year Benchmark* is the aggregate expenditure target of the NGACO for the Performance Year. It is equal to the sum of the Aggregate Adjusted Benchmark Expenditure for experience that accrues to the Aged & Disabled (AD) Benchmark and the Aggregate Adjusted Benchmark Expenditure for experience that accrues to the End Stage Renal Disease (ESRD) Benchmark, with the application of the Discount, the Quality Withhold, and Earned Quality Bonus.

2.1.1 Aggregate Adjusted Benchmark Expenditure

The *Aggregate Adjusted Benchmark Expenditure* is equal to the Adjusted Benchmark Expenditure PBPM multiplied by the number of months in the Period of Continuous Alignment accruing to the Benchmark during the Performance Year.

2.1.2 Adjusted Benchmark Expenditure PBPM

The *Adjusted Benchmark Expenditure PBPM* is equal to the Standardized Benchmark Expenditure PBPM with the Performance Year Benchmark Risk Score and Performance Year Geographic Standardization Factor applied.

2.1.3 Standardized Benchmark Expenditure PBPM

The *Standardized Benchmark Expenditure PBPM* is equal to the Standardized Baseline Expenditure PBPM with the Attained Performance Adjustment applied.

2.1.4 Standardized Baseline Expenditure PBPM

The *Standardized Baseline Expenditure PBPM* of the NGACO is the simple average of the Base Year 1 (BY1) and Base Year 2 (BY2) Trended Standardized Base Year Expenditure PBPM.

2.1.5 Trended Standardized Base Year Expenditure PBPM

The *Trended Standardized Base Year Expenditure PBPM* for each Base Year is the Standardized Base Year Expenditure PBPM with the Prospective Base Year Trend applied.

2.1.6 Standardized Base Year Expenditure PBPM

The *Standardized Base Year Expenditure PBPM* is the Shared Savings Expenditure accruing to the NGACO by Beneficiaries aligned to the NGACO in a Base Year, divided by the months in the Period of Continuous Alignment accruing to the NGACO by those Beneficiaries. It is standardized for risk and Geographic Adjustment Factors (GAFs).

2.1.7 Prospective Base Year Trend

For Performance Year 2021, the Prospective Base Year Trend is the projected trend in the Adjusted USPCC approved by the CMS Actuary prior to the start of Performance Year 2021. CMS may, at CMS's sole discretion, retroactively modify the projected trend used in calculating the Performance Year Benchmark if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change and/or other similarly unforeseen circumstance during the Performance Year, renders the projected trend invalid for assessing the expected level of spending between the Base Year and Performance Year in the population of NGACO Reference Beneficiaries.

2.1.8 Adjusted USPCC

The *Adjusted USPCC* (United States Per Capita Cost) is the USPCC as estimated by the CMS Office of the Actuary in the 4th Quarter of the calendar year preceding the Performance Year with adjustments approved by the Office of the Actuary to remove Uncompensated Care Payments from the USPCC and to correct for the difference in spending by all FFS beneficiaries and NGACO Reference Beneficiaries.

2.1.9 Shared Savings Expenditure

The *Shared Savings Expenditure* is: (a) the claim-based payment to a provider or supplier; plus (b) the amount withheld from the provider payment because of budget sequestration; plus (c) reductions that have been made to provider payments because the provider elected to participate in Population Based Payment (PBP) or All Inclusive Population Based Payment (AIPBP); less (d) Uncompensated Care Payments made to providers under hospital prospective payment systems; plus (e) payments for services provided to identifiable beneficiaries that are made outside the standard Part A and Part B claims systems.

2.2 Definitions Related to the Attained Performance Adjustment

The *Attained Performance Adjustment* is the increment that is made to the Standardized Baseline Expenditure PBPM of the NGACO to recognize the difference between the Standardized Baseline Operating Cost PBPM of the NGACO and the Standardized Regional Baseline Operating Cost PBPM of the NGACO. The Attained Performance Adjustment will increase the Standardized Baseline Expenditure of the NGACO if the Standardized Baseline Operating Cost PBPM of the NGACO is lower than the Standardized Regional Baseline Operating Cost PBPM of the NGACO. It will decrease the Standardized Baseline Expenditure of the NGACO if the Standardized Baseline Operating Cost PBPM of the NGACO is higher than the Standardized Regional Baseline Operating Cost PBPM of the NGACO.

2.2.1 Operating Cost

The *Operating Cost* is the Shared Savings Expenditure less Indirect Medical Education and Disproportionate Share Hospital payments made to providers under hospital prospective payment systems.

