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**PIONEER ACCOUNTABLE CARE ORGANIZATION
BENEFICIARY ALIGNMENT AND FINANCIAL RECONCILIATION
SPECIFICATIONS**

(Version 5.3)

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Contents

1.0	Specification summary.....	3
2.0	ACO alignment	4
2.1	Prospective ACO alignment-eligible population	4
2.2	ACO-aligned population	5
2.2.1	Initial Alignment	6
2.2.2	Realignment and Attestation	8
2.3	National reference population.....	9
2.4	Baseline decedent population	10
3.0	Savings calculation	11
3.1	Minimum savings/loss threshold	12
3.2	Maximum savings/loss.....	12
4.0	Performance period expenditure	13
4.1	Average expenditure per beneficiary (unweighted, uncapped, unannualized)	13
4.2	Annualized expenditures	14
4.3	Capped, annualized expenditures.....	15
4.4	Weighted, capped, annualized expenditures	16
5.0	Baseline expenditure	18
5.1	Base year expenditure	19
5.1.1	Annualized base year expenditure	19
5.1.2	Capped, annualized base year expenditure.....	20
5.2	Trending of base year expenditures to common base year (BY3).....	21
5.3	3-year weighted average trended, capped, annualized expenditure for a beneficiary	22
5.4	Newly eligible and other aligned beneficiaries without 12 eligible base period months.....	23
5.5	Baseline expenditures for decedents	28
5.6	3-year baseline expenditure	28
6.0	Benchmark calculation.....	30
6.1	National reference population cohort	30
6.2	Reference population expenditure.....	31
6.3	Adjustment for beneficiary entitlement category, age, and sex	32
6.3.1	Performance period age-sex-adjusted reference expenditure	33
6.3.2	Baseline age-sex-adjusted reference expenditure	33
7.0	Population-based payments	35
8.0	Tables	36
	Table 8-1 Evaluation and management service codes included in beneficiary alignment criteria	36
	Table 8-2 Specialty codes for primary care physicians	38
	Table 8-3 Specialty codes for specialist physicians.....	39
	Table 8-4. Variables used in total beneficiary expenditure calculations	40
	Table 8-5. Schedule for Pioneer ACO beneficiary alignment and baseline expenses (performance years 1 through 3).....	41
	Table 8.6 Age and Sex Categories by Entitlement Category	43

1.0 Specification summary

This specification provides a detailed specification of the methods that will be used to identify or calculate:

- The ACO-aligned population;
- The reference population;
- Baseline expenditures;
- The expenditure benchmark; and,
- Performance period expenditures.

This specification does not address the development of the quality performance score or its use in the calculation of shared savings (or loss) amounts.

These specifications are based on the Request for Applications that was published May 17, 2011. They may be revised subsequent to the publication of the final rules for the Medicare Shared Savings Program or in response to comments and further analysis conducted during the review of applications and negotiation of agreements with successful applicants. They are intended to provide a more detailed and specific statement of the methods that are expected to be included in those agreements to aid applicants in their evaluation of the Pioneer model.

2.0 ACO alignment

The ACO-aligned population and the national reference population on which the trend factors used to develop the benchmark will be based will both be drawn from the ACO alignment-eligible population. The ACO-aligned population will include those ACO-alignment-eligible beneficiaries who meet the requirements for alignment with an ACO.

Both the ACO-aligned and national reference populations will be identified on a prospective basis prior to the start of a performance period. Final financial settlement for a performance year will be based on the claims experience of those prospectively aligned beneficiaries that continued to meet the ACO-alignment requirements during the performance period.

2.1 Prospective ACO alignment-eligible population

The prospective alignment-eligible population will be identified using eligibility and claims data for a 36-month alignment period that will be specific to each performance year as shown in Table 2-1. Table 2-1 also shows the baseline periods that will be used during the first three Pioneer performance years.¹ The alignment period is updated for each new performance year, but the baseline period remains the same until the Pioneer ACO is "rebased" after 3 performance years (not shown in Table 2-1).

Table 2-1. Alignment and baseline periods for Pioneer ACOs for 2012 through 2014 performance years

Period	Performance Years		
	CY 2012	CY 2013	CY 2014
Alignment	7/1/2008 – 6/30/2009 7/1/2009 – 6/30/2010 7/1/2010 – 6/30/2011	7/1/2009 – 6/30/2010 7/1/2010 – 6/30/2011 7/1/2011 – 6/30/2012	7/1/2010 – 6/30/2011 7/1/2011 – 6/30/2012 7/1/2012 – 6/30/2013
Baseline	CY 2009 ¹ CY 2010 ¹ CY 2011	CY 2009 ¹ CY 2010 ¹ CY 2011	CY 2009 ¹ CY 2010 ¹ CY 2011

¹ The claims experience for the specified period will be trended forward to third base year, e.g., claims incurred during calendar year 2009 will be trended forward to be comparable to claims incurred during calendar year 2011 by applying the growth in expenditures for the reference population.

Source: CMS Pioneer ACO RFA.

To be eligible for prospective alignment, a beneficiary must be eligible for alignment in the third (latest) alignment year. That is, a beneficiary must have 12 months of fee-for-service (FFS) coverage under Medicare Part A and Medicare Part B and meet the other requirements for alignment-eligibility in the third alignment year.

¹ The term "performance year" generally refers to a calendar year. The Pioneer ACO Request for Applications indicated that the first performance year could be longer than 12 months. However, this specification assumes that the first performance year for Pioneer ACO's will begin January 1, 2012, and will be a calendar year.

A beneficiary's claims experience for an alignment year will be used in prospective alignment calculations and included in the prospective baseline expenditure estimate if the beneficiary:

- has 12 months of coverage under both Medicare Part A and Part B during the alignment year;
- has no months of coverage in which Medicare was the secondary payer during the alignment year;
- has no months of coverage under a Medicare managed care plan during the alignment year;
- was a U.S. resident during the alignment year; and,
- received at least one of the E&M services listed in Table 8-1 during the alignment year.

These requirements mean that a beneficiary who dies during an alignment year is not eligible for prospective alignment with an ACO. The identification of baseline decedents is discussed in sections 2.4, and the inclusion of decedent expenditures in the baseline is discussed in section 5.5.

The alignment-eligibility requirements also mean that a beneficiary will not be eligible for prospective alignment if the beneficiary first becomes covered by Medicare in the third alignment year or if the beneficiary was covered by a Medicare managed care plan in the third alignment year. A beneficiary will become eligible for prospective alignment in the year after she or he has accumulated at least 12 months of FFS experience. This requirement means, further, that expenditures by a beneficiary during their first months of Medicare coverage will not be included in baseline expenditures. Again, this is appropriate as expenditures during a performance year will not include expenditures during the first months of Medicare coverage.

The final ACO-aligned and reference populations for a performance period that will be included in financial reconciliation will be determined 3 months after the end of each performance period. A beneficiary that is included in the prospective alignment at the start of the performance period may fail to meet requirements for alignment during the performance period. (For example, a beneficiary may join a Medicare Advantage plan.) Prospective alignment will identify all beneficiaries that *may* be aligned with the ACO during the performance period. Final alignment will simply remove any prospectively aligned beneficiary who does not meet the alignment-eligibility requirements during the performance year.

2.2 ACO-aligned population

Pioneer ACOs will be accountable for the cost and quality outcomes of their aligned beneficiaries at each end-of-period reconciliation. The Pioneer ACO payment model may include either prospective or retrospective alignment. The ACO-aligned population described in this specifications report is consistent with prospective alignment. A Pioneer ACO may instead choose retrospective alignment. The retrospective alignment processes of the Medicare Shared Savings Program (MSSP) will be used, with changes as necessary to reflect differences in related design criteria between the Pioneer and MSSP payment models.

For a given performance period, the population of Medicare beneficiaries for whom a Pioneer ACO is accountable will be identified as those beneficiaries that the ACO has provided a plurality of eligible evaluation and management (E&M) services in the prior three years (alignment period), with the more recent years weighted more heavily (60%, 30%, 10%). That is, the allowed charges for E&M services incurred in alignment year 3 will be weighted by a factor of 0.6, those from alignment year 2 by 0.3, and

those from alignment year 1 by 0.1. The beneficiary will be aligned with the ACO if it provided the plurality of E&M services to the beneficiary during the three alignment years.

At all times, Medicare beneficiaries will remain free to select the providers and services of their choice. The Pioneer ACO payment model does not include any restrictions on or changes to Medicare fee-for-service benefits, nor does it include provisions for beneficiaries to opt out of alignment with an ACO for purposes of expenditure calculations and quality performance measurement. Any future possible provisions for beneficiaries to opt out of expenditure calculations and quality measurement will mirror those in the final regulations for the MSSP.

2.2.1 Initial Alignment

For each performance year, the following steps will determine the Pioneer ACO “prospective alignment” using information from the 3-year alignment period (the 3 alignment years immediately prior to the performance period). At the end of the performance year, prospectively aligned beneficiaries who did not meet the criteria for alignment during the performance year will be identified and eliminated from financial reconciliation calculations. Because of these additional, later steps, some beneficiaries who are initially aligned will not be included in financial reconciliation for the performance period.

To be prospectively aligned to an ACO, a beneficiary must meet each of the following general criteria:

- 1) Must have 12 months² of Medicare Part A and B enrollment in the last year of the alignment period.
- 2) Must not have any months of Medicare Advantage (MA) enrollment or Medicare Secondary Payer (MSP) status in the last year of the alignment period.
- 3) Must be a US resident in the last year of the alignment period.
- 4) Must be alive on the last day of the alignment period.
- 5) Must have a plurality of eligible evaluation and management (E&M) services at the ACO during the alignment period (see details below).

