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National Provider Call

Medicare Shared Savings Program Accountable Care Organization:

Application Process, National Provider Call

April 8, 2014

Presented by: Centers for Medicare & Medicaid Services
Laura Dash, Director, Division of Application, Compliance & Outreach
Terri Postma, MD

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Introduction

Laura Dash
Director, Division of Application, Compliance & Outreach
Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services

Agenda

This presentation will cover:

- Introduction
- What is an Accountable Care Organization?
- Organizational Structure and Governance
- Antitrust and ACOs
- Application Process for January 2015

Purpose of Today's Call

- 2015 Medicare Shared Savings Program application will be posted on the Shared Savings Program Application Web page.

- Prior to submitting an application, you should:
  - Establish your organizational structure
  - Establish your governance and leadership structure
  - Ensure all agreements meet requirements, are finalized and signed
  - Prepare:
    - Sample of agreement
    - Template listing all participants
    - Signed signature pages for all ACO participants
  - Establish repayment mechanism, **only if** you are Track 2

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What is an Accountable Care Organization?

Terri Postma, MD
Medical Officer
Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services

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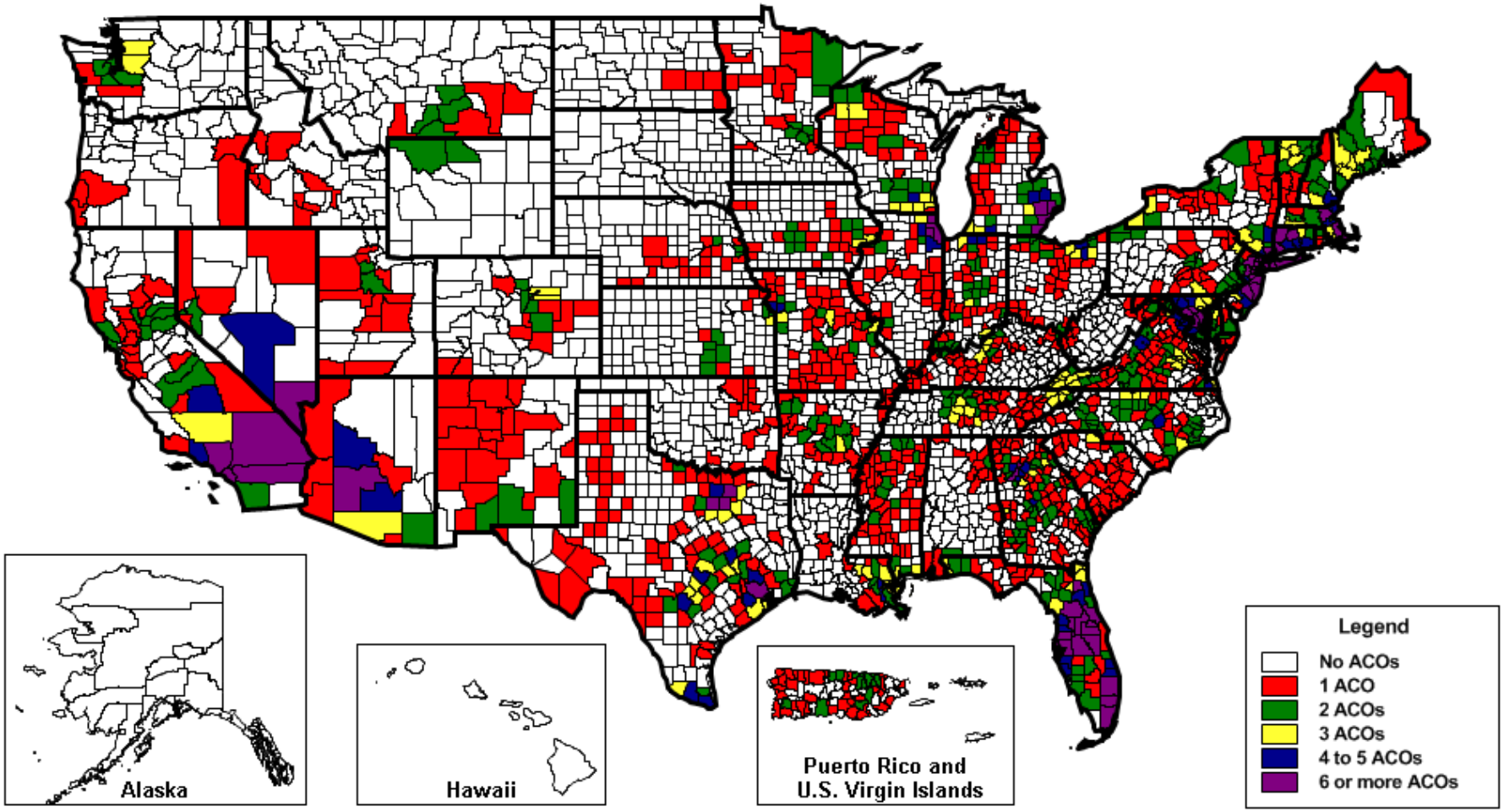
Shared Savings Program: Background

