



Frequently Asked Questions May 2021

General Model Questions

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

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

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

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

All of CMS’s ACO models are part of the Original Medicare Program and generally follow Original Medicare rules and processes, and beneficiaries aligned to ACOs have freedom of choice to go to the Original Medicare providers and suppliers of their choice, as opposed to the defined provider network of an MA plan.

There is no requirement that a beneficiary receive services from an ACO, nor is there additional premium paid by the beneficiary for being aligned to an ACO. In addition, beneficiaries aligned to Next Generation ACOs maintain all Original Medicare benefits. Beneficiaries who are aligned to an ACO also may receive certain “benefit enhancements” but are not penalized in any way for seeing non-ACO providers. The Next Generation ACO Model does not require beneficiary enrollment. Beneficiaries are aligned to ACOs through claims or through voluntary alignment, when beneficiaries confirm a care relationship with a health care provider participating in the ACO.

3. How did CMS select participants for the Model?

- A. CMS evaluated applications in accordance with specific criteria in five key domains: (1) organizational structure; (2) leadership and management; (3) financial plan and experience with risk sharing; (4) patient centeredness; and (5) clinical care model.

These domains and associated point scores are detailed in Appendix F of the [RFA](#). In addition, we considered whether applicants had demonstrated that their organizational structures promote the goals of the Model by including diverse sets of providers and suppliers who would demonstrate a commitment to high quality care. Lastly, applicants with prior participation in a CMS program or demonstration were asked to demonstrate good performance and conduct in the previous initiative. CMS accepted applicants for participation beginning in 2016, 2017, and 2018 but does not currently plan to open the Model to additional applicants.

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

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

5. When did this Model start?

- A. The Next Generation ACO Model began in 2016. New cohorts of ACOs began participating in the Model in each of 2017 and 2018. In the NGACO Model, 2016 is often referred to as Performance Year 1 (PY1), 2017 is referred to as Performance Year 2 (PY2) and 2018 is referred to as Performance Year 3 (PY3). The Next Generation ACO Model began testing new benefit enhancements and an updated financial methodology for 2019 and 2020, which are often referred to as Performance Year 4 (PY4) and Performance Year 5 (PY5), respectively. The model was extended for an additional Performance Year 6 (PY6), in order to maintain stability for organizations impacted by Coronavirus disease 2019.

6. Is this a capitated ACO model?

- A. Beginning in PY2 (2017), Next Generation ACOs have had the option to participate in a capitation-like payment mechanism, called All-Inclusive Population-Based Payments (AIPBP). AIPBP is one of three available alternative payment mechanisms from which the ACOs can select. AIPBP in the Next Generation ACO Model is a payment mechanism, which is distinct from the risk arrangement that the ACO selects. All ACO benchmarks are calculated the same way, independent of the alternative payment mechanism and risk arrangement an ACO selects.

AIPBP functions by estimating total annual expenditures for care furnished to aligned beneficiaries by AIPBP-participating providers and suppliers and paying that projected amount to the ACO in a monthly AIPBP payment. Medicare then makes a corresponding 100% reduction in Medicare FFS payments to these providers and suppliers, called the AIPBP Fee Reduction. Next Generation ACOs that participate in AIPBP are responsible for paying claims for their AIPBP-participating Next Generation Participants and Preferred Providers with whom the ACO has written arrangements regarding AIPBP. The difference between the monthly AIPBP amounts paid to the ACO and the AIPBP Fee Reduction is reconciled each year.

7. What happens if the projected trend used in calculating the performance year benchmark is higher or lower than the experienced trend?

- A. Under limited circumstances, CMS may retroactively adjust the projected trend used in calculating the performance year benchmark if CMS determines that unforeseen events have occurred during the performance year that have rendered the projected trend

invalid for purposes of assessing the expected level of Medicare FFS spending. Trend adjustments are intended to prevent ACOs from being unfairly penalized or rewarded for major payment changes beyond their control. The terms and conditions for trend adjustments in this Model are established in the Next Generation ACO Model Participation Agreement.