2.2.2 Standardized Baseline Operating Cost PBPM

The *Standardized Baseline Operating Cost PBPM* is the simple average of the Trended Standardized NGACO Base Year Operating Cost PBPM for the two base years.

2.2.3 Trended Standardized Base Year Operating Cost PBPM

The *Trended Standardized Base Year Operating Cost PBPM* is the Standardized Base Year Operating Cost PBPM multiplied by the Prospective Base Year Trend.

2.2.4 Standardized Base Year Operating Cost PBPM

The *Standardized Base Year Operating Cost PBPM* is the Operating Cost accruing to the NGACO by Beneficiaries aligned to the NGACO in a Base Year, divided by the number of months in the Period of Continuous Alignment accruing to the NGACO by those beneficiaries. It is standardized for risk and Geographic Adjustment Factors (GAFs).

2.2.5 Standardized Regional Baseline Operating Cost PBPM

The *Standardized Regional Baseline Operating Cost PBPM* of the NGACO is the weighted average of the Standardized Baseline Operating Cost PBPM of each county where the weights are the number of months in the Period of Continuous Alignment accruing to each county by Beneficiaries aligned to the NGACO in BY2. The Standardized Baseline Operating Cost PBPM for a county is the average Operating Cost PBPM incurred by Reference Beneficiaries residing in the county after standardizing using the Adjusted Risk Score of those Reference Beneficiaries and the Operating Cost GSF of the county, multiplied by the Prospective Base Year Trend.

2.2.6 Standardized National Baseline Operating Cost PBPM

The *Standardized National Baseline Operating Cost PBPM* of the NGACO is the weighted average of the Standardized Baseline Operating Cost PBPM of each county where the weights are the number of Alignment-Eligible months accruing to each county by Reference Beneficiaries in BY2. The Standardized Baseline Operating Cost PBPM for a county is the average Operating Cost PBPM incurred by Reference Beneficiaries residing in the county after standardizing using the Adjusted Risk Score of those Reference Beneficiaries and the Operating Cost GSF of the county, multiplied by the Prospective Base Year Trend.

2.3 Geographic Standardization Factor (GSF)

The *Geographic Standardization Factor* (GSF) is an estimate of the impact that Medicare FFS Geographic Adjustment Factors have on payments in a calendar year for covered services provided to beneficiaries residing in a county. Separate GSFs are calculated for the Shared Savings Expenditure and the Operating Cost.

The Base Year GSF is an estimate of the impact on provider payments of the GAFs that were used by Medicare to calculate provider payments in the Base Year.

The Performance Year GSF is an estimate of the impact on provider payments of the GAFs that will be used by Medicare to calculate provider payments in the Performance Year. The Performance Year GSF is developed using claims data from BY2.

2.3.1 Shared Savings GSF

The *Shared Savings GSF* for the NGACO is the weighted average of the Shared Savings GSF for each county where the weights are the number of months in the Period of Continuous Alignment accruing to each county by Beneficiaries aligned to the NGACO.

The Shared Savings GSF for BY1 is based on the BY1 Shared Savings GSFs and the Beneficiaries aligned to the NGACO in BY1.

The Shared Savings GSF for BY2 is based on the BY2 Shared Savings GSFs and the Beneficiaries aligned to the NGACO in BY2.

The Shared Savings GSF for the Performance Year is based on the Performance Year Shared Savings GSFs and the Beneficiaries aligned to the NGACO in the Performance Year.

2.3.2 Operating Cost GSF

The *Operating Cost GSF* for the NGACO is the weighted average of the Operating Cost GSF for each county where the weights are the number of months in the Period of Continuous Alignment accruing to each county by Beneficiaries aligned to the NGACO.

The Operating GSF for BY1 is based on the BY1 Operating Cost GSFs and the Beneficiaries aligned to the NGACO in BY1.

The Operating GSF for BY2 is based on the BY2 Operating Cost GSFs and the Beneficiaries aligned to the NGACO in BY2.

2.4 Definitions Related to the Benchmark Risk Score

The *Benchmark Risk Score* is the risk score that is applied to the Standardized Benchmark Expenditure PBPM to calculate the Adjusted Benchmark Expenditure PBPM.

2.4.1 Raw Risk Score

The *Raw Risk Score* is the CMS-HCC (Hierarchical Condition Category) risk score for a beneficiary calculated using the statistical models that are used by the Medicare Advantage program after removing the normalization and coding adjustments applied by Medicare Advantage for purposes of calculating plan payments.