- Shared Savings Program Web site
- Mandated by Section 3022 of the Affordable Care Act
- Established a Shared Savings Program (SSP) using Accountable Care Organizations (ACOs)
- Medicare Shared Savings Program must be established by January 1, 2012
- Notice of proposed rulemaking issued March 31, 2011
- CMS sought and received over 1,300 comments on the proposal
- Issued Final Rule November 2011

Geographic Distribution of MSSP ACO Assigned Patient Population (Includes 2012 – 2014 starters)

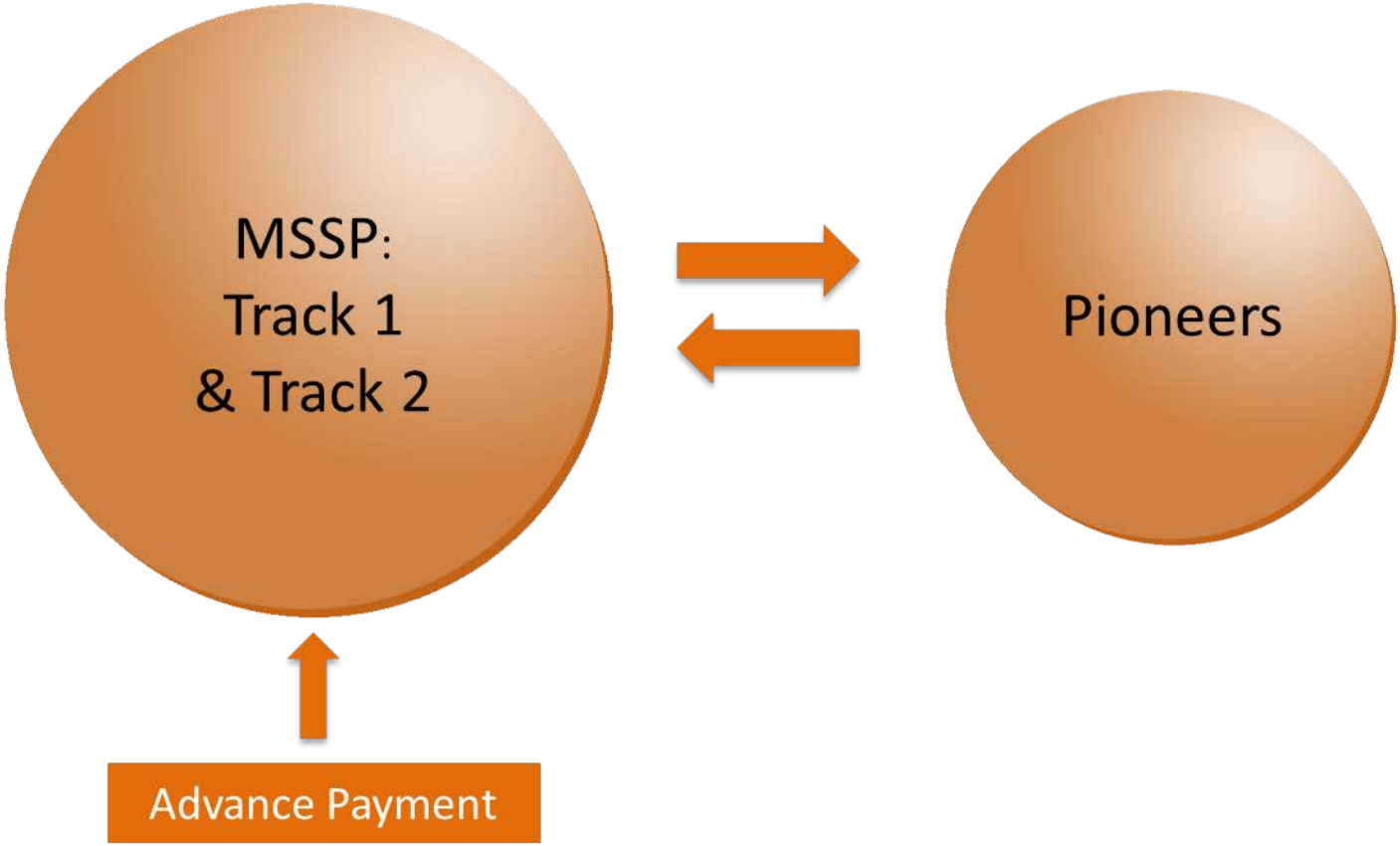


Shared Savings Program: Vision

ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health, and lower growth in expenditures by:

- Putting the beneficiary and family at the center
- Remembering patients over time and place
- Attending carefully to care transitions
- Managing resources carefully and respectfully
- Managing the beneficiary's care proactively
- Evaluating data to improve care and patient outcomes
- Using innovations focused on the three-part aim
- Investing in care teams and their workforce

CMS's ACO Strategy: Creating Multiple Pathways with Constant Learning and Improving



Shared Savings Program: Definitions

Accountable Care Organization (ACO):