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

- A. The Next Generation ACO Model seeks to mitigate fluctuations in the aligned beneficiary population and respect beneficiary preferences by supplementing claims-based alignment with voluntary alignment. Under voluntary alignment, Next Generation ACOs may offer beneficiaries the option to confirm or deny their care relationships with specific Next Generation Participants. This beneficiary input will be reflected in alignment for the subsequent performance year (e.g., during PY4 (2019), beneficiaries can confirm relationships that affect alignment for PY5 (2020), provided such beneficiaries meet all applicable eligibility criteria). Confirmations of care relationships through voluntary alignment supersede claims-based attributions. For example, a beneficiary who indicates that a Next Generation Participant is her main source of care may be aligned with the ACO, even if claims-based alignment would not result in alignment. This enables more alignment continuity across performance years.

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

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

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

10. My ACO is interested in benefit enhancements, but we did not implement some or any in our first years in the Model. Can we elect to participate in later years?

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

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

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

- A. Next Generation ACOs could elect to participate in three benefit enhancements in PY1 (2016) and PY2 (2017), including a waiver of the three-day skilled nursing facility rule; coverage for telehealth services furnished in non-Health Professional Shortage Areas and

at the beneficiary's place of residence; and allowing auxiliary personnel (e.g., licensed clinicians) to perform "incident to" post-discharge home visit services under the general supervision of a Next Generation Participant or Preferred Provider two times in a 30-day period.

Beginning in PY3 (2018), the telehealth benefit enhancement included asynchronous (i.e., store and forward) coverage of teledermatology and teleophthalmology services. The post-discharge home visits benefit enhancement allowed for up to nine visits in a 90-day period, rather than two visits in a 30-day period.

For PY4 (2019) and PY5 (2020), ACOs can elect to participate in three new benefit enhancements, in addition to the existing three. The Cost Sharing Support for Medicare Part B Services Benefit Enhancement allows NGACOs, subject to certain conditions and safeguards, to enter into Cost Sharing Support Arrangements with their Next Generation Participants and Preferred Providers, under which the Next Generation Participants and Preferred Providers would agree not to collect cost sharing amounts (in whole or in part) from those categories of beneficiaries (i.e., a sub-set) and Part B services identified by the NGACO. The second new benefit enhancement is the Chronic Disease Management Reward Program allows NGACOs to provide gift cards to eligible beneficiaries for the purpose of incentivizing participation in a qualifying chronic disease management program. The aggregate value of any and all gift cards provided to a beneficiary in a year cannot exceed \$75, cannot be offered in the form of cash or monetary discounts or rebates, including reduced cost-sharing or reduced premiums, and cannot be redeemable for cash. Lastly, the Care Management Home Visits Benefit Enhancement is intended to equip NGACOs with the ability to provide home visits proactively and in advance of a potential hospitalization. Aligned beneficiaries determined by the NGACO to be at risk of hospitalization, and for whom a Next Generation Participant or Preferred Provider has initiated a care treatment plan will be eligible for coverage of up to two Care Management Home Visits within 90 days of seeing that Next Generation Participant or Preferred Provider

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

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

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

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

Financial Model

14. What materials are available for the NGACO model financial methodology?

- A.** The Next Generation Model's financial methodology for PY1 (2016) through PY3 (2018), the updated financial methodology for PY4 (2019) through PY5 (2020), and the PY6 methodology which had changes to account for COVID-19 are currently posted on the Next Generation ACO Model website.

15. What is the PY4 (2019) and PY5 (2020) financial methodology? Why did CMS update the methodology?

- A. As referenced in the original Request for Application, the NGACO model will test an updated financial methodology for the final two performance years of the model, which are provided as an optional “renewal period” for the ACOs that participated in the Model through PY3 (2018). The updates to the NGACO Model benchmarking methodology are intended to test new methods designed to improve the long-term sustainability for both the ACOs and CMS, by shifting from an emphasis that rewards ACOs for improvement, to one that rewards ACOs for having attained efficiency in their expenditures.