Criteria 1-4 guarantee that there is complete and recent data to determine whether the ACO has historically provided the plurality of E&M services to the beneficiary. These criteria prospectively identify the beneficiaries who will be included in the reference population. Criterion 5 identifies the cohort of beneficiaries that the ACO is accountable for. Criterion 5 identifies those members of the prospectively identified reference population that are aligned with the ACO. The ACO has some control over the health care of beneficiaries that it provides the plurality of E&M services to, and thus has some ability to coordinate their care.

The detailed steps for initial alignment are as follows:

Step 1) Identify all billing Tax Identification Numbers (TINs) used by providers affiliated with each ACO.³

² As used in this document “month” and “month of eligibility” means any calendar month in which a beneficiary met the eligibility requirements for ACO alignment on at least one day.

³ The ACO may be its own legal entity and have its own TIN, but in the case of an ACO that is not itself a Medicare provider, the ACO TIN would not appear on the claim.

Step 2) Identify billing TINs from Step 1 in which the ACO only reports a subset of their providers. For these billing TINs, identify the appropriate National Provider Identifiers (NPIs).⁴

Step 3) Identify all Part B carrier (physician/supplier) claims line items for qualifying E&M services that were provided during the three-year alignment period (at any provider, not just ACO affiliated providers). The qualifying E&M services refer to the E&M service codes (see Table 8-1 in section 8) of primary care and select specialist physicians from Tables 8-2 and 8-3 in section 8. "Allowed charges" will be used as a measure of services provided.

Step 4) Identify all Medicare beneficiary Health Insurance Claim Numbers (HICNs)⁵ of beneficiaries with a qualifying E&M service from Step 3.

Step 5) Using "allowed charges", determine the percentage of qualifying E&M services that are provided by primary care physicians (see Table 8-2 for list of specialty codes). For beneficiaries where this percentage is less than 10%, skip Step 6 and align using Step 7.

Step 6) Align each beneficiary to a provider (ACO or non-ACO TIN) based on the plurality of primary care services and other criteria.

Details on Step 6 -- Identify the provider (ACO or non-ACO TIN) that provides the plurality of the beneficiary's primary care qualified E&M services,⁶ as measured by allowed charges, and flag the beneficiary as being aligned to this provider. To do this, calculate a "primary care services alignment ratio" for each provider. The alignment ratio for primary care services is defined to be the proportion of total qualifying E&M services billed by a provider's (ACO or non-ACO TIN) primary care physicians (see Table 2 for list of specialty codes). For each provider, sum the beneficiaries allowed charges over the 3-year alignment period, using weights of 60%/30%/10%, with the earliest year weighted least. To obtain the primary care services alignment ratio, divide the weighted sum of allowed charges for a given provider by the total weighted sum of allowed charges at all providers. Align the beneficiary to the provider who has the highest primary care services alignment ratio. In the case of a tie align the beneficiary to the provider who performed the most recent primary care E&M service. In the event of a further tie, proceed to Step 8.

Step 7) For beneficiaries who receive less than 10% of their qualifying E&M services from primary care physicians (see Step 5), align the beneficiary using services provided by specialist physicians.

Details on Step 7 -- Identify the provider (ACO or non-ACO TIN) that provides the plurality of the beneficiary's specialist (see Table 8-3 in section 8) E&M services, as measured by allowed charges, and flag the beneficiary as being aligned to this provider. To do this, calculate a specialty care services alignment ratio for each provider. The alignment ratio for specialty care services is defined to be the proportion of total qualifying E&M services billed by a provider's (ACO or non-ACO TIN) specialist physicians (select specialties from Table 8-3). For each provider, sum the beneficiaries allowed charges over the 3-year alignment period, using weights of 60%/30%/10%, with the most distant year weighted

⁴ Multiple NPIs may bill through each TIN. E&M services with the ACO-specified TIN/NPI combinations will be identified and used for alignment.

⁵ An alternative Medicare beneficiary identifier, the Beneficiary Link Key, might be used in place of the HICN.

⁶ "Total qualifying E&M services" refers to qualifying E&M services provided by ALL providers (TINs). For Step 6, consider only E&M services (line items) with primary care specialty codes.

least. To obtain the specialty care services alignment ratio, divide the weighted sum of allowed charges for a given provider by the total weighted sum of allowed charges at all providers. Align the beneficiary to the provider who has the highest specialty care services alignment ratio. In the event of a tie, align the beneficiary to the provider who performed the most recent specialty care E&M service. In the event of a further tie, proceed to Step 8.

Step 8) Tie-break rule: For beneficiaries not aligned in Steps 6 or 7 due to ties, perform beneficiary alignment using ALL Part B carrier (physician/supplier) claims for qualifying E&M visits.

Details on Step 8 -- Using allowed charges, align the beneficiary to the provider (ACO or non-ACO TIN) who provides the plurality of a beneficiary's Part B carrier (physician/supplier) services, using a "Part B services" alignment ratio and 60%/30%/10% weighting in a similar fashion to the previous two steps. In the event of a tie, align the beneficiary to the provider who performed the most recent Part B service.

Step 9) Drop beneficiaries from initial alignment if they did not meet one or more of the following in the last year of the alignment period: a) 12 months of Medicare Part A and B enrollment; b) no months of MA enrollment or MSP status, c) US resident.

Step 10) Drop beneficiaries from initial alignment if they were not alive on the first day of the performance year.

Notes on Step 10 -- Date of death can be recorded in the Medicare enrollment file months after a beneficiary has died. The most recent Medicare enrollment file will be used to identify deaths that have been recorded by the time initial alignment is conducted. More recent Medicare enrollment files will be available for performance period re-alignment and additional beneficiaries who died during the alignment period may be dropped from financial reconciliation.

2.2.2 Realignment and Attestation

ACOs that select prospective alignment will be accountable for the cost and quality outcomes of all their prospectively aligned beneficiaries at each end-of-period reconciliation, with certain exceptions. Beneficiaries initially aligned to an ACO will be considered no longer being in the ACO's designated patient population for purposes of performance measurement and expenditure calculations if they satisfy one or more of the following conditions in the performance year:

- 1) Has zero months of Part A and B enrollment.
- 2) Has at least one month of Part A-only enrollment or Part B-only enrollment or MA enrollment or MSP status.
- 3) Is a non-US resident.
- 4) Transfers Medicare address to a Core Based Statistical Area (CBSA) or rural county that does not overlap with or is not adjacent to the ACO's location (where the majority of its clinicians are located).

- 5) Receives more than 50% of their E&M allowed charges in non-overlapping, non-adjacent CBSAs or rural counties during the performance period.

In addition, as noted previously, if more recent Medicare enrollment files, than were available during the initial alignment process, shows that the beneficiary died during the alignment period, they will no longer be aligned to the ACO.

Finally, beneficiaries who newly enroll in Medicare or who disenroll from an MA plan may also be aligned with ACOs through an affirmative attestation on behalf of the beneficiary that a specific ACO is his or her primary provider. These beneficiaries will be included in the financial calculations for the ACO in the first performance year after they have accrued 12 months of fee-for-service experience. Beneficiaries who already have 12 or more months of fee-for-service experience may attest at any time, but will not be included in the ACO's expenditure calculations until the subsequent performance period.

For example, a 65 year old who enrolls in Medicare before July 1 of the first performance period will be eligible for alignment and expenditure calculations at the beginning of the third performance period. The intent of procedures for beneficiary attestation is to allow patients and providers to align based on mutually acknowledged care relationships rather than claims-based algorithms. However, attestation is not intended to result in ACOs selecting some types of beneficiaries more than others for inclusion in their expenditure baseline and benchmark, and this provision may be revised if program monitoring reveals differences between attesting patients and those patients treated by the ACO who do not attest.

2.3 National reference population

The factors that will be used to calculate the ACO-specific expenditure benchmark as discussed in section 6 will be calculated from the expenditures of the national reference population of all ACO-alignment-eligible beneficiaries. Just as the ACO-aligned population is specific to a performance year, the reference population will be redefined for each new performance year.

The prospectively identified alignment-eligible population will be used to calculate the preliminary baseline expenditure for the reference population.

The final reference population that is used in financial reconciliation will consist of all prospectively identified alignment-eligible beneficiaries that also meet the requirements for alignment-eligibility in the performance period. Specifically, the final reference population will consist of any prospectively identified alignment-eligible beneficiary who:

- (a) Was covered under Medicare parts A and part B in the first month of the performance year;
- (b) Had no months of Part A-only or Part B-only coverage during the performance year;
- (c) Had no months of enrollment in a Medicare private health plan during the performance year;
- (d) Had no months coverage during the performance year during which Medicare was the secondary payer; and,
- (e) Was not a U.S. resident during the performance year.

The national reference population will also include, for purposes of developing baseline reference expenditures, baseline decedents as defined in section 2.4.

2.4 Baseline decedent population

As noted in section 2.1, the prospective alignment-eligible population does not include decedents. To make sure that baseline expenditures for the reference population as well as the ACO-aligned population reflects expenditures incurred by decedents, baseline decedents will be identified for each performance year.

Decedent beneficiaries will be eligible for alignment with an ACO during a performance year if the beneficiary:

- was covered under both Medicare Part A and Part B during the first month of an 3rd alignment year;
- had 12 months of Medicare Part A-only or Part B-only coverage during the 2nd alignment years;
- had no months of coverage in which Medicare was the secondary payer during the 2nd or 3rd alignment years;
- had no months of coverage under a Medicare managed care plan during the 2nd or 3rd alignment years;
- was a U.S. resident during the 2nd and 3rd alignment years; and,
- received at least one of the E&M services listed in Table 8-1 during the 2nd alignment year.

