Next Generation ACO Model Participation Agreement

Amendment to Appendix F, Appendix J, and to add Section XI.A.5 and Appendix R

Performance Year 2019 Amendment No. 2

CMS hereby amends the Amended and Restated Next Generation ACO Model Participation Agreement between the Centers for Medicare & Medicaid Services ("CMS") and ThedaCare, Inc. ("ACO") (the "Agreement"), to: change the quality measures used in establishing quality performance standards for Performance Year 2020; to carve out services covered under section 1899(l) of the Social Security Act (the "Act") from the scope of services covered under the Telehealth Expansion Benefit Enhancement for Performance Year 2020; to set forth the terms and conditions under which Next Generation Participants may receive payment for telehealth services furnished to Next Generation Beneficiaries pursuant to section 1899(l) of the Act; to provide for a waiver of the originating site requirements to allow for Medicare payment for otherwise covered telehealth services furnished to Beneficiaries by Next Generation Participants during a grace period; and to incorporate Beneficiary safeguards to ensure that Beneficiaries are not charged for certain non-covered telehealth services furnished by a Next Generation Participant.

Section XXI.D of the Agreement authorizes CMS to amend the Agreement without the consent of the ACO for good cause or as necessary to comply with applicable federal or state law. Section 50324 of the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123), codified as Section 1899(l) of the Act, provides for Medicare payment for certain telehealth services furnished to aligned beneficiaries by a physician or other practitioner participating in an applicable ACO, to include an ACO participating in the Next Generation ACO Model, without regard for the geographic requirements under Section 1834(m)(4)(C)(i) of the Act, effective January 1, 2020. To avoid causing undue hardship for Beneficiaries, CMS has also found good cause to include certain new Beneficiary protections as part of the implementation of this provision for purposes of the Next Generation ACO Model.

Section VIII.B of the Agreement authorizes CMS to amend Appendix F of the Agreement (Quality Measures) without the consent of the ACO prior to the beginning of a Performance Year to change the quality measures to be used for the Performance Year. CMS wishes to amend the quality measures used in establishing quality performance standards for Performance Year 2020.

The Agreement is therefore amended as follows:

1. **Quality Measures.** Appendix F of the Agreement is hereby stricken and replaced in full with the Appendix F included as Attachment A to this amendment.

2. **Telehealth Expansion Benefit Enhancement.**

(a) Section XI.A of the Agreement is hereby amended by adding at the end the following new paragraph:

5. *Regardless of whether the ACO selects to provide the Telehealth Expansion Benefit Enhancement under Section X for Performance Year 2020, payment to Next Generation Participants for telehealth services furnished to Beneficiaries pursuant to Section 1899(l) of the Act is governed by the terms and conditions of Appendix R of this Agreement.*

(b) Appendix J of the Agreement is hereby stricken and replaced in full with the Appendix J included as Attachment B to this amendment.

3. **Payment for Telehealth Services under Section 1899(l).** The Agreement is amended to add after Appendix Q a new Appendix R included as Attachment C to this amendment.

4. **Effective Date.** This amendment shall be effective on January 1, 2020.

5. **Effect of Amendment.** All other terms and conditions of the Agreement shall remain in full force and effect. In the event of any inconsistency between the provisions of this amendment and the provisions of the Agreement, the provisions of this amendment shall prevail.

[SIGNATURE PAGE FOLLOWS]

CENTERS FOR MEDICARE & MEDICAID SERVICES

By: Amy Bassano

Name: Amy Bassano

Title: Acting Director
Center for Medicare & Medicaid Innovation

Date: 12/10/19

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Appendix F

Quality Measures

This version of Appendix F represents Appendix F in its entirety for Performance Year 2020. The quality measures used in establishing quality performance standards for Performance Year 2019 and each preceding Performance Year are governed by the terms of the version of Appendix F included in the version of this Agreement in effect on January 1, 2019.

The following quality measures are the measures for use in establishing quality performance standards in the fifth Performance Year of the Model (CY2020).

The column "2018 Starters" indicates whether each measure is pay-for-reporting ("R") or pay-for-performance ("P") for ACOs for which the start date in the Model is January 1, 2018; the column "2017 Starters" indicates whether each measure is pay-for-reporting ("R") or pay-for-performance ("P") for ACOs for which the start date in the Model is January 1, 2017; the column "2016 Starters" indicates whether each measure is pay-for-reporting ("R") or pay-for-performance ("P") for ACOs for which the start date in the Model is January 1, 2016.