16. What are the key updates to the undated financial methodology for PY4 (2019), PY5 (2020) and PY6 (2021)?

- A. CMS introduced a number of refinements to the financial methodology for PY4 and PY5 which were also used for the PY6 extension. The most significant updates to the benchmarking methodology relate to the calculation of ACO baseline expenditures (i.e., the expenditures that are used to construct an ACO's Performance Year Benchmark). The updated benchmarking methodology includes a new “attained performance adjustment” to the baseline that reflects the efficiency of an ACO during the baseline period. Specifically, CMS incorporates expenditures for the ACO's region with the ACO's historical expenditures to calculate the ACO's baseline expenditures. The exact proportions of regional and historical ACO expenditures included within an ACO's baseline (the “regional blend”) is dependent on the ACO's efficiency relative to its region and the efficiency of the ACO's region relative to the national average. For example, lower-cost ACOs are rewarded for having attained efficiency relative to their region, with a greater proportion of regional expenditures reflected in the baseline (between 30% and 40% regional expenditures). Conversely, an ACO with a baseline expenditure that is higher than the average expenditure in its region will have a lower proportion of regional expenditures reflected in its baseline (between 10% and 15% regional expenditures). CMS applies a “cap” and “floor” on the adjustments to an ACO's baseline expenditures stemming from the inclusion of the regional expenditures in the baseline (a 10% maximum upward baseline adjustment and a -2% maximum downward baseline adjustment) to constrain excessively high/low adjustments.

A second major update to the baseline calculation relates to the period of time that is used to construct an ACO's baseline expenditure. In the first three years of the model, the NGACO benchmark methodology used a single, fixed base year (CY 2014) for each Performance Year. For PY4 and PY5, the NGACO Model will incorporate a continuously updating 2-year baseline. The use of a continuously updated baseline period increases the comparability of the baseline and the Performance Year aligned populations, encourages continuous improvement, and will increase the reliability of the ACO's baseline expenditures (i.e., a two-year baseline period is subject to less random variation than a one-year baseline period). For example, for PY 4 (2019), ACOs will have a 2-year baseline from 2016 - 2017.

Additionally, the new methodology makes changes to increase the precision and predictability of calculations that are conducted as part of financial settlement. Under the updated financial methodology, the stop-loss arrangement will use multiple attachment points (i.e., the dollar threshold at which stop-loss protection begins) with decreasing levels of ACO risk exposure, thereby better reflecting ACO efforts to improve care and manage costs for beneficiaries incurring very high costs. These attachment points will be established *prospectively* and will be geographically adjusted to reflect regional spending differences. Lastly, the NGACO Model will incorporate partial-year financial data for beneficiaries who lose alignment eligibility part way through the year (e.g., beneficiary who joins Medicare Advantage during the year), rather than excluding their expenditures for the entire year. This refinement will help to better account for ACO efforts to coordinate care and manage patient costs while the beneficiary was still aligned to the ACO.

17. The Next Generation financial model includes a discount. How is this determined in the PY4 (2019), PY5 (2020) and PY6 (2021) financial methodology? How is ACO performance on quality measures rewarded?

- A. The discount is an adjustment that is incorporated into each ACO's benchmark. As ACOs are eligible to retain up to 100% of savings, this discount helps to ensure that savings for CMS are also generated from the model. Beginning in PY4 (2019), the discount that is applied to an ACO's trended, risk adjusted baseline will be dependent on the risk arrangement that is selected by the NGACO for the Performance Year. ACOs that select a full risk arrangement (100% savings/losses) will have a discount of 1.25% applied in calculating the Performance Year Benchmark. ACOs that select a partial risk arrangement (80% savings/losses) will have a discount of 0.5% applied in calculating the Performance Year Benchmark. For example, for an ACO that selects a full risk arrangement with a trended, risk adjusted benchmark of \$10,000 per beneficiary, the discounted benchmark would be \$9,875 per beneficiary.