Decedent beneficiaries will be aligned with an ACO using the same methods described in section 2.2 but using data for only the 1st and 2nd alignment years.

The decedent population will be identified using data for the 36-month period from July 1, 2008 through June 30, 2010. The alignment of beneficiaries who died during that period will be based on the providers affiliated with the ACO for each performance year.

3.0 Savings calculation

The gross savings achieved by an ACO in a performance year is the difference between the observed expenditures incurred by the beneficiaries aligned with the ACO in the performance year and the expenditure benchmark for the ACO's population.

$$S_{py} = (B_{py}^*) - (E_{py}) \quad (\text{Formula 3.1})$$

where

S_{py} = savings (per aligned beneficiary¹) for the performance year

B_{py}^* = benchmark for the performance year

E_{py} = expenditure of aligned population in the performance year

The amount of the gross savings that is available to the ACO (before application of quality incentive adjustments) is given by:

$$A_{py} = (S_{py})(P_{py})(Q_{py}) \quad (\text{Formula 3.2})$$

where

A_{py} = amount of savings (loss) paid to (recovered from) the ACO in the performance year

S_{py} = gross savings (loss) borne by ACO in the performance year

P_{py} = percentage of gross savings (loss) borne by ACO in the performance year

Q_{py} = adjustment for quality performance score in the performance year

The Pioneer RFA specifies a range for the fraction of gross savings (loss) to be borne by the ACO. The range is determined by the performance year:

- In PY1, between 50% and 70% of savings (loss) is borne by the ACO
- In PY2, between 60% and 75% of savings (loss) is borne by the ACO
- In PY3, between 70% and 75% of savings (loss) is borne by the ACO

The fraction of gross savings (loss) borne by the ACO will be adjusted by the ACO's quality performance score. The specific methods used to adjust the gross savings fraction for quality performance will be defined following publication of the final rule for the Medicare Shared Savings Program, as noted in the Pioneer RFA.

3.1 Minimum savings/loss threshold

If the amount of gross savings (loss) is less than 1% of the benchmark, no savings (loss) will be paid to (recovered from) the ACO.

3.2 Maximum savings/loss

The Pioneer RFA specifies a range for the maximum savings (loss) that will be paid to (recovered from) the ACO. The maximum savings (loss) is specified as a percentage of the benchmark and determined by the performance year:

- In PY1, the maximum savings (loss) paid to or recovered from the ACO is 5% to 15%
- In PY2, the maximum savings (loss) paid to or recovered from the ACO is 10% to 15%
- In PY3, the maximum savings (loss) paid to or recovered from the ACO is 15%

The development of the expenditure in a performance period is described in section 4, the benchmark for the performance period in section 5, and the baseline expenditure for the performance period in section 6.

4.0 Performance period expenditure

The expenditure (per aligned beneficiary) in a performance period is the sum of all Medicare payments on claims:

- (a) for services covered by Part A or Part B of Medicare;
- (b) that are incurred (i.e., with a date-of-service) during the performance period; and,
- (c) that are paid (and considered to be the “final action”) not more than 3 months after the last day of the performance period.

except that:

- (d) Medicare inpatient pass-through payment amounts (estimates) on inpatient claims will be excluded from expenditures.⁷

The date of service for each type of covered service is as follows:

- Inpatient hospital claim: the discharge date or last day of coverage for an inpatient hospital stay;
- SNF claim: the last day of a SNF stay that is covered by Medicare Part A;
- HHA claim: the “through date” of a claim for HHA services;
- Outpatient hospital claim: the date of service for the claim line-item;
- Physician or other provider claim: the “through date” for the claim line-item (HCPCS procedure);
- DME or other supplier claim: the date of service for the claim line item (HCPCS item/service);
- Hospice claim: the claim through date.

The specific requirements for the inclusion of claims are given in Table 8-4 in section 8.

4.1 Average expenditure per beneficiary (unweighted, uncapped, unannualized)

The basic statement of the average expenditure per beneficiary in a performance period is given by:

$$E_{py} = \frac{\sum_{i=0}^{N_{py}} (C_{py,i})}{N_{py}} \quad \text{(Formula 4.1)}$$

where

E_{py} is the average expenditure per beneficiary in the PY

$\sum_{i=0}^{N_{py}}$ denotes the sum over all beneficiaries (i) in the ACO-aligned population in the PY

$C_{py,i}$ = total incurred claims of aligned beneficiary i in the PY

⁷ The pass-through amounts—such as direct medical education and bad debt—are ultimately reconciled and paid based on hospitals' Medicare Cost Reports. The amounts on claims are estimates by Medicare claims-processing contractors and can be unreliable.

N_{py} = number of beneficiaries aligned with the ACO in the PY

Not all beneficiaries in a performance period will have 12 months of exposure (i.e., coverage under Medicare Parts A and B). The most important group of beneficiaries with fewer than 12 months of experience will be decedents.

As a result, formula 4.1 must be modified for use in calculating performance period expenditures and savings. These modifications involve three steps:

- Annualization to correct for a beneficiary with fewer than 12 months of exposure;
- Application of the cap on annual (or annualized) expenditures; and,
- Re-weighting to calculate the average annualized expenditure per beneficiary life-year (or person-year).

These three steps are discussed in sections 4.2 through 4.4. Comparable adjustments must also be made to the baseline expenditures of the ACO-aligned beneficiaries and to both the baseline and performance period expenditures of the reference population.

4.2 Annualized expenditures

To adjust for the effect of having fewer than 12 months experience, the expenditures incurred during the performance period will be annualized. The annualized expenditures incurred by a beneficiary during performance year 1 is given by:

$$C'_{py,i} = \frac{C_{py,i}}{Y_{py,i}} \quad (\text{Formula 4.2})$$

$$Y_{py,i} = \frac{M_{py,i}}{12} \quad (\text{Formula 4.2a})$$

where

$C'_{py,i}$ = annualized expenditure of aligned beneficiary i in PY

$C_{py,i}$ = total incurred claims of aligned beneficiary i in PY

$Y_{py,i}$ = number of alignment-eligible-life-years of experience of beneficiary i in PY

$M_{py,i}$ = number of alignment-eligible-months of experience of beneficiary i in PY

Note, further, that the annualized expenditure of beneficiary i is equal to the average monthly expenditure of the beneficiary multiplied by 12.

4.3 Capped, annualized expenditures

ACOs may elect to cap the expenditures incurred by an individual beneficiary to reduce the impact of beneficiaries who incur extraordinary claims on the average performance year expenditure of the ACO-aligned population.⁸ Different reference population trend factors will be calculated and used for those ACO's that elect to cap and for those that elect not to cap annualized expenditures. For ACO's that elect to cap annualized expenditures, the annualized capped expenditure is given by:

$$C''_{py,i} = \begin{cases} C'_{py,i} & \text{if } C'_{py,i} \leq K_{py,i} \\ K_{py,i} & \text{if } C'_{py,i} > K_{py,i} \end{cases} \quad (\text{Formula 4.3})$$

where

$C''_{py,i}$ = is the capped, annualized expenditure of beneficiary i in PY

$C'_{py,i}$ = is the annualized expenditure of beneficiary i in PY (from formula 4.2)

$K_{py,i}$ = the cap on annual expenditures applicable to beneficiary i in PY

For aligned beneficiaries entitled by age or disability, the cap $K_{py,i}$ will be the unweighted 99th percentile of the annualized expenditure distribution in the aged-disabled national reference population for each performance year.

For aligned ESRD beneficiaries the cap $K_{py,i}$ developed from the national reference population for each performance year will be:

- 1) the weighted mean, annualized uncapped expenditures of ESRD beneficiaries; plus
- 2) the difference of (a) the aged-disabled cap and (b) the weighted mean, annualized, expenditures of aged-disabled beneficiaries.

The cap for beneficiaries classified as having ESRD in some but not all months during the performance year will be a weighted average of the ESRD and aged-disabled caps according to the proportion of the eligible months in each status. The weighted average cap for such a beneficiary is given by:

$$K_{py,i} = \frac{[(K_{ad,py})(M_{ad,py,i}) + (K_{esrd,py})(M_{esrd,py,i})]}{[(M_{ad,py,i}) + (M_{esrd,py,i})]} \quad (\text{Formula 4.4})$$

where

$K_{py,i}$ = the cap on annual expenditures applicable to beneficiary i in PY

⁸ The election to cap, or not to cap, annualized expenditures will apply to both baseline and performance year expenditures. That is, if an ACO elects not to cap annualized expenditures both the average baseline and performance year expenditures will be calculated on an uncapped basis. If an ACO elects to cap annualized expenditures both the average baseline and performance year expenditures will be calculated on a capped basis.

$K_{ad,py}$ = the cap on annual expenditures for aged and disabled beneficiaries in PY

$K_{esrd,py}$ = the cap on annual expenditures for ESRD beneficiaries in PY

$M_{ad,py,i}$ = number of alignment-eligible-months of ESRD-free experience of beneficiary i in PY

$M_{esrd,py,i}$ = number of alignment-eligible-months of experience with ESRD of beneficiary i in PY

4.4 Weighted, capped, annualized expenditures

A beneficiary with fewer than 12 months exposure in the performance year should not be counted equally with beneficiaries with a full 12 months of exposure because the beneficiary does not incur claims in every month of the performance year. The annualized, capped expenditure will be weighted based on the number of exposure months of the beneficiary in the performance period. The weighted, capped, annualized expenditure is given by:

E''_{py} = mean of capped, annualized expenditures weighted by life-years

$$E''_{py} = \frac{\sum_{i=0}^{N_{py}} [(C''_{py,i})(Y_{py,i})]}{\sum_{i=0}^{N_{py}} (Y_{py,i})} \quad (\text{Formula 4.5})$$

where

E''_{py} is the average weighted, capped, annualized expenditure per beneficiary in PY1

$C''_{py,i}$ = capped annualized expenditures of beneficiary i in PY1

$Y_{py,i}$ = number of life-years of experience incurred by aligned beneficiary i in PY

$\sum_{i=0}^{N_{py}}$ means sum over all beneficiaries (i) in the ACO-aligned population in PY.