ACO means a legal entity that is recognized and authorized under applicable State or tribal law, as identified by a Taxpayer Identification Number (TIN), and comprised of eligible groups of eligible providers and suppliers (as defined at § 425.102) that work together to manage and coordinate care for Medicare FFS beneficiaries.

ACO Participants:
Individuals or groups of Medicare-enrolled providers (as defined in § 400.202) or suppliers (as defined at § 400.202), as identified by a TIN.

ACO Provider/Supplier:
A provider or supplier that bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations.

Shared Savings Program: ACO Professionals

- **ACO Professional**:
  - Doctor of Medicine (MD)
  - Doctor of Osteopathic Medicine (DO)
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialists (CNS)
- **Primary Care Physician**:
  - General practice
  - Internal medicine
  - Family practice
  - Geriatric medicine
- **Primary Care Services**:
  - Certain Evaluation and Management (E&M) Healthcare Common Procedure Coding System (HCPCS) codes
  - Revenue center codes
  - G codes

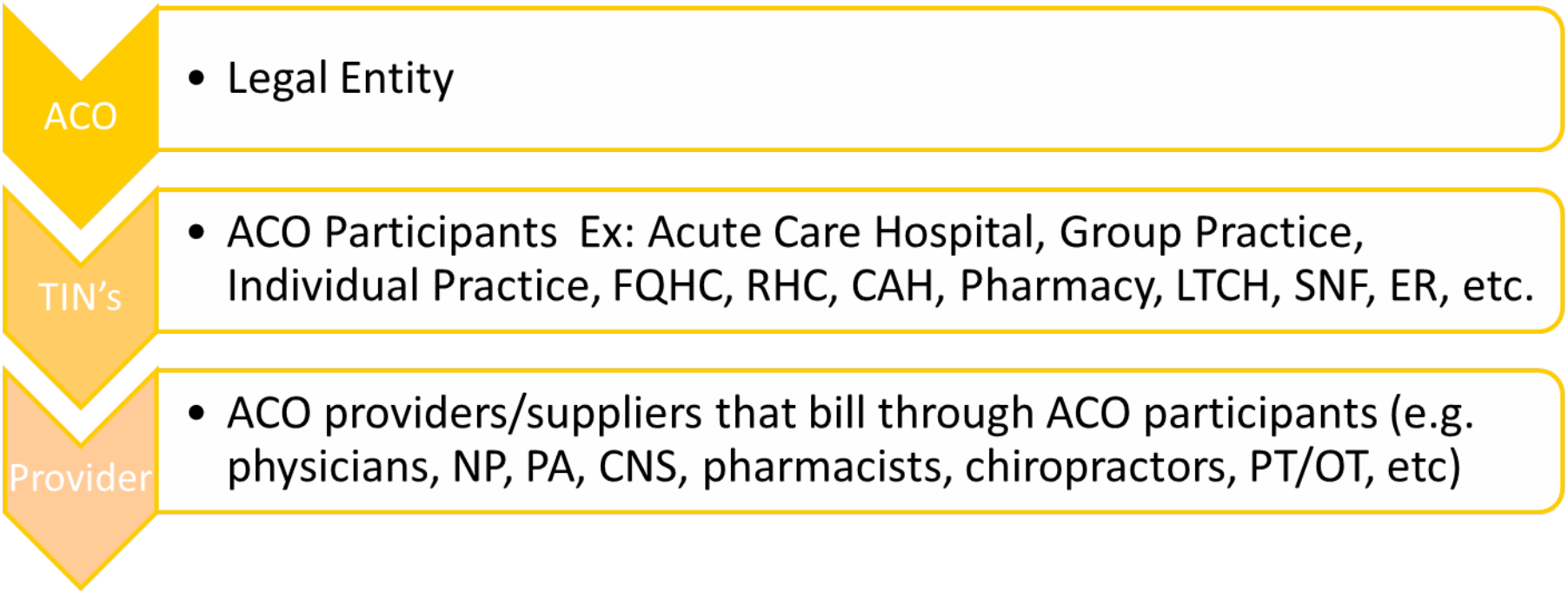
Shared Savings Program: Statutory Requirements