In addition to the discount, CMS uses a quality "withhold," in which a portion of an ACO's performance year benchmark is held "at-risk," contingent upon the ACO's quality score. An ACO that achieves a 100% quality score (a function of the ACO meeting quality measure benchmarks and reporting requirements) will have the full withhold re-attributed to its performance year benchmark at settlement, while an ACO that achieves less than a 100% quality score will have a proportionate amount discounted from the withhold and re-attributed to its performance year benchmark.

18. What financial methodology changes were made to adjust for the impact of COVID-19?

- A. In order to protect ACOs from inappropriate losses stemming from the impact of COVID-19, the Next Generation ACO Model adopted a similar Extreme and Uncontrollable circumstances policy to the Medicare Shared Savings Program. For PY5 and PY6, Shared Losses accrued by a Next Generation ACO are reduced by the number of months in the Performance Year with a declared Public Health Emergency. Changes were also made to the risk adjustment methodology. Additionally, the Next Generation ACO Model maintains the ability to update the prospective trend in the event of a pandemic or other exogenous factor that renders the prospective trend invalid. CMS will determine the necessity of a retrospective trend update after the end of PY6.

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

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

20. Will the baseline be static, or will it change during the initial three performance years (2016-2018) or final three performance years (2019-2021)?

- A. The baseline year (2014) was static for the first three performance years of the model (2016-2018). For PY4 (2019), PY5 (2020) and PY6 (2021), a continuously updating 2-year baseline will be implemented. Historical baseline expenditures will be calculated as a simple rolling average across the two baseline years (i.e., the baseline years will be weighted equally).

21. How is risk adjustment used in calculating the performance year benchmarks for NGACOs? Which risk scores are used?

- A. Risk scores are used to adjust the performance year benchmark and reflect changes in beneficiary health status between the baseline period and performance year. CMS also incorporates risk scores into quarterly financial reports according to the schedule of when CMS Hierarchical Condition Category (HCC) risk scores are computed for purposes of the Medicare Advantage program. Final risk scores for a given year are not available until spring of the following year. For example, the final 2019 risk scores are not available until spring 2020.
- Risk scores are predictive in the sense of using diagnoses for claims incurred in the prior year (for 2019 risk scores, claims incurred in 2018). Fully complete claims for 2018 are not available until after the end of 2019 because of run-out on claims incurred in 2018.
 - Risk scores use beneficiary-level data which is not completely reported and available until after the end of the year for which risk scores are produced (e.g., after the end of 2019 for 2019 risk scores). For example, the HCC risk adjustment system uses separate HCC model segments for different types of beneficiaries (e.g., community, institutional, new enrollee, etc.). The assignment of a beneficiary into one of these CMS-HCC model segments – and thus the risk score for a given beneficiary – is partially dependent on information that is not completely determined until the final risk score computation is made.

This timeline for providing risk scores is currently a common constraint across all CMS ACO initiatives.

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

- A. We use CMS Hierarchical Condition Category (HCC) model to determine an ACO's average risk score for the ACO's baseline year population and the ACO's average risk scores for the performance-year population. The performance year benchmark is risk adjusted to reflect the change in average risk score between the base- and performance year populations. The risk ratio is defined as the ratio of the average performance-year risk score to the average baseline-year risk score. The increase in average performance year Benchmark risk score is capped at 3%, while the decrease in average performance year Benchmark risk score is limited to no less than the risk score for the nearest baseline year to the performance year; put another way, the [risk?] ratio is limited to between 1.00 – 1.03. For PY1 (2016), CMS applied a policy called re-normalization to account for changes in coding intensity between the base year and the performance year. In PY2 (2017), the Next Generation ACO Model gave NGACOs the option to select whether to be subject to the policy of re-normalization or a prospective coding factor adjustment. The coding factor adjustment policy applies to all NGACOs beginning in performance year 3 (2018).