Ignoring the effect of capping, the average weighted annualized expenditure (E''_{py}) equals the average expenditure per alignment-eligible month multiplied by 12. This can be seen by replacing $C''_{py,i}$ with $C'_{py,i}$ in Formula 4.5 (because we are ignoring the effect of capping) and substituting the definition of $C'_{py,i}$ from Formula 4.2:

$$E''_{py} = \frac{\sum_{i=0}^{N_{py}} \left[\frac{(C_{py,i})}{(Y_{py,i})} (Y_{py,i}) \right]}{\sum_{i=0}^{N_{py}} (Y_{py,i})} \quad (\text{Formula 4.5a})$$

Simplifying, formula 4.5a can be rewritten as simply the average expenditure of ACO-aligned beneficiaries per life-year:

$$E''_{py} = \frac{\sum_{i=0}^{N_{py}} (C_{py,i})}{\sum_{i=0}^{N_{py}} (Y_{py,i})} \quad (\text{Formula 4.5b})$$

Substituting the definition of $Y_{py,i}$ from Formula 4.2a:

$$E''_{py} = \frac{\sum_{i=0}^{N_{py}} (C_{py,i})}{\sum_{i=0}^{N_{py}} \left(\frac{M_{py,i}}{12} \right)} \quad (\text{Formula 4.5c})$$

$$E''_{py} = 12 \left[\frac{\sum_{i=0}^{N_{py}} (C_{py,i})}{\sum_{i=0}^{N_{py}} (M_{py,i})} \right] \quad (\text{Formula 4.5d})$$

where

E''_{py} is the average weighted, capped, annualized expenditure per beneficiary in PY1

$C''_{py,i}$ = capped annualized expenditures of beneficiary i in PY1

$C_{py1,i}$ = total incurred claims of aligned beneficiary i in PY

$Y_{py,i}$ = number of life-years of experience incurred by aligned beneficiary i in PY

$M_{py,i}$ = number of alignment-eligible-months of experience of beneficiary i in PY

$\sum_{i=0}^{N_{py}}$ means sum over all beneficiaries (i) in the ACO-aligned population in PY.

In other words, setting aside the effect of capping, the average weighted annualized expenditure per beneficiary is equal to the average monthly expenditure of ACO-aligned beneficiaries multiplied by 12.

5.0 Baseline expenditure

Because the ACO-aligned population changes from one performance year to the next, baseline expenditures are specific to a performance year, and will be recalculated for each performance year. A preliminary baseline expenditure will be calculated near the beginning of the ACO's 3-year agreement period, using the prospectively aligned PY1 population. The final baseline expenditure will not be calculated until the ACO's finally-aligned population for a performance year is available, which will be after the conclusion of the performance year. See Table 8-5 for a summary of the sequencing of alignment, baseline, and performance year calculations during performance years 1 through 3.

The baseline expenditure for an ACO is based on the expenditures incurred by the ACO-aligned population over a 3-year baseline period. In this section, we denote the 3 years of the baseline period by BY1 (calendar year 2009), BY2 (calendar year 2010), and BY3 (calendar year 2011), where BY3 is the most recent (latest) baseline year.

Two different types of ACO-aligned beneficiaries contribute to the baseline expenditure: (1) established beneficiaries who had at least a full year of fee-for-service coverage under Parts A and B of Medicare during the baseline period; and (2) "newly eligible" beneficiaries who had less than a full year of fee-for-service coverage under Parts A and B during the baseline period. This second type of beneficiary includes new Medicare program enrollees, and beneficiaries disenrolling from a private Medicare health plan.

The same procedures apply to the calculation of baseline expenditures for the population aligned with an ACO and for the reference population of all alignment-eligible beneficiaries.

The development of the baseline expenditure involves 9 steps. The first six of these steps involve the calculation of the baseline for beneficiaries who were eligible for established beneficiaries.

1. Calculate the total Medicare Part A and Part B claims incurred by the ACO-aligned (or alignment-eligible) beneficiary in each of the three base years included in the baseline period.
2. Calculate the total months in each of the three base years during which the ACO-aligned (or alignment-eligible) beneficiary was eligible for alignment.
3. Calculate the annualized expenditure for each ACO-aligned (or alignment-eligible) beneficiary for each of the three base years included in the alignment period
4. Calculate the capped, annualized expenditure for each ACO-aligned beneficiary (or alignment-eligible) for each of the three years included in the baseline period.⁹
5. Trend the capped, annualized expenditure for each ACO-aligned (or alignment-eligible) beneficiary for each base year to a common base year, specifically to base year 3.
6. Calculate the 3-year weighted average of the trended, capped, annualized baseline expenditure for each ACO-aligned (or alignment-eligible) beneficiary. This is the 3-year weighted average expenditure baseline for the ACO-aligned (or alignment-eligible) beneficiary.

The last two steps involve the calculation of the baseline for "newly eligible" beneficiaries.

⁹ This step applies only if the ACO elects to use capped expenditures in the savings calculations.

7. Calculate the 3-year trended, capped, annualized baseline expenditure for each newly eligible ACO-aligned beneficiary.
8. Calculate the 3-year trended, capped, annualized baseline expenditure for ACO-aligned decedents as defined in section 2.4.
9. Calculate the weighted average of the 3-year weighted average expenditure baseline for all ACO-aligned beneficiaries, including both all prospectively-eligible beneficiaries (from step 6), newly eligible beneficiaries (from step 7), and decedents (from step 8). This is the baseline that will be used in the calculation of the benchmark for a performance year.

In Section 5.1 we describe the development of a beneficiary's baseline expenditure for each of the three baseline years.

In Section 5.2 we describe the trending of expenditure from BY1 and BY2 to BY3.

In section 5.3 we describe the calculation of the 3-year baseline expenditure for each ACO-aligned beneficiary as a weighted average of the beneficiaries capped, annualized expenditures in each of the 3 baseline years.

In Section 5.4, we describe the calculation of the 3-year baseline expenditure for the "newly eligible" beneficiaries who do not have 12 eligible months in BY3.

In Section 5.5, we describe the calculation of the 3-year baseline expenditure for "decedents".

In Section 5.6, we describe the calculation of the 3-year weighted average expenditure baseline for all ACO-alignment eligible beneficiaries.

5.1 Base year expenditure

The baseline expenditure for a beneficiary is developed from the expenditure incurred by a beneficiary in each of the three years that comprise the baseline period (2009 through 2011). The methods used to calculate the beneficiary's expenditure for each of these three years are the same as those used to develop the performance period expenditure that are described in section 4, with one exception. The beneficiary's expenditure for each base year is not weighted by the beneficiary's months of alignment-eligibility until the three years are combined into a single baseline expenditure amount.

5.1.1 Annualized base year expenditure

The annualized expenditure incurred by a beneficiary in each of the three base years adjusts the amount of the claims incurred during each year for the months of ACO-alignment eligibility during that year. The annualized base year expenditure for base year 1 is given by:

$$C'_{by1,i} = \frac{C_{by1,i}}{Y_{by1,i}} \quad (\text{Formula 5.1})$$

$$Y_{by1,i} = \frac{M_{by1,i}}{12} \quad (\text{Formula 5.1a})$$

$$C'_{by1,i} = \left(\frac{C_{by1,i}}{M_{by1,i}} \right) 12 \quad (\text{Formula 5.1b})$$

where

$C'_{by1,i}$ = annualized expenditure of aligned beneficiary i in BY1

$C_{by1,i}$ = total incurred claims of aligned beneficiary i in BY1

$Y_{by1,i}$ = number of alignment-eligible-life-years of experience of beneficiary i in BY1

$M_{by1,i}$ = number of alignment-eligible-months of experience of beneficiary i in BY1

The formulas for BY2 and BY3 are the same as formulas 6.1 through 6.1b except that $by2$ and $by3$ are substituted, respectively, for $by1$.

As discussed above, the annualized expenditure is an estimate of the claims that would have been incurred by the beneficiary with fewer than 12 months of eligibility if the beneficiary had incurred claims for 12 months at the same rate as in months of eligibility. That is, a beneficiary who incurred claims at a rate of \$6,000 during each of her six months of eligibility would, if that rate of spending had continued for 12 months, have incurred claims of \$72,000 during the calendar year.

5.1.2 Capped, annualized base year expenditure

The development of the capped annualized expenditure for a beneficiary in each base year uses the same methods and formulas discussed in section 4 in connection with performance period expenditures. The basic formula for the capped, annualized expenditure is given by formula 4.3.