By statute, ACOs must meet the following eligibility criteria:

- Agree to participate in the program for at least a 3-year period
- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
- Have a formal legal structure to receive and distribute payments
- Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
- Shall provide information regarding the ACO professionals as the Secretary determines necessary
- Define processes to:
  - promote evidenced-based medicine
  - promote patient engagement
  - report quality and cost measures
  - coordinate care
- Demonstrate it meets patient-centeredness criteria

Shared Savings Program: ACO Structure

Most Common ACO Structure



Statutory Requirements: Assignment

- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries

- Assignment is based on primary care services rendered by primary care physicians.
  - This means some of the ACO participants must bill for primary care services (e.g. hospitals employing ACO professionals, group practices of ACO professionals, etc).

Statutory Requirements: Governance & Leadership

- Shared governance through a governing body with representation by ACO participants and beneficiaries
  - ACO participant representation
  - ACO participants hold at least 75% control of the governing body
  - Beneficiary on the governing body
  - Flexibility for organizations to meet requirements

- Demonstrate an organizational commitment, leadership, and resources necessary to achieve the three-part aim and demonstrate clinical integration
  - Experienced leadership team
  - Medical Director
  - Qualified health professional to lead the quality assurance/improvement process

Patient Population

- ACO accepts responsibility for an “assigned” patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Assignment will not affect beneficiaries’ guaranteed benefits or choice of doctor or any other provider
- Finalized a preliminary prospective assignment with a retrospective reconciliation

Patient Population (cont.)

- Identify all beneficiaries who have had at least one primary care service rendered by a physician in the ACO

- Followed by a two step assignment process:

  - First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
  - Second, for beneficiaries that remain unassigned, identify beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any ACO professional

Other Program Requirements

- ACO participants cannot concurrently participate in other Medicare Shared Savings initiatives
- Data sharing
- Beneficiary communication
- Quality
- Benchmarking

Participation in Other Shared Savings Initiatives

- ACO participants cannot participate in multiple Medicare initiatives involving shared savings, including:
  - Independence at Home Medical Practice Demonstration (ACA Sec. 3024)
  - Medicare Healthcare Quality Demonstration (MMA Sec. 646)*
  - Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)*
  - Physician Group Practice Transition Demonstration
  - Pioneer ACO Model demonstration
  - Other ongoing demonstrations involving shared savings
- Additional programs, demonstrations, or models with a shared savings component may be introduced in the Medicare program in the future

*only contracts with shared savings arrangements

Data Sharing

- Aggregate data reports provided at the start of the agreement period, quarterly aggregate data reports thereafter and in conjunction with year end performance reports