23. Is the 3% HCC risk score cap applicable per performance year or across all performance years?

- A. The 3% risk adjustment cap applies to each performance year as compared to the baseline year nearest to the performance year. If this difference was +2% between the average risk scores for that baseline year and PY4 (2019), the ACO's risk ratio would reflect the entire 2% increase because 2% is below the 3% cap. If then in PY5 (2020), the difference was +4%, which is over the cap, the ACO's risk score would only reflect a 3% increase (the capped limit).

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

- A. Part D prescription spending is not included in calculating the Next Generation ACO performance year benchmarks. ACOs are only accountable for total Parts A and B expenditures for aligned beneficiaries.
- 25. As NGACO does not have a MSR/MLR, how does the discount work on the loss side? For example, is the ACO exposed to first dollar losses based on the discounted performance year benchmark or the undiscounted performance year benchmark?**
- A. The discount is built into the performance year benchmark, so all ACO performance year benchmarks inherently include a discount—there is no undiscounted performance year benchmark. Next Generation ACOs will receive first dollar shared savings for spending below the discounted performance year benchmark and are accountable for first dollar shared losses for spending above the discounted performance year benchmark.
- 26. Do infrastructure payments count as a medical expense in the reconciliation to determine shared savings/losses? Must all infrastructure payments be repaid to CMS?**
- A. No, infrastructure payments do not count in the total Parts A and B expenditures used to determine an ACO's shared savings or shared losses. Yes, all infrastructure payments must be repaid to CMS.
- 27. All-Inclusive Population-Based Payments (AIPBP) became available beginning in 2017. Do ACOs have to participate in a lower risk arrangement before entering into AIPBP?**
- A. A NGACO's selected risk arrangement and alternative payment mechanism are independent in the Next Generation ACO Model. ACOs that have selected either risk arrangement may select any of the available alternative payment mechanisms, including AIPBP, and vice versa. Beginning in performance year 2 (2017), all Next Generation ACOs (regardless of start date) had the option to select the AIPBP payment mechanism. ACOs are not required to select AIPBP and can select one of the other two available alternative payment mechanisms or no alternative payment mechanism. The AIPBP payment mechanism became operational in April 2017.
- 28. Will ACOs participating in the AIPBP alternative payment mechanism be allowed to determine payment rates for providers under capitation agreements, or is it mandated that current CMS Medicare payment rates be applied? How will beneficiary liability be calculated?**
- A. ACOs are allowed to determine payment rates for providers and suppliers under AIPBP arrangements and will not be required to pay AIPBP-participating providers and suppliers 100 percent of FFS rates, as long as payment arrangements are consistent with all applicable laws. Additional financial requirements for ACOs participating in AIPBP are described in the Model's participation agreement. Beneficiary liabilities are not affected by the AIPBP payment mechanism and will continue to be calculated based on what Medicare would have paid in the absence of the ACO's participation in AIPBP.
- 29. Under Population Based Payments (PBP), do ACOs have the ability to elect FFS reduction percentages at the TIN/NPI level?**
- A. Yes, Next Generation ACOs have the ability to differentiate participation in PBP at the TIN/NPI level. The amount of the PBP Fee Reduction is set at the TIN level. This means that NPIs within a TIN may either choose the PBP Fee Reduction percentage agreed to by the TIN or not to participate in PBP (no PBP Fee Reduction).
- 30. Do infrastructure payments also require discounted FFS payments to participating providers?**
- A. No, infrastructure payments do not affect FFS claims processing. All FFS claims are submitted and paid as normal, but the ACO also receives a monthly infrastructure payment, which must be repaid to CMS.