The capped, annualized expenditure of a beneficiary is the lesser of two amounts: (a) the annualized expenditures incurred by the beneficiary during months of ACO-alignment eligibility in each base year; and (b) the maximum annualized expenditure in each of the base years:

$$C''_{by1,i} = \begin{cases} C'_{by1,i} & \text{if } C'_{by1,i} \leq K_{by1,i} \\ K_{by1,i} & \text{if } C'_{by1,i} > K_{by1,i} \end{cases} \quad (\text{Formula 5.2a})$$

$$C''_{by2,i} = \begin{cases} C'_{by2,i} & \text{if } C'_{by2,i} \leq K_{by2,i} \\ K_{by2,i} & \text{if } C'_{by2,i} > K_{by2,i} \end{cases} \quad (\text{Formula 5.2b})$$

$$C''_{by3,i} = \begin{cases} C'_{by3,i} & \text{if } C'_{by3,i} \leq K_{by3,i} \\ K_{by3,i} & \text{if } C'_{by3,i} > K_{by3,i} \end{cases} \quad (\text{Formula 5.2c})$$

where

$C''_{by1,i}$ = capped, annualized expenditure of beneficiary i in BY1

$C'_{by1,i}$ = annualized expenditure of beneficiary i in BY1 (from formula 4.1)

$K_{by1,i}$ = cap on annual expenditures applicable to beneficiary i in BY1

The definition of the terms for BY2 and BY3 are the same except that $by2$ and $by3$ are substituted, respectively, for $by1$.

As discussed in section 4.3, the cap ($K_{by1,i}$, $K_{by2,i}$, or $K_{by3,i}$) that will be applied to annual expenditures will depend on whether the beneficiary has ESRD. The cap that is applied to aged and disabled beneficiaries without ESRD will be equal to the unweighted 99th percentile of the annualized expenditure distribution for the aged-disabled national reference population for the specified base year.

For aligned ESRD beneficiaries the cap developed from the national reference population for the specified base year will be the mean, annualized uncapped expenditures of ESRD beneficiaries plus the difference between the aged-disabled cap and the unweighted mean, annualized, expenditures of aged-disabled beneficiaries.

The cap for beneficiaries classified as having ESRD in some but not all months during the performance year will be a weighted average of the caps for ESRD and aged-disabled beneficiaries where the weight applied is the proportion of the eligible months in each status. See section 4.3 for a detailed specification.

5.2 Trending of base year expenditures to common base year (BY3)

The capped, annualized expenditure for each of the first and second years of the baseline period will be trended forward to the third (last) year of the baseline period by applying trend factors derived from the national reference population.

To derive these trend factors, the national reference population will be defined to include beneficiaries alive at the end of BY3 with 12 eligible months in BY3.

The trend factor that is applied to the beneficiaries' capped, annualized expenditure will be specific to the entitlement/age/sex category to which the beneficiary belongs. Each aligned and reference beneficiary will be assigned to her or his entitlement/age/sex cell based on BY3 (2011) entitlement status, age and sex.

$$B_{by1,i} = (C''_{by1,i}) \left(\frac{R''_{by3,a_i}}{R''_{by1,a_i}} \right) \quad \text{(Formula 5.3a)}$$

$$B_{by2,i} = (C''_{by2,i}) \left(\frac{R''_{by3,a_i}}{R''_{by2,a_i}} \right) \quad \text{(Formula 5.3b)}$$

$$B_{by3,i} = (C''_{by3,i}) \quad (\text{Formula 5.3c})$$

where

$B_{by1,i}$ = capped, annualized expenditure of beneficiary i in BY1 (2009) trended to BY3 (2011)

$B_{by2,i}$ = capped, annualized expenditure of beneficiary i in BY2 (2010) trended to BY3 (2011)

$B_{by3,i}$ = capped, annualized expenditure of beneficiary i in BY3 (2011)

R''_{by1,a_i} = average capped, annualized expenditure of reference population in the entitlement/age/sex category to which beneficiary i belongs (a_i) in BY1 (2009)

R''_{by2,a_i} = average capped, annualized expenditure of reference population in the entitlement/age/sex category to which beneficiary i belongs (a_i) in BY2 (2010)

R''_{by3,a_i} = average capped, annualized expenditure of reference population in the entitlement/age/sex category to which beneficiary i belongs (a_i) in BY3 (2011)

$C''_{by1,i}$ = capped, annualized expenditure of beneficiary i in BY1 (2009)

$C''_{by2,i}$ = capped, annualized expenditure of beneficiary i in BY2 (2010)

$C''_{by3,i}$ = capped, annualized expenditure of beneficiary i in BY3 (2011)

5.3 3-year weighted average trended, capped, annualized expenditure for a beneficiary

The trended, capped, annualized expenditures for each of the three base years will be combined to give the baseline expenditure for each ACO-aligned beneficiary. The beneficiary's expenditure for each base year will be weighted by the number of months of ACO-eligibility in that year and the weight assigned to that year by the ACO baseline policy (i.e., 60% of the eligibility-months in the 3rd baseline year, 30% of the eligibility-months in the 2nd baseline year, and 10% of the eligibility months in the 3rd baseline year).

$$\bar{B}_{b3,i} = (B_{by1,i})(W_{by1,i}) + (B_{by2,i})(W_{by2,i}) + (B_{by3,i})(W_{by3,i}) \quad (\text{Formula 5.4})$$

$$W_{by1,i} = \frac{(M_{by1,i})(0.1)}{[(M_{by1,i})(0.1) + (M_{by2,i})(0.3) + (M_{by3,i})(0.6)]} \quad (\text{Formula 5.4a})$$

$$W_{by2,i} = \frac{(M_{by2,i})(0.3)}{[(M_{by1,i})(0.1) + (M_{by2,i})(0.3) + (M_{by3,i})(0.6)]} \quad (\text{Formula 5.4b})$$

$$W_{by3,i} = \frac{(M_{by3,i})(0.6)}{[(M_{by1,i})(0.1) + (M_{by2,i})(0.3) + (M_{by3,i})(0.6)]} \quad (\text{Formula 5.4c})$$

where

$\bar{B}_{b3,i}$ = 3-year average baseline of beneficiary i expenditures trended to BY3 (2011)

$B_{by1,i}$ = capped, annualized expenditure of beneficiary i in BY1 (2009) trended to BY3 (2011)

$B_{by2,i}$ = capped, annualized expenditure of beneficiary i in BY2 (2010) trended to BY3 (2011)

$B_{by3,i}$ = capped, annualized expenditure of beneficiary i in BY3 (2011)

$W_{by1,i}$ = weighted contribution of BY1 (2009) expenditure of beneficiary i to the 3-year baseline of beneficiary i

$W_{by2,i}$ = weighted contribution of BY2 (2010) expenditure of beneficiary i to the 3-year baseline of beneficiary i

$W_{by3,i}$ = weighted contribution of BY3 (2011) expenditure of beneficiary i to the 3-year baseline of beneficiary i

$M_{by1,i}$ = alignment-eligible months of beneficiary i in BY1 (2009)

$M_{by2,i}$ = alignment-eligible months of beneficiary i in BY2 (2010)

$M_{by3,i}$ = alignment-eligible months of beneficiary i in BY3 (2011)

5.4 Newly eligible and other aligned beneficiaries without 12 eligible base period months

In the first performance period all beneficiaries will have 12 months of experience in the 3rd baseline year (i.e., 2010) because this is a requirement for alignment. There will, therefore, be no need for special provisions to calculate and include in the ACO baseline an amount that represents the experience of newly eligible beneficiaries. However in the second and third performance years, special provision will be made to include a baseline expenditure amount for newly eligible beneficiaries. This section focuses on calculating baseline expenditures for "newly eligible beneficiaries", by which we mean new Medicare program enrollees who enroll in Medicare after the first month of the 3rd baseline year. Similar issues arise for disenrollees from Medicare private health plans or other beneficiaries who may be eligible for ACO alignment in performance years 2 and 3, but who do not have 12 eligible months of expenditure data in the 3 baseline years. The methods described in this section will be used to calculate baseline

expenditures for all aligned beneficiaries without 12 months of eligible experience in the 3 base period years.¹⁰

In performance year 1 (2012), the alignment period is the substantially the same as the baseline period. As a result, beneficiaries with 12 months of experience in the 3rd year of the alignment period (ending June 2011), which is a requirement for alignment, will also have 6 months of experience in the 3rd year of the baseline period. Many of these beneficiaries will also have eligible experience in the 1st and 2nd years of the baseline period (ending in 2009 and 2010, respectively). Claims incurred during 2009 through 2011 will be used to develop the baseline expenditure for these beneficiaries using the method specified in the previous section.

In performance year 2 (2013), the alignment period differs from the baseline period. The alignment period covers the three 12-month periods ending in June 2010, 2011, and 2012. A beneficiary with 12 months experience in the third alignment year (ending 2012), will not necessarily have 12 months (or any months) of eligible experience in the 3-year baseline period 2009-2011. Similarly in performance year 3 (2014), alignment-eligible beneficiaries will not necessarily have 12, or any, eligible months of experience in the baseline period. Beneficiaries who were enrolled in a Medicare private health care plan during some or all of the baseline period may be eligible for alignment in performance years 2 and 3, yet also may not have 12 eligible months in the baseline period. Baseline expenditures for these types of beneficiaries will be calculated using the methods described in this section.

In the case of these newly eligible or other beneficiaries without 12 eligible months in the original 3-year baseline period (CY 2009 through CY 2011), their 3-year baseline period will be defined as the 3-year alignment period for the performance year. Further, the 3 base years will be weighted as follows:

- The 3rd year of the alignment period will be treated as if it were the 1st year of the baseline period, and will be weighted 10%.
- The 2nd year of the alignment period will be treated as if it were the 2nd year of the baseline period, and will be weighted 30%.
- The 1st year of the alignment period will be treated as if it were the 3rd year of the baseline period, and will be weighted 60%.