The Raw Risk Score is resolved, in that the experience accrued by a beneficiary in a calendar month is based on the characteristics of the beneficiary in that month (e.g., reason for entitlement, dual-eligibility, institutional status, dialysis status, etc.).

For Performance Year 2021, the Raw Risk Scores will be calculated using the CY2020 CMS-HCC Risk Models as identified in the Announcement of Calendar Year (CY) 2021 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

2.4.2 Adjusted Risk Score

The *Adjusted Risk Score* for a Base Year is the Raw Risk Score to which a Projected Coding Factor has been applied to control for the impact on risk scores of changes in the completeness of coding between each Base Year and the Performance Year.

2.4.3 Projected Coding Factor

The *Projected Coding Factor* for a Base Year is the ratio of the average projected Raw Risk Score for the Performance Year to the average Raw Risk Score for the Base Year for Reference Beneficiaries that accrue experience to the AD Benchmark. The Projected Coding Factor for each Base Year will be developed in consultation with the Office of the Actuary prior to the start of the Performance Year.

For PY2021, CMS will retroactively modify the Projected Coding Factor for each Base Year based on the *Observed Reference Risk Score Trend* between that Base Year and PY2021. CMS will update the Projected Coding Factor separately for Beneficiaries that accrue experience to the AD Benchmark and for Beneficiaries that accrue experience to the ESRD Benchmark.

2.4.4 Benchmark Risk Score

The Benchmark Risk Score for the Performance Year will be the Raw Risk Score for the Performance Year if the Raw Risk Score for the Performance Year is less than 103% of the BY2 Adjusted Risk Score, or greater than or equal to the BY2 Adjusted Risk Score.

If the Performance Year Raw Risk Score exceeds 103% of the BY2 Adjusted Risk Score, the Benchmark Risk Score for the Performance Year will be 103% of the BY2 Adjusted Risk Score.

If the Performance Year Raw Risk Score is less than the BY2 Adjusted Risk Score, the Benchmark Risk Score for the Performance Year will be the BY2 Adjusted Risk Score.

2.4.5 Observed Reference Risk Score Trend

The *Observed Reference Risk Score Trend* is the change in the average Raw Risk Score of the population of NGACO Reference Beneficiaries between each Base Year and the Performance Year.

2.5 Other Definitions

2.5.1 Reference Beneficiary

A *Reference Beneficiary* for a calendar year is any beneficiary who accrues one or more months of experience during a Period of Continuous Alignment-Eligibility during that year.

2.5.2 Core Service Area

The Core Service Area of an NGACO consists of all counties in which Participants practice, identified by the NGACO when it submits its final Participant list for the Performance Year.

2.5.3 Extended Service Area

The Extended Service Area of an NGACO consists of all CSA counties and all contiguous counties.

2.6 Definitions Related to the Earned Quality Bonus

The *Earned Quality Bonus* is equal to the product of the Quality Withhold and the quality score of the NGACO for the Performance Year.

2.6.1 Quality Withhold

The Quality Withhold is equal to 2% of the Adjusted Benchmark Expenditure in PY2021.

2.6.2 Quality Measures and the Quality Score

Appendix F of the Participation Agreement describes quality measures for the NGACO Model and the calculation of the Quality Score.

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. In such an event, the NGACO quality score for purposes of the Earned Quality Bonus will be 0%.

2.7 Discount

The Discount that is applied to the Adjusted Benchmark Expenditure will be dependent on the Risk Arrangement that is selected by the NGACO for a Performance Year. The Discount is applied to the Adjusted Benchmark Expenditure prior to the application of the Quality Withhold and Earned Quality Bonus. The Discount will be as follows:

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- 1.25% of the Adjusted Benchmark Expenditure for organizations that select full risk (100% Risk Arrangement); or
- 0.5% of the Adjusted Benchmark Expenditure for organizations that select partial risk (80% Risk Arrangement).

2.8 Risk Arrangement

The Risk Arrangement is the percent of Gross Savings (Loss) shared by an NGACO. NGACOs select one of two Risk Arrangements:

- Partial risk: 80%; or
- Full risk: 100%.

3.0 General Description of the NGACO Shared Savings Calculation

In the NGACO Model, Gross Savings (or Loss) is the difference between: (1) the Performance Year Benchmark for the Performance Year; and (2) the Performance Year Expenditure incurred by Beneficiaries aligned to the NGACO for that year.