- Aggregate data reports will contain a list of the beneficiaries used to generate the report

- Beneficiary identifiable claims data provided for patients seen by ACO primary care providers who have been notified and **not declined to have data shared**

Beneficiary Communication

- Beneficiaries will be notified that their provider is participating in the program (ACO) via letter from the provider, or during an office visit
- Beneficiaries will receive general notification about the program and what it means for their care
- CMS will provide parameters around marketing materials in order to prevent beneficiary steering, inappropriate advertising and to ensure information about ACOs is consistent and accurate
- ACOs must give beneficiaries an opportunity to decline data sharing

Quality Measure & Performance

- ACO Quality Performance Standard is made up of 33 measures intended to do the following:

  - Improve individual health and the health of populations
  - Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination
  - Support the Shared Savings Program goals of better care, better health, and lower cost
  - Align with other incentive programs like the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs

Incorporating Other Quality Reporting Requirements

- Meeting the program's requirements for reporting quality data through the ACO GPRO has consequences for:
  - PQRS
  - EHR Incentive Program
- Value-Based Payment Modifier
  - CMS will not apply the value-based payment modifier to ACOs and ACO participant TINs.

Quality Data Reporting

- Quality data is collected in three ways:
  - Claims/Administrative data
  - ACO Group Practice Reporting Option (GPRO) tool
  - Clinician & Group Consumer Assessment of Health Providers and Systems (CAHPS) Survey (patient/caregiver experience survey)

- Complete and accurate reporting in the first year qualifies the ACO to share in the maximum available quality sharing rate

- Pay for performance is phased in for the remaining performance years

- Shared savings payments linked to quality performance are based on a sliding scale that rewards attainment
  - High performing ACOs receive a higher sharing rate

ACO GPRO Reporting & PQRS

- ***ACO reporting matters!***
  - Eligible professionals billing through ACO participant TINs will avoid the PQRS payment adjustment only if the ACO satisfactorily reports GPRO quality measures under the Shared Savings Program.
  - ACO participant TINs, and their eligible professionals, may not report PQRS information independently (outside of the ACO).
- For more information, see "Medicare Shared Savings Program Interaction with the Physician Quality Reporting Program" http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PQRS-FAQs.pdf

Alignment with EHR Incentive Program

- To signal the importance of EHR use, the percent of PCPs that earn an EHR Incentive Payment measure (ACO #11) is double weighted for scoring purposes.
- EPs participating in the Shared Savings Program meet submission requirements and satisfy their Clinical Quality Measures (CQM) reporting for the EHR Incentive Program if the ACO satisfactorily reports via the ACO GPRO web interface ***and*** the EPs meet the other program requirements for Meaningful Use stage 2.
- For additional information about the EHR Incentive Program see http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html

Prepare for Quality Reporting

- Understand your reporting responsibilities:
  - Complete and accurate GPRO reporting is crucial. ACOs are responsible for searching elsewhere, including providers outside the ACO, if necessary to locate the information needed to completely report on each patient in the GPRO web interface.
  - Select a vendor to administer the CG CAHPS survey.
- Prepare for quality reporting ***now*** by:
  - Securing providers' buy-in to ACO quality reporting;
  - Educating your ACO participant TINs and ACO providers/ suppliers on the stake they have in helping the ACO succeed in quality reporting.

Financial Performance

- ACOs demonstrate savings if the actual assigned patient population expenditures are below the established benchmark **and** the performance year expenditures meet or exceed the minimum savings rate (MSR)
- The MSR takes into account normal variations in expenditures
- Under the one-sided model, the MSR varies based on the size of the ACO's population
- Under the two-sided model, the MSR is 2% of the benchmark

Interagency Coordination

Three notices were issued with the Shared Savings Program Final Rule:

- Federal Trade Commission (FTC) and Department of Justice (DOJ): Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program

- Internal Revenue Service (IRS): Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations

- Office of the Inspector General (OIG) and CMS: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center Interim Final with Comment

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Medicare Shared Savings Program Accountable Care Organization:

Antitrust and ACOs

Robert Canterman, Attorney
Federal Trade Commission
Antitrust Division
U.S. Department of Justice

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Key Antitrust Issues for ACOs