For performance year 2, the baseline years will be:

- Base year 1 (2012), which will be weighted 10%.
- Base year 2 (2011), which will be weighted 30%.
- Base year 3 (2010), which will be weighted 60%.

For performance year 3, the baseline years will be:

- Base year 1 (2013), which will be weighted 10%.
- Base year 2 (2012), which will be weighted 30%.
- Base year 3 (2011), which will be weighted 60%.

¹⁰ Baseline expenditures for all beneficiaries with at least 12 eligible months in the 3-year baseline period 2008-2010 will be calculated from baseline period expenditures, according to the methods described earlier in Section 5.

For newly eligible beneficiaries without experience in the baseline period, the older baseline years will more closely represent patterns of utilization and expenditure in the original 3rd base period year 2011, which is the fundamental base year used in the Pioneer ACO benchmark calculation. Consequently, it is appropriate to give *greater* weight to the years that are closer to the original baseline period. All aligned beneficiaries without 12 eligible months in the original baseline period 2009-2011 are guaranteed to have at least 12 eligible months in the redefined baseline period because all aligned beneficiaries must have 12 eligible months in the 3rd year of the alignment period.

A further stipulation is that the baseline period for a beneficiary will be determined by the year in which the beneficiary first becomes eligible for ACO-alignment. This means that the baseline expenditure for a beneficiary, once calculated, will not be changed (recalculated). If a beneficiary qualifies for alignment in PY1 and her or his baseline expenditures are calculated, those same baseline expenditures will be used for PY2 and PY3. Similarly, baseline expenditures calculated for newly-aligned beneficiaries in PY2 will be used for PY3. In PY3, baseline expenditures will only be calculated for beneficiaries newly aligned in PY3, whose baseline expenditures were not calculated for PY1 or PY2.

Because the claims experience of newly eligible beneficiaries may be from a year that is *later* than the 3rd baseline period year (2010), these expenditures must be rolled *back* to the 3rd baseline year by applying trend factors derived from the national reference population. For performance year 2:

$$B_{ay3,i} = (C''_{ay3,i}) \left(\frac{R''_{by3,a_i}}{U''_{ay3,a_i}} \right) \quad (\text{Formula 5.6a})$$

$$B_{ay2,i} = (C''_{ay2,i}) \left(\frac{R''_{by3,a_i}}{U''_{ay2,a_i}} \right) \quad (\text{Formula 5.6b})$$

$$B_{ay1,i} = (C''_{ay1,i}) \quad (\text{Formula 5.6c})$$

where

$B_{ay3,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 3 (2012)¹¹ trended to BY3 (2011)

$B_{ay2,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 2 (2011)¹¹ trended to BY3 (2011)

$B_{ay1,i}$ = capped, annualized expenditure of newly aligned beneficiary i in alignment year 1 (2010)¹¹

U''_{ay3,a_i} = average capped, annualized expenditure of newly eligible reference population in the age/sex category to which newly eligible beneficiary i belongs (a_i) in alignment year 3 (2012)

¹¹ For beneficiaries who first become enrolled in Medicare after 2010, the eligibility months and expenditure during BY3 will, of course, be zero.

U''_{ay2,a_i} = average capped, annualized expenditure of newly eligible reference population in the age/sex category to which newly eligible beneficiary i belongs (a_i) in alignment year 2 (2011)

R''_{by3,a_i} = average capped, annualized expenditure of reference population in the age/sex category to which beneficiary i belongs (a_i) in BY3 (2011)¹³

$C''_{ay3,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 3 (2012)

$C''_{ay2,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 2 (2011)

$C''_{ay1,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 1 (2010)¹³

The available years of experience would be combined using the same method of weighting the individual base year expenditures:

$$\bar{B}_{b3,i} = (B_{ay3,i})(W_{ay3,i}) + (B_{ay2,i})(W_{ay2,i}) + (B_{ay1,i})(W_{ay1,i}) \quad (\text{Formula 5.7})$$

$$W_{ay3,i} = \frac{(M_{ay3,i})(0.1)}{[(M_{ay3,i})(0.1) + (M_{by2,i})(0.1) + (M_{ay1,i})(0.6)]} \quad (\text{Formula 5.7a})$$

$$W_{ay2,i} = \frac{(M_{ay2,i})(0.3)}{[(M_{ay3,i})(0.1) + (M_{ay2,i})(0.3) + (M_{ay1,i})(0.6)]} \quad (\text{Formula 5.7b})$$

$$W_{ay1,i} = \frac{(M_{ay1,i})(0.6)}{[(M_{ay3,i})(0.1) + (M_{ay2,i})(0.3) + (M_{ay1,i})(0.6)]} \quad (\text{Formula 5.7c})$$

where

$\bar{B}_{b3,i}$ = 3-year average baseline of newly eligible beneficiary i expenditures trended to BY3 (2010)

$B_{ay3,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 3 (2012) trended to BY3 (2010)

$B_{by2,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 2 (2011) trended to BY3 (2010)

$B_{ay1,i}$ = capped, annualized expenditure of newly eligible beneficiary i in alignment year 1 (2010)

$W_{by3,i}$ = weighted contribution of alignment year 3 (2012) expenditure of newly eligible beneficiary i to the 3-year baseline of beneficiary i

$W_{by2,i}$ = weighted contribution of alignment year 2 (2011) expenditure of newly eligible beneficiary i to the 3-year baseline of beneficiary i

$W_{ay1,i}$ = weighted contribution of alignment year 1 (2010) expenditure of newly eligible beneficiary i to the 3-year baseline of beneficiary i

$M_{ay3,i}$ = alignment-eligible months of newly eligible beneficiary i in alignment year 3 (2012)

$M_{ay2,i}$ = alignment-eligible months of newly eligible beneficiary i in alignment year 2 (2011)

$M_{ay1,i}$ = alignment-eligible months of newly eligible beneficiary i in alignment year 1 (2010)

Using these methods, a baseline expenditure is obtained for every aligned beneficiary with less than 12 eligible months in the original baseline period (2009-2011). These baseline expenditures are included in the unweighted average baseline expenditures across all aligned beneficiaries, to obtain overall ACO baseline expenditures, as given by Formula 6.5.

An example may make this clearer. Assume a beneficiary became eligible for Medicare in October 2011 and was continuously ACO-eligible through December 2012. The beneficiary therefore has:

- 12 months of ACO-alignment-eligibility in 2012
- 3 months of ACO-alignment-eligibility in 2011
- 0 months of ACO-alignment-eligibility in 2010 and earlier

The beneficiary has, in total 15 months of ACO-alignment-eligibility. On a weighted eligibility basis, the annual weights for each year are:

- 10% of the 12 months of experience in 2012, normalized by the total 2.1 weighted eligible months, which equals a 2012 weight of $1.2/2.1 = 57\%$.
- 30% of the 3 months of experience in 2011, normalized by the total 2.1 weighted eligible months, which equals a 2011 weight of $0.9/2.1 = 43\%$
- 60% of the 0 months of experience in 2010, which equals a 2010 weight of 0.

If the beneficiary's capped, annualized expenditure (after trending to the 3rd baseline year (2010)) are \$2,400 in 2011 and \$3,100 in 2012. The beneficiary incurred no Medicare expenditures in 2010. The weighted 3-year average baseline expenditure for the beneficiary would be:

- For 2012 (treated as the 1st year of the baseline): $\$3,100 \times (1.2/2.1) = \$1,771.43$
- For 2011 (treated as the 2nd year of the baseline): $\$2,400 \times (0.9/2.1) = \$1,028.57$
- For 2010 (treated as the 3rd year of the baseline): $\$0 \times 0.0 \text{ weighted months} = \0

Summing these amounts gives a baseline expenditure of \$2,800 for this beneficiary.

5.5 Baseline expenditures for decedents

The baseline expenditure of decedents will be calculated using the methods described in sections 5.1, 5.2 and 5.3. The baseline decedent expenditure will be calculated once for the beneficiaries identified in section 2.4, i.e., beneficiaries who died during the 36-month alignment period for performance period 1. The baseline expenditure for each of these beneficiaries will be included in the calculation of baseline expenditures for each performance year.

5.6 3-year baseline expenditure

The baseline expenditure for an ACO's performance year is the weighted average of the baseline expenditures of the beneficiaries aligned to the ACO in the performance year where the beneficiary-level expenditures are weighted by the weighted life-year. The ACO's baseline expenditure can be written:

$$\bar{\bar{B}}_{b3} = \frac{\sum_{i=1}^N [(\bar{B}_{b3,i})(\bar{Y}_{b3,i})]}{\sum_{i=1}^N (\bar{Y}_{b3,i})} \quad (\text{Formula 5.8})$$

where

$\bar{\bar{B}}_{b3}$ = the ACO's 3-year baseline expenditure for a performance year

$\sum_{i=1}^N$ denotes the sum over all beneficiaries (i) in the ACO-aligned population for the performance year

$\bar{B}_{b3,i}$ = 3-year baseline expenditure of beneficiary i expressed in annualized, BY3 dollars

$\bar{Y}_{b3,i}$ = 3-year weighted average life-years of beneficiary i

N = number of beneficiaries aligned with the ACO in the performance year.