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting; P—Performance		
				2018 Starters (ACO PY3)	2017 Starters (ACO PY4)	2016 Starters (ACO PY5)
AIM: Better Care for Individuals						
Patient / Caregiver Experience	ACO – 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	P	P	P
	ACO – 2	CAHPS: How Well Your Providers Communicate	Survey	P	P	P
	ACO – 3	CAHPS: Patients' Rating of Provider	Survey	P	P	P
	ACO – 4	CAHPS: Access to Specialists	Survey	P	P	P
	ACO – 5	CAHPS: Health Promotion and Education	Survey	P	P	P
	ACO – 6	CAHPS: Shared Decision Making	Survey	P	P	P
	ACO – 7	CAHPS: Health Status/Functional Status	Survey	R	R	R
	ACO - 34	CAHPS: Stewardship of Patient Resources	Survey	P	P	P
	ACO - 45	CAHPS: Courteous and Helpful Office Staff*	Survey	R	R	R
	ACO - 46	CAHPS: Care Coordination	Survey	R	R	R
Care Coordination / Patient Safety	ACO - 8	Risk-Standardized, All Condition Readmission	Claims	P	P	P
	ACO - 38	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Claims	P	P	P

Domain	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting; P—Performance		
				2018 Starters (ACO PY3)	2017 Starters (ACO PY4)	2016 Starters (ACO PY5)
	ACO - 43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator [PQI] #91) (version with additional Risk Adjustment)[1]	Claims	R	R	R
	ACO -13	Falls: Screening for Future Falls Risk	CMS Web Interface	P	P	P
AIM: Better Care for Populations						
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	P	P	P
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	P	P	P
	ACO - 18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	CMS Web Interface	P	P	P
	ACO - 19	Colorectal Cancer Screening	CMS Web Interface	P	P	P
	ACO - 20	Breast Cancer Screening	CMS Web Interface	P	P	P
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Depression	ACO - 40	Depression Remission at Twelve Months	CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Mellitus: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface	P	P	P
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension: Controlling High Blood Pressure	CMS Web Interface	P	P	P

NOTE: Measures are from the 2020 Physician Fee Schedule final rule

[1] Measure reverted to pay-for-reporting for two years (2020 and 2021) in the 2020 Physician Fee Schedule Final Rule to account for a substantive change to the measure

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Appendix J

Telehealth Expansion Benefit Enhancement

Appendix R of the Agreement governs payment pursuant to Section 1899(l) of the Act for telehealth services furnished by a physician or other practitioner who is a Next Generation Participant on or after January 1, 2020. If the ACO has elected the Telehealth Expansion Benefit Enhancement in accordance with Section I of this Appendix J, this Telehealth Expansion Benefit Enhancement further increases the availability to Beneficiaries of otherwise covered telehealth services furnished via interactive telecommunications systems while also providing flexibility for Beneficiaries to receive certain teledermatology and teleopthalmology services furnished using asynchronous store and forward technologies.

This version of Appendix J represents Appendix J in its entirety for Performance Year 2020. The Telehealth Expansion Benefit Enhancement for Performance Year 2019 and each preceding Performance Year is governed by the terms of the version of Appendix J included in the version of this Agreement in effect on January 1, 2019.

I. Election of the Telehealth Expansion Benefit Enhancement

If the ACO wishes to offer the Telehealth Expansion Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its election of the Telehealth Expansion Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement for the Telehealth Expansion Benefit Enhancement; and

B. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Next Generation Participants that have agreed to participate in the Telehealth Expansion Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Telehealth Expansion Benefit Enhancement.

II. Waiver

A. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to otherwise covered telehealth services furnished by an Eligible Telehealth Provider (as that term is defined in Section III.A of this Appendix) in accordance with the terms and conditions set forth in this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 CFR § 410.78(b)(3)–(4) with respect to telehealth services furnished in accordance with this Appendix.

2. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that

telehealth services be "furnished at an originating site" when the services are furnished in accordance with this Appendix.

3. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 CFR § 414.65(b) with respect to telehealth services furnished to a Beneficiary at his/her home or place of residence when furnished in accordance with this Appendix.