- Antitrust agencies recognize many ACOs are procompetitive and may benefit patients by improving quality of care and lowering costs.
- But, under certain conditions, ACOs may raise antitrust concerns, and participation in the MSSP does not confer antitrust immunity.
  - Price-fixing
    - Agreements among competing providers on price or other competitive terms not part of a legitimate provider joint venture.
    - Improper sharing of competitively sensitive information among competing ACO participants could facilitate collusion in providing services outside ACO.
  - Monopolization
    - Power profitably to raise prices above competitive level or reduce output, and exclusionary or other anticompetitive conduct to achieve or maintain power.
  - Mergers
    - Consolidations that may lessen competition in a relevant market.

FTC/DOJ Antitrust Enforcement Policy Statement

- Provides guidance to form procompetitive ACOs.
  - Applies to collaborations among independent providers.
  - Establishes rule-of-reason analysis for ACOs that use same governance, leadership, clinical and administrative processes for both MSSP and for commercial business.
  - Creates ACO Safety Zone.
  - Includes guidance for ACOs outside Safety Zone.
- Provides for 90-day, expedited voluntary review.
- Policy Statement and other guidance available at:
- http://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care/accountable-care-organizations
- http://www.justice.gov/atr/public/health_care/aco.html

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Medicare Shared Savings Program Accountable Care Organization:

Application Process for January 2015 Starters

Laura Dash
Director, Division of Application, Compliance and Outreach
Performance-Based Payment Policy Group
Center for Medicare & Medicaid Services

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Application Process

- Deadlines
- Application Toolkit
- Step 1 – Submit Your Notice of Intent (NOI) to Apply
- Step 2 – Obtain a CMS User ID
- Step 3 – Submit Your Application

Application Cycle: Deadlines to Apply for Program Year 2015

Notice of Intent to Apply Process	Deadlines
NOI Memo Posted on CMS Web site	April 1, 2014
NOI Form Posted on CMS Web site	May 1, 2014
NOI Accepted	May 1, 2014 – May 30, 2014
NOI Due	**May 30, 2014 at 8:00 pm Eastern Time**
CMS User ID Forms Accepted	May 6, 2014 – June 9, 2014

Application Process	Deadlines
Application Posted on CMS Web site	May 30, 2014
Applications Accepted	July 1, 2014 – July 31, 2014
Applications Due	**July 31, 2014 at 8:00 pm Eastern Time**
Application Approval or Denial Decision Sent to Applicants	Fall 2014
Reconsideration review deadline	15 Days from Notice of Denial

Application Toolkit

- The Toolkit provides directions and examples for each application question including:
  - Regulation reference page, guidance, and FAQs
  - Link to Form CMS 20037 Application for Access to CMS Computer Systems
  - Link to Form CMS-588 Electronic Funds Transfer
  - Templates:
    - ACO Participant List Template
    - Governing Body Template
    - ACO Participant Agreement Template
    - Executed Agreements Template

Step 1 – Notice of Intent to Apply

- The first step in the application process is to submit a Notice of Intent to Apply (NOI) to the Medicare Shared Savings Program

- The NOI memo will be posted on the Shared Savings Program Application Web site on April 1, 2014

- NOI Process:
  - Complete NOI and submit by **May 30, 2014 at 8:00pm Eastern Time**
  - You will get a confirmation notice e-mail containing your ACO ID and instructions on how to complete CMS Form 20037 Application for Access to CMS Computer Systems in order to obtain a CMS User ID.
  - Submitting an NOI **does not** require you to submit an application for 2015 program start date. However, without an ACO ID and CMS User ID you will not be able to access the appropriate modules in the Health Plan Management System (HPMS) to complete any of the required 2015 application.

Step 2 – Obtaining a New CMS User ID

- The second step in the application process is to obtain a CMS User ID.
  - You must have at least four (4) CMS Users.
  - Use the CMS guidance available in the Toolkit
  - Send the completed CMS User ID form by traceable mail (i.e. FedEx or UPS) to CMS:

    Centers for Medicare & Medicaid Services
    Attention: Adam Foltz
    Mail Stop: C4-18-13
    7500 Security Boulevard
    Baltimore, MD 21244
  - It takes 3-4 weeks to process the requests. **Submit the form(s) immediately upon receiving your NOI confirmation notice E-mail.**
  - CMS Form 20037 is due **June 9, 2014**.