The Performance Year Benchmark is the expenditure target for the Performance Year. If the Performance Year Expenditure is less than the Performance Year Benchmark, an NGACO will earn a Shared Savings Payment as provided for in the Participation Agreement. If the Performance Year Expenditure exceeds the Performance Year Benchmark an NGACO will incur a repayable loss. The Performance Year Benchmark is calculated by applying the Discount, Quality Withhold and Earned Quality Bonus to the sum of:

1. The Aggregate Adjusted Benchmark Expenditure for experience that accrues to the AD Benchmark; and,
2. The Aggregate Adjusted Benchmark Expenditure for experience that accrues to the ESRD Benchmark.

The Aggregate Adjusted Benchmark Expenditure for experience that accrues to AD experience is the product of the Adjusted Benchmark Expenditure PBPM for experience accruing to the AD Benchmark and the number of months in the Period of Continuous Alignment accruing to the AD Benchmark during the Performance Year. Similarly, the Aggregate Adjusted Benchmark Expenditure for experience that accrues to the ESRD Benchmark is the product of the Adjusted Benchmark Expenditure PBPM for experience accruing to the ESRD Benchmark and the number of months in the Period of Continuous Alignment accruing to the ESRD Benchmark during the Performance Year.¹

The Adjusted Benchmark Expenditure PBPM (for either AD or ESRD experience) is calculated by multiplying the (respective) Standardized Benchmark Expenditure PBPM by:

¹Section 4 discusses the accrual of experience to a benchmark.

1. The Performance Year Geographic Standardization Factor for AD or ESRD experience;
2. The Performance Year Benchmark Risk Score for AD or ESRD experience.

The Gross Savings (Loss) before Stop-Loss is calculated by subtracting from the Performance Year Benchmark the Performance Year Expenditure. If the NGACO has elected to participate in the optional Stop-Loss Arrangement (see section 7), the Stop-Loss Charge is subtracted and the Stop-Loss Payout is added to the Gross Savings (Loss) before Stop-Loss.²

The maximum Gross Savings (Loss) is equal to the Savings/Losses Cap multiplied by the Performance Year Benchmark. If the Gross Savings (Loss) after Stop-Loss exceeds the maximum Gross Savings (Loss), the Shared Savings (Loss) is calculated based on the maximum Gross Savings (Loss). Otherwise the Shared Savings (Loss) is calculated based on the Gross Savings (Loss) after Stop-Loss.

The risk arrangement chosen by the NGACO (80% or 100%) is applied to the Gross Savings (Loss) after the application of the Savings/Losses Cap.

After the application of the NGACO's selected risk arrangement, the Shared Losses, if any, will be reduced prior to recoupment by an amount determined by multiplying the Shared Losses by the percentage of total months during the Performance Year affected by an extreme and uncontrollable circumstance, such as the Public Health Emergency (PHE) for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200, and the percentage of Next Generation Beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance. CMS applies determinations made under the Quality Payment Program with respect to whether an extreme and uncontrollable circumstance has occurred and the affected areas. CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's assigned beneficiaries residing in the affected areas.

Budget Sequestration applies to the payment of Shared Savings but does not apply to the repayment of a Shared Loss.

In the event that the inclusion of payments under the Bundled Payments for Care Improvement Initiative (BPCI) in the calculation of the Performance Year Benchmark and the Performance Year Expenditure is the sole cause of losses, the Performance Year Benchmark and the Performance Year Expenditure will be calculated without including BPCI payments.

² If the Stop-Loss Payout is greater than the Stop-Loss Charge, Gross Savings are increased (or Gross Loss is reduced), but if the Stop-Loss Charge is greater than the Stop-Loss Payout, Gross Savings are reduced (or Gross Loss is increased).

4.0 Accrual of Experience in the NGACO Model

The experience incurred by an aligned Beneficiary within the Period of Continuous Alignment accrues to either the AD Benchmark or the End Stage Renal Disease (ESRD) Benchmark.

Experience accrues to the ESRD Benchmark in a month: (a) during which the beneficiary was receiving maintenance dialysis; or (b) that falls within a three month period beginning in a month in which the beneficiary received a transplanted kidney.

Experience accrues to the AD Benchmark Expenditure a month that does not accrue to the ESRD Benchmark.

CMS will exclude all months of an episode of care for treatment of COVID-19 during the Public Health Emergency (PHE) for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200 from the experience accrued to both the AD Benchmark and the ESRD Benchmark. CMS will identify an episode of care for treatment of COVID-19 as described in Section 4.3.