The 3-year weighted average life-years $\bar{Y}_{b3,i}$ used in Formula 6.8 is given by:

$$\bar{Y}_{b3,i} = \frac{[(M_{by1,i})(0.1) + (M_{by2,i})(0.3) + (M_{by3,i})(0.6)]}{12} \quad (\text{Formula 5.9})$$

where

$\bar{Y}_{b3,i}$ = 3-year weighted average life-years of beneficiary i

$M_{by1,i}$ = alignment-eligible months of beneficiary i in BY1

$M_{by2,i}$ = alignment-eligible months of beneficiary i in BY2

$M_{by3,i}$ = alignment-eligible months of beneficiary i in BY3

The 3-year baseline represents the total expenditure that was incurred by all aligned beneficiaries over the 3 baseline years. However, each baseline year does not contribute equally to an aligned beneficiary's baseline expenditures for two reasons:

- The 60%/30%/10% baseline years weighting gives less weight to a base year that is more distant (in time) from the performance year. This weighting, in effect, assumes that the more time that has elapsed since a base year and the performance year the less predictive expenditures in that base year will be of performance year expenditure.
- Some beneficiaries will have less experience to contribute to the total expenditure of the aligned population over the three base years. Some beneficiaries will have been alignment-eligible for only one or two years, while other beneficiaries (specifically decedents) will have fewer than 12 months of experience in a baseline year. Because the performance year expenditure (calculated as described in section 4) represents an expenditure per person-year, and because an aligned beneficiary with fewer than 12 months of experience in the performance year contributes less to the average expenditure per person-year in the performance year than a beneficiary with 12 months of experience, it is appropriate to weight baseline expenditures for the amount of experience contributed by each beneficiary.

6.0 Benchmark calculation

The Pioneer ACO RFA specifies that the expenditure benchmark will be equal to the ACO's baseline per capita expenditure increased by an amount equal to 50% of the national per capita percentage growth rate applied to the ACO's 3-year baseline expenditure plus 50% of the dollar change in the national per capita expenditure.

This formula for calculating the benchmark can be written:

$$B_{py}^* = \bar{\bar{B}}_{b3} + 0.5 \left[\bar{\bar{B}}_{b3} \left(\frac{\Delta R_{py}}{\bar{\bar{R}}_{b3}} \right) \right] + 0.5(\Delta R_{py}) \quad (\text{Formula 6.1})$$

$$\Delta R_{py} = R_{py} - \bar{\bar{R}}_{b3} \quad (\text{Formula 6.1a})$$

where

B_{py}^* = per capita benchmark for PY

$\bar{\bar{B}}_{b3}$ = 3-year baseline per capita expenditure of aligned population expressed in BY3 dollars

R_{py} = per capita expenditure of reference population in PY

$\bar{\bar{R}}_{b3}$ = per capita expenditure of reference population for 3-year base period

ΔR_{py} = dollar change in per capita expenditure of reference population from to PY.

This basic formula can be restated as:

$$B_{py}^* = \bar{\bar{B}}_{b3} + \left(\frac{\Delta R_{py}}{R_{b3}} \right) \left(\frac{[\bar{\bar{B}}_{b3} + \bar{\bar{R}}_{b3}]}{2} \right) \quad (\text{Formula 6.1b})$$

Stated in English: the benchmark is the baseline plus the reference population growth rate multiplied by the simple average of the baseline ACO expenditure and the baseline reference population expenditure. This restatement shows that, effectively, the Pioneer benchmark is adjusting the ACO-specific baseline expenditures upwards or downwards halfway toward the national average baseline, and then applying the national percentage growth rate.

6.1 National reference population cohort

The basic eligibility requirements for the national reference population are discussed in Section 2.3. The national reference population includes all alignment-eligible beneficiaries, whether or not they are

actually aligned to any specific ACO. The national reference population includes both beneficiaries aligned to ACOs and beneficiaries not aligned to any ACO. The national reference population excludes beneficiaries not residing in the United States.

The dollar and percentage change in national reference population expenditures will be calculated for the prospectively identified cohort of beneficiaries who are ACO-alignment-eligible for each performance year. More explicitly:

- The reference cohort for PY1 will consist of beneficiaries who were alignment-eligible in alignment year 1 for PY1 (July 2008 through June 2011).
- The reference cohort for PY2 will consist of beneficiaries who were alignment-eligible in alignment year 1 for PY2 (July 2009 through June 2012).
- The reference cohort for PY3 will consist of beneficiaries who were alignment-eligible in alignment year 1 for PY3 (July 2010 through June 2013).

A prospectively defined reference population cohort will be defined for each performance year, just as an ACO's aligned population will be redefined for each performance year.

An alignment-eligible beneficiary would contribute to the expenditure baseline of the reference population and to the baseline of an ACO with which she or he is aligned only in those base years in which she or he was alignment eligible.

6.2 Reference population expenditure

The expenditure (per ACO-eligible beneficiary) in a performance period is the sum of all Medicare payments on claims associated with an ACO alignment-eligible beneficiary:

- (a) for services covered by Part A or Part B of Medicare;
- (b) that are incurred (i.e., with a date-of-service) during the performance period; and,
- (c) that are paid (and considered to be the "final action") not more than 3 months after the last day of the performance period,

except that:

- (d) Medicare inpatient pass-through payment amounts (estimates) on inpatient claims will be excluded from expenditures.¹²

Alignment with an ACO is not a requirement for the reference population. That is, the reference expenditure will be based on all claims incurred by any ACO-alignment-eligible beneficiary whether or not the beneficiary is aligned with an ACO.

The dates of service for each type of covered service are the same as for the ACO-aligned population:

- Inpatient hospital claim: the discharge date or last day of coverage for an inpatient hospital stay;
- SNF claim: the last day of a SNF stay that is covered by Medicare Part A;

¹² The pass-through amounts—such as direct medical education and bad debt—are ultimately reconciled and paid based on hospitals' Medicare Cost Reports. The amounts on claims are estimates by Medicare claims-processing contractors and can be unreliable.

- HHA claim: the “through date” of a claim for HHA services;
- Outpatient hospital claim: the date of service for the claim line-item;
- Physician or other provider claim: the date of service for the claim line-item (HCPCS procedure);
- DME or other supplier claim: the date of service for the claim line item (HCPCS item/service);
- Hospice claim: claim through date.

Reference population expenditures will be calculated using the same methods that are used to calculate ACO-aligned beneficiary expenditures. As described in Section 4, expenditures will be annualized and capped, and mean expenditures will be weighted by beneficiaries' eligibility fraction. Expenditures for the reference population cohort will be calculated in the baseline year (2011) and in the performance year.

The baseline expenditure for the reference population will also include the expenditures for the baseline decedent population (see section 2.4) in the same way that the baseline expenditure of the ACO-aligned population will include expenditures of aligned baseline decedents (see section 5.5).

6.3 Adjustment for beneficiary entitlement category, age, and sex

The reference population's expenditures for the baseline and performance period will be adjusted to reflect the composition of the ACO's aligned population. For purposes of this adjustment, beneficiaries will be grouped into age/sex categories within three entitlement categories:

- (1) Beneficiaries originally entitled to Medicare coverage on the basis of age who do not have ESRD will be grouped into not more than 16 age/sex categories;
- (2) Beneficiaries originally entitled to Medicare coverage on the basis of disability who do not have ESRD will be grouped into not more than 20 age/sex categories;
- (3) Beneficiaries having ESRD, regardless of the original basis of entitlement, will be grouped into not more than 14 age/sex categories.

The anticipated age/sex categories for each of these eligibility categories are given in Table 8.6. The specific categories may be redefined based on further analysis.

As described in this section, adjustment for the composition of the ACO's aligned population will be accomplished by multiplying the reference population mean expenditure in each entitlement/age/sex cell by the ACO's proportion of aligned beneficiary person years in each entitlement/age/sex cell. For the benchmark calculation, the reference population's absolute and percentage expenditure changes from the baseline to the performance period will be based on the entitlement/age/sex-adjusted reference population expenditures.¹³

¹³ Taking an average of the *absolute* expenditure changes in the national reference cohort weighted by the ACO's aligned beneficiary age-sex proportions gives the same result as the method described in this section. However, taking a weighted average of national *percentage* changes gives a different, incorrect answer. This is because the overall percentage change is affected by the baseline expenditure *levels* of the age-sex cells, not just their percentage changes. The method described in this section gives the correct result for both absolute and percentage age-sex-adjusted changes.

For a performance year, both the ACO-aligned population and the national reference population are cohorts that consist of the same individuals in the baseline period and in the performance year. Thus, the ACO age-sex proportions do not vary by baseline or performance period. For convenience, we define the age and sex of members of the ACO aligned and reference populations as baseline values (in the last year of the baseline period).

6.3.1 Performance period age-sex-adjusted reference expenditure

The age-sex-adjusted reference expenditure for a performance period is given by:

$$R'''_{py} = \frac{\sum_a [(N_{by,a})(R'''_{py,a})]}{\sum_a (N_{by,a})} \quad (\text{Formula 6.2})$$

where

R'''_{py} = ACO-adjusted weighted, capped, annualized reference expenditure in the PY

\sum_a means sum over all entitlement/age/sex categories a

$N_{by,a}$ = Number of ACO-aligned beneficiary person years in entitlement/age/sex category (a) for the baseline period

$R'''_{py,a}$ = the average weighted, capped, annualized expenditure of the reference population in entitlement/age/sex category (a) for the PY

6.3.2 Baseline age-sex-adjusted reference expenditure

The average ACO-adjusted reference expenditure in the baseline period is given by:

$$R'''_{by3} = \frac{\sum_a [(N_{by,a})(R'''_{by3,a})]}{\sum_a (N_{by,a})} \quad (\text{Formula 6.3})$$

where

R'''_{by3} = age/sex-adjusted weighted, capped, annualized reference expenditure in PY

\sum_a means sum over all age/sex categories a

$N_{by,a}$ = Number of ACO-aligned beneficiary person years in age/sex category (a) for the baseline period

$R'''_{by3,a}$ = the average weighted, capped, annualized expenditure of the reference population in age/sex category (a) for performance period 1

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7.0 Population-based payments

If an ACO generates a minimum average annual savings (defined below) over periods 1 and 2, the ACO's payment will transition to population-based payment in period 3. Population-based payment is a per-beneficiary per month payment amount intended to replace a significant portion of the ACO's FFS payment with a prospective payment. If the ACO does not generate the minimum average amount of savings over periods 1 and 2, the ACO will not transition to population-based payment in period 3. Instead, the period 3 arrangement will revert to the period 1 arrangement and the ACO's Agreement will conclude at the end of three years.