Existing CMS User IDs

- CMS User IDs are unique to the individual, not the ACO.

- If a User already has a CMS ID, an ACO authorized contact must send an email to HPMS_Access@cms.hhs.gov that includes the following:

  - Clearly identify the User's name and existing CMS issued User ID.
  - Clearly identify the ACO Legal Business Name and CMS Issued ACO ID.
  - A statement that authorizes the user to gain access to the ACO's data maintained in CMS systems.
  - CMS issued ACO ID number for each ACO the user requests access.

Existing CMS User IDs for Consultants

If a Consultant already has a CMS ID, he or she must submit an email to HPMS_Access@cms.hhs.gov including:

- A pdf letter on ACO letterhead that authorizes the consultant to gain access to the ACO's data maintained in CMS systems.
- Clearly indicate the consultant's name, CMS issued User ID, and state that the he or she will be serving as a consultant on behalf of the ACO(s).
- ACO Legal Business Name and CMS Issued Identification Number(s) (ACO ID) the User is authorized to access.
- If multiple users from the same consulting firm are authorized to gain access, include all user names and User IDs.
- If the consultant is working with multiple ACOs, one letter is required from each ACO. These .pdf letters can be attached in one e-mail.
- Letter must be signed by the ACO's authorizing official.

Fraudulent Use of CMS User IDs

- It is considered fraud if you use another person's CMS User ID and password or, conversely, allow someone else to use your CMS User ID and password.

- This activity is strictly prohibited and may result in the termination of the individual's CMS User ID and password.

Step 3 – Submit Your Application

- The 2015 Application will be posted on the Application Web page on May 30, 2014.

- 2015 applications are accepted July 1 through July 30, 2014. The deadline is at 8:00pm Eastern Time.

- You may review the 2014 Application materials on the Application Web page for reference until the 2015 Application is posted.

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Banking Information

- Establish a valid **checking** account
- Use the ACO's legal business name and TIN
- You **will only** receive your electronic funds transfer (EFT) if this information is complete and accurate
- Submit CMS Form 588 to:

  Centers for Medicare &Medicaid Services
  ATTENTION: Jonnice McQuay, Location: C4-02-02
  7500 Security Blvd., Mail Stop: C5-15-12
  Baltimore, MD 21244-1850

- Applications are incomplete without CMS Form 588

Recap Important Application Steps

- ACT EARLY
- Educate your participants about the importance of reporting
- List at least 4 contacts for your ACO (Primary and Secondary Application Contacts and Primary and Secondary IT Contacts)
- Include ACO ID number and legal business name on all correspondence
- Never share CMS User IDs and passwords
- Contact CMS: SSPACO_Applications@cms.hhs.gov if you have any questions about the application process

Upcoming Application Calls

- **April 22: Shared Savings Program ACO Application Process: ACO Agreements, Participant List, and Assignment**
  - Topics
    - Beneficiary assignment
    - Participant List
    - Agreements between ACOs and providers
  - Registration information and complete call details

- **Save the date:**
  - June 10: 2015 Application Submission Review
  - July 8: Training on HPMS Application Module Submission
  - July 15: ACO Application Question & Answer Session

Contacts for Assistance

- Shared Savings Program Application Web site
- For NOI submission and application questions:
  SSPACO_Applications@cms.hhs.gov
- For help with Form CMS-20037 and CMS User ID (e.g. new access to HPMS, trouble finding the HPMS Web site):
  HPMS_Access@cms.hhs.gov or (800) 220-2028
- For password resets and if your account is locked:
  CMS_IT_Service_Desk@cms.hhs.gov or 1-800-562-1963
- For help using HPMS and technical assistance:
  HPMS@cms.hhs.gov or (800) 220-2028

Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects National Provider Call Program by providing your feedback about today's call.
- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call.
- Evaluations are anonymous, confidential, and voluntary.
- All registrants will receive a reminder email about the evaluation for this call. Please disregard the email if you have already completed the evaluation.
- We appreciate your feedback.

Thank You

- For more information about the MLN Connects National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html

- For more information about the Medicare Learning Network (MLN), please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html