4.1 Period of Continuous Alignment-Eligibility

The *Period of Continuous Alignment-Eligibility* for a Beneficiary consists of all consecutive months of a calendar year, beginning with January, during which a beneficiary was alignment-eligible. A beneficiary is alignment-eligible in a calendar month if: (1) The beneficiary is enrolled in Part A and Part B of Medicare; (2) The beneficiary is not enrolled in a Medicare Advantage or other Medicare managed care plan; (3) Medicare is not the secondary payer; and (4) The beneficiary is a resident of the United States.

4.2 Period of Continuous Alignment

The *Period of Continuous Alignment* for a Beneficiary consists of all consecutive months within a Period of Continuous Alignment-Eligibility during which the Beneficiary resided in a county that is included in the Extended Service Area (ESA) of the NGACO, or during which the Beneficiary's county-of-residence was the same as the county-of-residence in the first month of the second Alignment Year.

The Period of Continuous Alignment-Eligibility will not be considered a Period of Continuous Alignment if, during the Period of Continuous Alignment-Eligibility, the Beneficiary: (a) received at least one Primary Care Qualified Evaluation and Management (PQEM) service from a place of service that is not located in a county that is included in the ESA of the NGACO; and (b) received no PQEM services from: (i) an NGACO Participant; or (ii) a place of service that is located in a county that is included in the ESA of the NGACO.

4.3 Accrual of Expenditures

The *Accrued Expenditure* (either the Shared Savings Expenditure or the Operating Cost) for a Base Year or the Performance Year consists of the expenditure incurred by a Beneficiary during a Period of Continuous Alignment that is paid within three months of the end of the Base or Performance Year. The incurred date for a claim is the date of service. The date of service is:

- For institutional claims, the through date on the claim header record.
- For a professional or durable medical equipment claim, the through date on the line-item record.

The paid date for a claim is the date the claim is included in National Claims History. This is effectively the date on which payment will be made.

CMS will exclude from the Accrued Expenditure calculations for the Performance Year all Parts A and B payment amounts for an episode of care for treatment of COVID-19, as specified on Parts A and B claims with dates of service during the episode. All Parts A and B payment amounts with dates of service during the months in a COVID-19 episode of care will be removed from Accrued Expenditure calculations. CMS will identify an episode of care for treatment of COVID-19 based on the criteria specified in 42 C.F.R. § 425.611(b)(1). Episodes of care for treatment of COVID-19 will be triggered by an inpatient admission for acute care either at an acute care hospital or other healthcare facility, which may include temporary expansion sites, Medicare-enrolled ambulatory surgical centers (ASCs) providing hospital services to help address the urgent need to increase hospital capacity to treat COVID-19 patients, CAHs, and potentially other types of providers. CMS will define the episode of care as starting in the month in which the inpatient stay begins as identified by the admission date, all months during the inpatient stay, and the month following the end of the inpatient stay as indicated by the discharge date. CMS will only remove episodes of care for treatment of COVID-19 when the discharge occurs during the Public Health Emergency (PHE) for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200.

5.0 Standardized Benchmark Expenditure PBPM

The *Standardized Benchmark Expenditure PBPM* is the foundation for the calculation of the Performance Year Benchmark. It includes the Attained Performance Adjustment to the Standardized Baseline Expenditure of the NGACO. It is standardized for risk (i.e., expected cost) and the GAFs that are applied by FFS payment systems for services provided to beneficiaries living in the NGACO's region.³

A separate Standardized Benchmark Expenditure PBPM is calculated for experience that accrues to the AD and ESRD benchmarks by:

1. Calculating the Standardized Baseline Expenditure PBPM for the NGACO (simple average of the Trended Standardized Base Year Expenditure PBPM for each Base Year); and,
2. Multiplying the Standardized Baseline Expenditure PBPM by the Attained Performance Factor.

Section 5.1 discusses the calculation of the Trended Standardized Base Year Expenditure PBPM. Section 5.2 discusses the calculation of the Attained Performance Factor.

5.1 Trended Standardized Base Year Expenditure PBPM

The *Trended Standardized NGACO Base Year Expenditure PBPM* for a Base Year is:

1. The NGACO Base Year Shared Savings Expenditure PBPM;
2. Divided by the product of the average Adjusted NGACO Risk Score for the Base Year and the Shared Savings GSF for the Base Year; and,
3. Multiplied by the Prospective Base Year Trend.

The Trended Standardized NGACO Base Year Expenditure PBPM is an estimate of the Shared Savings Expenditure that would have been incurred in the Performance Year by the Base Year Aligned Beneficiaries if their average risk score had been 1.0000 and if the average Geographic Adjustment Factor that was applied when calculating FFS provider payments was 1.0000.