B. Waiver of Interactive Telecommunications System Requirement: CMS waives the following requirements with respect to otherwise covered teledermatology and teleophthalmology services furnished by an Eligible Asynchronous Telehealth Provider (as that term is defined in Section III.B of this Appendix), using asynchronous store and forward technologies, in accordance with the terms and conditions set forth in this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirement in Section 1834(m)(4)(C)(i) of the Act regarding the location of the originating site and the requirements of 42 CFR § 410.78(b)(4) with respect to covered teledermatology and teleophthalmology furnished using asynchronous store and forward technologies in accordance with this Appendix.

2. Waiver of Interactive Telecommunications System Requirement: CMS waives the requirement under Section 1834(m)(1) of the Act and 42 CFR § 410.78(b) that telehealth services be furnished via an "interactive telecommunication system," as that term is defined under 42 CFR § 410.78(a)(3), when such services are furnished in accordance with this Appendix.

C. The waivers described in Section II.A and II.B of this Appendix are collectively referred to as the "**Telehealth Expansion Benefit Enhancement**".

III. Eligible Telehealth Providers and Eligible Asynchronous Telehealth Providers

A. For purposes of this Telehealth Expansion Benefit Enhancement, an "**Eligible Telehealth Provider**" is a Preferred Provider who meets the requirements under Section XI.C.2 of the Agreement.

B. For the purposes of this Telehealth Expansion Benefit Enhancement, an "**Eligible Asynchronous Telehealth Provider**" is a Next Generation Participant or Preferred Provider who meets the requirements under Section XI.C.4 of the Agreement.

C. CMS review and approval of a Next Generation Participant or a Preferred Provider to provide services in accordance with the Telehealth Expansion Benefit Enhancement under Section II of this Appendix includes consideration of the program integrity history of the Next Generation Participant or Preferred Provider and any other factors that CMS determines may affect the qualifications of the Next Generation Participant or Preferred Provider to provide telehealth services under the terms of the Telehealth Expansion Benefit Enhancement.

IV. Eligibility Requirements

A. In order for telehealth services to be eligible for reimbursement under the terms of the waivers under Section II.A of this Appendix, the Beneficiary must be:
   1. A Next Generation Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
   2. Located at an originating site that is either:
      a. One of the sites listed in section 1834(m)(4)(C)(ii) of the Act; or
      b. The Beneficiary's home or place of residence.

B. In order for telehealth services to be eligible for reimbursement under the terms of the waiver under Section II.B of this Appendix, the Beneficiary must be:
   1. A Next Generation Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
   2. Located at an originating site that is one of the sites listed in Section 1834(m)(4)(C)(ii) of the Act.

C. Claims for telehealth services furnished under the terms of the waiver under Section II.A of this Appendix for which the originating site is a Beneficiary's home or place of residence will be denied unless submitted using one of the HCPCS codes G9481-G9489.

D. Claims for asynchronous teledermatology and teleophthalmology services furnished under the terms of the waiver under Section II.B of this Appendix will be denied unless submitted using one of the HCPCS codes G9868-G9870.

E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider shall not submit a claim for such telehealth services.

F. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining requirements of Section 1834(m) of the Act and 42 CFR §§ 410.78 and 414.65.

G. An Eligible Telehealth Provider or an Eligible Asynchronous Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knows or should know in person services are medically necessary.

V. Grace Period for Excluded Beneficiaries

In the case of an Originally Aligned Beneficiary who is excluded from alignment to the ACO during the Performance Year, CMS shall make payment for telehealth services furnished to such Beneficiary under the terms of the Telehealth Expansion Benefit Enhancement as if the Beneficiary were still a Next Generation Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

VI. Responsibility for Denied Claims

A. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider under the Telehealth Expansion Benefit Enhancement is denied as a result of a CMS error and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred.

B. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider is denied for any reason other than a CMS error and CMS determines that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

   1. CMS shall, notwithstanding such denial, pay for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

   2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

   3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

   1. CMS shall not make payment to the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider for such services;

   2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

   3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If a Next Generation Participant or Preferred Provider that is not an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider submits claims for telehealth

services for which CMS only would have made payment if the Next Generation Participant or Preferred Provider was an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider participating in this Telehealth Expansion Benefit Enhancement at the time of service:

1. CMS shall not make payment to the Next Generation Participant or Preferred Provider for such services;
2. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Next Generation Participant or Preferred Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Compliance and Enforcement

A. CMS may reject the ACO's designation of a Preferred Provider as an Eligible Telehealth Provider or of a Next Generation Participant or Preferred Provider as an Eligible Asynchronous Telehealth Provider at any time if the Next Generation Participant or Preferred Provider's participation in this Telehealth Expansion Benefit Enhancement might compromise the integrity of the Model.

B. The ACO must have appropriate procedures in place to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. [RESERVED]

D. CMS will monitor the ACO's use of the Telehealth Expansion Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.

E. In accordance with Section XIX of this Agreement, CMS may terminate or suspend one or more of the waivers under Section II of this Appendix or take other remedial action if the ACO or any of its Next Generation Participants or Preferred Providers fails to comply with the terms and conditions of the Telehealth Expansion Benefit Enhancement.

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Appendix R

Payment for Telehealth Services under Section 1899(l)

Section 50324 of the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123) (codified at Section 1899(l) of the Act) provides for Medicare payment for certain telehealth services furnished by a physician or other practitioner participating in an applicable ACO to Beneficiaries who are prospectively aligned to that ACO without regard for the geographic requirements under Section 1834(m)(4)(C)(i) of the Act, effective January 1, 2020. This Appendix sets forth the terms and conditions under which Next Generation Participants may receive payment for telehealth services furnished to Next Generation Beneficiaries pursuant to Section 1899(l) of the Act, provides for a waiver of the originating site requirements to allow for Medicare payment for otherwise covered telehealth services furnished to Beneficiaries by Next Generation Participants during a grace period, and incorporates Beneficiary safeguards to ensure Beneficiaries are not charged for certain non-covered telehealth services furnished by a Next Generation Participant.

I. General

Payment is available for otherwise covered telehealth services furnished on or after January 1, 2020, without regard for the geographic requirements of Section 1834(m)(4)(C)(i) of the Act in accordance with the following requirements:

A. The telehealth service must furnished by a physician or other practitioner who is a Next Generation Participant.

B. The Beneficiary must be:

   1. A Next Generation Beneficiary at the time the telehealth services are furnished or within a grace period under Section II of this Appendix; and

   2. Located at an originating site that is either:

      a. One of the sites listed in Section 1834(m)(4)(C)(ii) of the Act; or

      b. The place of residence used as the home of the beneficiary (the "Beneficiary's home").

C. Claims for telehealth services for which the originating site is the Beneficiary's home will be denied if such services are inappropriate to furnish in the home setting, such as services that are typically furnished in inpatient settings.

D. CMS does not pay a facility fee under Section 1834(m)(2)(B) when the originating site is the Beneficiary's home.

E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to furnish such telehealth services, the Next Generation Participant shall not submit a claim for such telehealth services.

F. The telehealth services must be furnished in accordance with all applicable state and Federal laws and all other Medicare coverage and payment criteria, including the

applicable requirements of Section 1834(m) of the Act and 42 CFR §§ 410.78 and 414.65.

G. A Next Generation Participant shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Next Generation Participant knows or should know that in person services are medically necessary.

II. Grace Period for Excluded Beneficiaries

A. In the case of an Originally Aligned Beneficiary who is excluded from alignment to the ACO during the Performance Year, CMS shall make payment for telehealth services furnished to such Beneficiary as if the Beneficiary were still a Next Generation Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section I of this Appendix are met.

B. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to telehealth services furnished in accordance with Section I of this Appendix solely as necessary to allow for Medicare payment for such telehealth services furnished during the grace period under Section II.A of this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 CFR § 410.78(b)(3)–(4).

2. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be "furnished at an originating site."

3. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 CFR § 414.65(b) with respect to telehealth services furnished in the Beneficiary's home.

III. Responsibility for Denied Claims

In the event CMS makes no payment for a telehealth service furnished by a physician or practitioner who is a Next Generation Participant, and the only reason the claim was non-covered is that the Beneficiary is not a Next Generation Beneficiary or in the 90-day grace period under Section II of this Appendix at the time the telehealth service was furnished, the following beneficiary protections apply:

A. The ACO shall ensure that the Next Generation Participant that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

B. The ACO shall ensure that the Next Generation Participant that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.