The minimum average annual savings amount will be no greater than 5% (for ACOs in states with the lowest historical Medicare expenditure levels) and no less than 1% (for ACOs in states with the highest historical Medicare expenditure levels), and will vary inversely with the relative Medicare expenditure level in the state where the ACO is located. For ACOs located in more than one state, CMS will set the minimum average annual savings amount based on the state where the plurality of the ACO's aligned beneficiaries reside.

CMS will make a provisional determination of whether an ACO qualifies for population-based payment at the end of the second performance period. Payment for the third performance period will begin based on this provisional assessment, and will then be adjusted, if necessary, based on CMS' final assessment after three months of claims run-out.

The ACO's providers and suppliers will receive fee-for-service payments at 50% of fee-for-service payment rates on submitted claims for services delivered to aligned beneficiaries. CMS will provide a monthly population-based payment that will equal the remainder of the ACO's projected FFS revenue for its aligned Medicare patients as a per-beneficiary-per-month payment (PBPM). "Projected FFS revenue" is defined as the ACO's benchmark expenditures for the performance year, the calculation of which is described in Section 5. Upon end-of-period reconciliation, the ACO will still receive up to 70% shared savings and losses, subject to quality performance adjustments. End-of-period reconciliation is described in Section 3.

The ACO will have the option for period 4 of the same payment arrangements as Period 3, except that the ACO's expenditure baseline will be reset to reflect average Medicare spending for its aligned beneficiaries in years 2011, 2012, and 2013. For Period 5, the ACO will have the option of continuing the Period 4 payment arrangements, without additional resetting of the expenditure baseline. Finally, if the ACO chooses "Option B" as defined in the CMS Pioneer ACO RFA, the ACO will receive population-based payments in period 3 (and, optionally, in periods 4 and 5) and end-of-period reconciliation with a 75% sharing rate for shared savings and shared losses, with a maximum savings/loss of 15% of the benchmark.

8.0 Tables

Table 8-1
Evaluation and management service codes included in beneficiary alignment criteria

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

Initial Nursing Facility Care

- 99304 New or Established Patient, brief
- 99305 New or Established Patient, moderate
- 99306 New or Established Patient, comprehensive

Subsequent Nursing Facility Care

- 99307 New or Established Patient, brief
- 99308 New or Established Patient, limited
- 99309 New or Established Patient, comprehensive
- 99310 New or Established Patient, extensive

Nursing Facility Discharge Services

- 99315 New or Established Patient, brief
- 99316 New or Established Patient, comprehensive

Other Nursing Facility Services

- 99318 New or Established Patient

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

Wellness Visits

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

SOURCE: List of E&M Codes from the Medicare Shared Savings Program [MSSP]. The Pioneer RFA states that for eligibility requirements, the intent is to have the Pioneer Model be consistent with the proposed regulations of the MSSP.

Table 8-2
Specialty codes for primary care physicians

Code	Specialty
1	general practice
8	family practice
11	internal medicine
38	geriatric medicine
50	nurse practitioner
97	physician assistant

SOURCE: MSSP proposed regulations. The Pioneer RFA states that the primary care providers will consist of the primary care providers used in the MSSP program, as well as the addition of nurse practitioners and physician assistants.

Table 8-3
Specialty codes for specialist physicians

39 (nephrology)

Oncology:

83 (hematology/oncology)

90 (medical oncology)

91 (surgical oncology)

92 (radiation oncology)

98 (gynecological/oncology)

66 (rheumatology)

46 (endocrinology)

29 (pulmonology)

13 (neurology)

86 (neuropsychiatry)

6 (cardiology)

SOURCE: Pioneer RFA list of eligible specialties plus personal communication from Hoangmai Pham of CMS.

Table 8-4.
Variables used in total beneficiary expenditure calculations

	Payment is Equal to	Claim Denied if	Line Item Denied if	Through Date
SNF	Claim Payment Amount	Any value for 'Claim Medicare Non-Payment reason code '	No exclusion	Claim Through Date
Inpatient ¹	Claim Payment Amount	Any value for 'Claim Medicare Non-Payment reason code '	No exclusion	Claim Through Date
Outpatient	Claim Payment Amount	Any value for 'Claim Medicare Non-Payment reason code '	No exclusion	Claim Through Date
Home Health	Claim Payment Amount	Any value for 'Claim Medicare Non-Payment reason code '	No exclusion	Claim Through Date
Physician/Supplier Part B	Line NCH Payment Amount	'Carrier Claim Payment Denial Code' = 0 or D through Y	Line Processing Indicator Code ≠ A, R, or S	Line Through Date
DME	Line NCH Payment Amount	'Carrier Claim Payment Denial Code' = 0 or D through Y	Line Processing Indicator Code ≠ A, R, or S	Line Through Date
Hospice	Claim Payment Amount	Any value for 'Claim Medicare Non-Payment reason code '	No exclusion	Claim Through Date

¹Inpatient expenditures will not include pass-through amounts.

**Table 8-5.
Schedule for Pioneer ACO beneficiary alignment and baseline expenses
(performance years 1 through 3)**

Date	Applies to PY	Event
September 30, 2011	PY1	Preliminary identification of aligned population for PY1 for purposes of (a) determining eligibility of ACO to participate in the Pioneer program and (b) generating a de-identified dataset for use by ACO in planning for PY1. This preliminary identification would be based on data for claims that were (a) incurred during the 3-year alignment period ending the June 30, 2011, and (b) paid through June 30, 2011 (i.e., no run-out of claims experience).
December 1, 2011	PY1	Identification of prospectively aligned population for PY1 based on data for claims that were (a) incurred during the 3-year alignment period ending the June 30, 2011, and (b) paid through September 30, 2011 (i.e., with a 3-month run-out of claims experience). This is the "official" list of prospectively aligned beneficiaries for PY1. It will differ from the preliminary list (provided only for PY1) as a result of the claims run-out.
May 1, 2012	PY1	Calculation of prospective PY1 baselines for the ACO's prospectively aligned PY1 population and for the PY1 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012.
December 1, 2012	PY2	Identification of prospectively aligned population for PY2 based on data for claims that were (a) incurred during the 3-year alignment period ending the June 30, 2012, and (b) paid through September 30, 2012.
May 1, 2013	PY2	Calculation of PY2 prospective baselines for the ACO's prospectively aligned PY2 population and for the PY2 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012.
May 1, 2013	PY1	Identification of final PY1 aligned population (i.e., identification of PY1 prospectively aligned beneficiaries who were not alignment-eligible during PY1). Identification of final PY1 reference population (i.e., identification of PY1 prospectively identified alignment-eligible beneficiaries who were not alignment-eligible during PY1).
June 1, 2013	PY1	Calculation of PY1 final baselines for the ACO's final aligned PY1 population and for the PY1 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012. Calculation of PY1 performance year expenditures for the ACO's final aligned PY1 population and for the PY1 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012.

Date	Applies to PY	Event
December 1, 2013	PY3	Identification of prospectively aligned population for PY3 based on data for claims that were (a) incurred during the 3-year alignment period ending the June 30, 2013, and (b) paid through September 30, 2013.
May 1, 2014	PY2	Identification of final PY2 aligned population (i.e., identification of PY2 prospectively aligned beneficiaries who were not alignment-eligible during PY2). Identification of final PY2 reference population (i.e., identification of PY2 prospectively identified alignment-eligible beneficiaries who were not alignment-eligible during PY2).
June 1, 2014	PY2	Calculation of PY2 final baselines for the ACO's final aligned PY2 population and for the PY2 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012. Calculation of PY1 performance year expenditures for the ACO's final aligned PY2 population and for the PY2 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012.
May 1, 2015	PY3	Identification of final PY3 aligned population (i.e., identification of PY3 prospectively aligned beneficiaries who were not alignment-eligible during PY3). Identification of final PY3 reference population (i.e., identification of PY3 prospectively identified alignment-eligible beneficiaries who were not alignment-eligible during PY3).
June 1, 2015	PY3	Calculation of PY3 final baselines for the ACO's final aligned PY3 population and for the PY3 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012. Calculation of PY3 performance year expenditures for the ACO's final aligned PY3 population and for the PY3 reference population based on data for claims that were (a) incurred during the 3-year baseline period ending December 31, 2011, and (b) paid through March 31, 2012.

Table 8.6
Age and Sex Categories by Entitlement Category

Originally Aged beneficiaries without current ESRD

- Age 65 to 69
- Age 65 to 69
- Age 70 to 74
- Age 75 to 79
- Age 80 to 84
- Age 85 to 89
- Age 90 to 94
- Age 95 and older

Originally Disabled beneficiaries without current ESRD

- Age 0 to 34
- Age 35 to 44
- Age 45 to 54
- Age 55 to 59
- Age 60 to 64
- Age 65 to 69
- Age 70 to 74
- Age 75 to 79
- Age 80 to 84
- Age 85 and older

Current ESRD

- Age 0 to 34
- Age 35 to 44
- Age 45 to 54
- Age 55 to 59
- Age 60 to 64
- Age 65 to 69
- Age 70 and older