5.2 Attained Performance Factor

The Attained Performance Factor is an adjustment to the Standardized Baseline Expenditure PBPM that reflects the magnitude of the difference between the NGACO's Standardized Baseline Operating Cost PBPM and the Standardized Regional Baseline Operating Cost PBPM. The Attained Performance Factor for an NGACO may not be greater than 1.1000 (+10%) or less than 0.9800 (-2%).

³ In this document "standardization" refers to the removal of the impact of a factor on expenditure. The "standardized" expenditure is an estimate of the expenditure that would be incurred by a "standard" beneficiary with a risk score of 1.0000 who lives in a county with a Geographic Standardization Factor of 1.0000. The standardized expenditure is calculated by dividing the incurred expenditure by the product of the benchmark risk score and the GSF.

The Attained Performance Factor is equal to:

- (a) the Standardized Regional Baseline Operating Cost PBPM LESS the Standardized Baseline Operating Cost PBPM;
- (b) TIMES the Blend Percentage;
- (c) DIVIDED BY the Standardized Baseline Operating Cost PBPM;
- (d) PLUS 1

The Blend Percentage ranges from 10% to 15% for an NGACO whose Standardized Baseline Operating Cost is above its Standardized Regional Baseline Operating Cost, depending on the difference between the Standardized Regional Baseline Operating Cost PBPM and the Standardized National Baseline Operating Cost PBPM. It ranges from 30% to 40% for an NGACO whose Operating Cost is below its Regional Operating Cost, depending on the difference between the Standardized Regional Baseline Operating Cost PBPM and the Standardized National Baseline Operating Cost PBPM.

5.2.1 Blend Percentage for an NGACO with High Operating Costs

The *Blend Percentage* ranges between 10% and 15% if the Standardized Baseline Operating Cost PBPM is greater than the Standardized Regional Baseline Operating Cost PBPM (i.e., if the NGACO has operating costs that are higher than operating costs in its region). The specific Blend Percentage depends on the difference between the Standardized Regional Baseline Operating Cost PBPM and the Standardized National Baseline Operating Cost PBPM. More specifically, the Blend Percentage is a linear interpolation between 10% and 15% based on the ratio of the Standardized Regional Baseline Operating Cost PBPM to the Standardized National Baseline Operating Cost PBPM. The ratio of the Standardized Regional Baseline Operating Cost PBPM to the Standardized National Baseline Operating Cost PBPM that is used to calculate the Blend Percentage may not be less than 0.9 or greater than 1.1.

5.2.2 Blend Percentage for an NGACO with Low Operating Costs

The *Blend Percentage* ranges between 30% and 40% if the Standardized Baseline Operating Cost PBPM is lower than the Standardized Regional Baseline Operating Cost PBPM (i.e., if the NGACO has operating costs that are lower than operating costs in its region). The specific Blend Percentage depends on the difference between the Standardized Regional Baseline Operating Cost PBPM and the Standardized National Baseline Operating Cost PBPM. More specifically, the Blend Percentage is a linear interpolation between 30% and 40% based on the ratio of the Standardized Regional Baseline Operating Cost PBPM to the Standardized National Baseline Operating Cost PBPM. The ratio of the Standardized Regional Baseline Operating Cost PBPM to the Standardized National Baseline Operating Cost PBPM that is used to calculate the Blend Percentage may not be less than 0.9 or greater than 1.1.

6.0 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 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 considered Other Monies Owed and deducted from any Shared Savings (or added to any Shared Losses) in accordance with Appendix G of this Agreement.

The Monthly PBP Payments that are made to an NGACO that participates in PBP will be reconciled with the Reduced FFS Payments in accordance with Appendix H of this Agreement. Any difference between the amounts will be considered Other Monies Owed, in accordance with Appendix H of this Agreement.

The payments that are made to an NGACO that participates in AIPBP will be reconciled with the Reduced FFS Payments in accordance with Appendix N of this Agreement. Any difference between the amounts will be considered Other Monies Owed, in accordance with Appendix N of this Agreement.

7.0 Optional Stop-Loss Arrangement

An NGACO has the option of participating in a Stop-Loss Arrangement. Under this arrangement, the Aggregate Stop-Loss Charge will be subtracted from the Aggregate Stop-Loss Payout, to yield an amount that is combined with Shared Savings (Loss) to determine Other Monies Owed.