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

- A. Each year the ACO has the ability to select its alternative payment mechanism for the upcoming performance year. ACOs are not required to move from normal FFS to any of the alternative payment mechanisms. Each Next Generation ACO selects one alternative payment mechanism for a given performance year. An ACO cannot select more than one alternative payment mechanism for a given performance year (i.e., the ACO cannot select AIPBP for some of its Next Generation Participants and Preferred Providers and PBP for others).

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

- A. Each year, Next Generation ACOs may select an alternative payment mechanism for the upcoming performance year. If an ACO selects PBP, the ACO must have in place written arrangements with each PBP-participating Next Generation Participant and Preferred Provider to accept PBP Fee Reductions. Likewise, if an ACO selects AIPBP, the ACO must have written arrangements regarding AIPBP with each participating Next Generation Participant and Preferred Provider. CMS looks at past spending for aligned beneficiaries by providers and suppliers participating in the alternative payment mechanism to project the percentage of care that those providers and suppliers will account for in the upcoming performance year to calculate the monthly payment made to the ACO. For example, if an ACO selects AIPBP and, in past years, providers and suppliers who have agreed to participate in AIPBP accounted for 75% of aligned beneficiary spending, the monthly payment would reflect an assumption that 75% of care will be from AIPBP-participating Next Generation Participants and Preferred Providers and 25% will be from other Medicare providers and suppliers.

Alignment

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

- A. Qualified Evaluation & Management (QEM) services are identified by specified Healthcare Common Procedure Coding System (HCPCS) codes and physician specialty. Specifically, a QEM service is a claim for a primary care service provided by a primary care specialist or, one of the selected non-primary care specialists. More information on claims-based alignment and QEM services is included in the Next Generation ACO Benchmark Methodology documents.

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

- A. Each fall, prior to the start of a performance year, CMS will run alignment using a claims-based methodology described in the Next Generation ACO [Model?] Benchmark Methodology for Performance Years 4-5 document. For PY1 (2016), Next Generation ACOs' beneficiaries were aligned only through claims (with the exception of beneficiaries that voluntarily aligned to the ACO under another Medicare ACO initiative). Beginning in 2017, ACOs have the option to allow beneficiaries to voluntarily align for the subsequent performance year through paper-based voluntary alignment. For example, for PY2 (2017) a Next Generation ACOs' aligned population consists of beneficiaries aligned through

claims along with beneficiaries who, in PY1 (2016), elected to voluntarily align with the ACO for PY2 (2017).

34. Are services furnished by Preferred Providers used for purposes of beneficiary alignment? A.

No, only services furnished by Next Generation Participants are used for alignment.

35. Do service area boundaries apply to voluntary alignment?

A. Yes. There are general beneficiary eligibility requirements for alignment to an ACO. Those requirements also apply to voluntary alignment.

Quality and Program Reporting

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

A. CMS expects that ACOs who are ready and able to take on high levels of risk under the Next Generation ACO Model are already using Electronic Health Records (EHR) and already have robust systems in place. Beginning in 2017, the ACO and its Next Generation Participants shall use certified EHR technology (as defined in section 1848(o) (4) of the Act) in a manner sufficient to meet the requirements for an "eligible alternative payment entity" under section 1833(z)(3)(D)(i)(I) of the Act (added by section 101 (e)(2) of MACRA) as prescribed through regulation.

37. Do eligible clinicians participating in a Next Generation ACO satisfy the Merit Based Incentive Payment System (MIPS) reporting requirements as long as their ACO successfully collects and reports required quality data through the Next Generation ACO Model quality reporting mechanisms?

A. Yes. For 2021, eligible clinicians participating in ACOs in the Next Generation ACO Model do not have to report quality measures to MIPS if the ACO reports all required quality measures completely and successfully.

38. If we have one TIN with 100 NPIs but only 25 participate in the Next Generation ACO Model, do the remaining 75 NPIs need to report to MIPS?

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

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

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

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

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

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

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

**This sentence was corrected by CMS on 9/30/2020.*