7.1 Aggregate Stop-Loss Payout

The Aggregate Stop-Loss Payout is equal to the sum of the Stop-Loss Payout for all Beneficiaries aligned to an NGACO in the Performance Year. The Stop-Loss Payout for a Beneficiary is equal to the sum of the expenditure incurred in each Stop-Loss Band multiplied by the Payout Rate for that Stop-Loss Band. A Stop-Loss Band is a range of expenditures, set in relation to the attachment points.

7.1.1 Attachment Point

The Attachment Point for a beneficiary will be equal to 12 times a PBPM attachment point that is prospectively established for the year based on the 99th percentile of the Shared Savings Expenditure PBPM accruing to the AD Benchmark by Reference Beneficiaries.

An adjustment will be applied to a Beneficiary's attachment point for each month of experience that the beneficiary accrues to the ESRD Benchmark. The ESRD Adjustment will be equal to the difference between the 99th percentile of the Shared Savings Expenditure PBPM accruing to the AD Benchmark and the 99th percentile of the Shared Savings Expenditure PBPM accruing to the ESRD Benchmark by Reference Beneficiaries.

The Beneficiary's attachment point will be adjusted to reflect the GSF of the county in which the Beneficiary resides in January of the Base or Performance Year.

7.1.2 Stop-Loss Payout Rate

The Stop-Loss Payout Rate is equal to a percentage of the expenditure incurred by an Aligned Beneficiary whose total Shared Savings Expenditure exceeds the prospectively established Attachment Point. That percentage depends on the difference between the beneficiary's incurred expenditure and the Stop-Loss Attachment Point as described in §7.1.3.

7.1.3 Stop-Loss Bands

The amount that is paid out under the Stop-Loss Arrangement will increase as the expenditure incurred by the beneficiary during the Period of Continuous Alignment increases according to the schedule shown in Table 7.1.3.

Table 7.1.3. Stop-Loss Payout Schedule

Stop-Loss Band	Expenditure Range	Stop-Loss Payout Rate ¹
Band 1	100% to 150% of the Attachment Point	70%
Band 2	150% to 200% of the Attachment Point	80%

Stop-Loss Band	Expenditure Range	Stop-Loss Payout Rate ¹
Band 3	200% to 250% of the Attachment Point	90%
Band 4	More than 250% of the Attachment Point	100%

¹ The Stop-Loss Payout Rate applies to the amount of the expenditure incurred by the Beneficiary that falls within the expenditure range. The payout for a Beneficiary incurring an expenditure equal to 175% of the Attachment Point would, therefore, be equal to 70% of the amount within Risk Bank 1 and 80% of the amount within Band 2.

7.2 Aggregate Stop-Loss Charge

The Aggregate Stop-Loss Charge will be the Trended, Risk- and GSF-Adjusted Baseline Expenditure for the Performance Year multiplied by the Average NGACO Stop-Loss Payout Percentage.

The Trended, Risk- and GSF-Adjusted Baseline Expenditure will be calculated by multiplying: (1) the Trended Standardized Baseline Expenditures PBPM; by (2) the product of: (a) the Performance Year Benchmark Risk Score; (c) the Performance Year GSF; and (c) the number of beneficiary-months for the Period of Continuous Alignment in the Performance Year.

The Average NGACO Stop-Loss Payout Percentage is the average of the Aggregate Stop-Loss Payout Percentage for the two Base Years. The Aggregate Stop-Loss Payout Percentage for a Base Year is the Aggregate Stop-Loss Payout expressed as a percentage of the total Shared Savings Expenditure accruing to the Base Year.

Addendum A. Next Generation ACO Model Alignment Procedures

A Beneficiary is aligned to an NGACO either by an algorithm based on the receipt of Qualifying Evaluation and Management (QEM) services from Participants of the NGACO (Algorithmically Aligned Beneficiaries) or based on the designation by the Beneficiary of an NGACO Participant Practice as her or his principal source of care (Voluntarily Aligned Beneficiaries). A Beneficiary may be Voluntarily Aligned to an NGACO by signing an Attestation Statement which is retained by the NGACO or by designation a Participant Practice as her or his principal source of care on MyMedicare.gov.

A.1 Alignment Years

The Performance Year and each 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 2019 (AY2019) is the 12-month period ending in June 2019.

Table A.1.1 specifies the period covered by the Base Years for Performance Year 2021, and the Alignment Years for each Base Year and the Performance Year.

Table A.1.1. Performance Year 2021

Period Covered	Performance Year 2021 CY2021	Base Year 1 CY2018	Base Year 2 CY2019
Alignment Year 1	July 2018 - June 2019	July 2015 - June 2016	July 2016 - June 2017
Alignment Year 2	July 2019 - June 2020	July 2016 - June 2017	July 2017 - June 2018

A.2 Definitions used in alignment procedures

A.2.1 “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.2.2 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-1, 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-2 or A-3.

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.2.3 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-1.

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.2.4 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-2.

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.2.5 Next Generation Participant

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

A.2.6 Participant Practice

A Participant Practice is a physician practice, Federally Qualified Health Center, Rural Health Clinic or Critical Access Hospital with at least one member who is a Participant of the NGACO.

A.3 Algorithmic 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 Base Year 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' 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 Participants.

A.3.1 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 first (earlier) Alignment Year will be weighted by a factor of $\frac{1}{3}$.
2. The allowable charge for QEM services provided during the second (later or more recent) Alignment Year will be weighted by a factor of $\frac{2}{3}$.

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 second Alignment Year as determined by the effective date of the claim.

A.3.2 The Two-Stage 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-2, 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-3.

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.3.3 Tie-breaker Rules

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.

In the event that the most recent PQEM service received by a Beneficiary would result in the Beneficiary being aligned to more than one NGACO, the Beneficiary will not be aligned an NGACO.

A.4 Voluntary Alignment

Voluntary Alignment takes precedence over Algorithmic Alignment. The same rules for accrual of experience to the NGACO apply to Algorithmically and Voluntarily Aligned Beneficiaries.

A.4.1 Paper-Based Voluntary Alignment

A Beneficiary who has signed an Attestation designating an NGACO Participant Practice as her or his primary source of care will be aligned to that NGACO for that Performance Year (and related Base Year) regardless of the NGACO with which the Beneficiary would be algorithmically aligned. Certain rules regarding Beneficiary overlap with other alternative payment models may prevent Beneficiary alignment to the NGACO, regardless of voluntary alignment choice.

A.4.2 Electronic Voluntary Alignment

A Beneficiary who has designated an NGACO Participant Practice as her or his primary source of care through MyMedicare.gov 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 algorithmically or by a Paper-Based voluntary alignment. A Beneficiary who has designated a practice as her or his primary source of care that is not an NGACO Participant will be removed from the alignment of the NGACO to which the Beneficiary is algorithmically aligned. Certain rules regarding Beneficiary overlap with other alternative payment models may prevent Beneficiary alignment to the NGACO, regardless of voluntary alignment choice.

Table A-1. Evaluation & Management Services – PY6/2021

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
99421	Online digital E&M for an est. patient, for up to 7 days, cumul. time 5–10 mins
99422	Online digital E&M for an est. patient, for up to 7 days, cumul. time 10–20 mins
99423	Online digital E&M for an est. patient, for up to 7 days, cumul. time 21+ mins
99441	Phone e/m phys/qhp 5-10 min to est pt
99442	Phone e/m phys/qhp 11-20 min to est pt
99443	Phone e/m phys/qhp 21-30 min to est pt
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
99350	Established Patient, extensive
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Office or Other Outpatient Services	

Chronic Care Management Services	
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99487	
99489	
99491	Chronic Care Management
G2058	Non-Complex CCM
G0506	Comprehensive assessment care plan CCM service
Advance Care Planning	
99497	ACP first 30 mins
99498	ACP add'l 30 mins
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Virtual check-ins	
G2010	'Store and forward' - Remote eval of recorded video and/or images submitted by an est. patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
Health Risk Assessment (screening and assessment)	
96160	Administration of HRA
96161	Administration of HRA
Behavioral Health Integration (BHI) Services	
99484	General, BHI
99492	Psychiatric Collaborative Care Model (CoCM), CoCM 1st month
99493	CoCM subsequent months
99494	Add-on CoCM
GCOL1	Psychiatric collaborative care model
G0444	Depression Screening Annual
Screening and Behavioral Counseling Interventions	
G0442	Annual alcohol screening 15 mins
G0443	Brief alcohol misuse counsel
Miscellaneous	
G0463	ETA hospitals
99483	Assessment of and care planning for patients with cognitive impairment
G2064	Principal Care Management
G2065	Principal Care Management

Table A-2. Specialty codes used for alignment based on primary care specialists – PY6/2021

Code ¹	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical nurse specialist
97	Physician Assistant

¹The 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 – PY6/2021

Code ¹	Specialty
6	Cardiology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonology
39	Nephrology
46	Endocrinology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventative medicine
90	Medical oncology
98	Gynecological/oncology
86	Neuropsychiatry

¹The 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>

