

Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model

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Operator: At this time I would like to welcome everyone to the Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application National Provider Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call. I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

Introduction

Leah Nguyen: Hello. I am Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application National Provider Call.

On October 20, 2011, the Centers for Medicare & Medicaid Services issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program, and a notice for the Advance Payment Initiative that will provide additional support to physician-owned and rural providers.

The new Shared Savings Program and Advance Payment Initiative will help providers participate in Medicare Accountable Care Organizations (ACOs) to improve quality of care for Medicare patients. During this national provider call, CMS subject-matter experts will discuss the application process for the Shared Savings Program and the Advance Payment Model. A question and answer session will follow the presentation. We are fortunate to have with us this afternoon our Administrator, Dr. Donald M. Berwick, who will provide us with opening remarks.

Before we get started I have a few announcements. This call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Teleconferences and Events section of the Medicare Shared Savings Program Web site following this call.

There is a slide presentation for this session. If you have not already done so, you can download this handout now from the Shared Savings Program website located at www.cms.gov/sharedsavingsprogram. At the left side of the Web page, select CMS Teleconferences and Events and scroll down the page to the Downloads section for the slide presentation.

Also, the Shared Savings Program Application section of the Shared Savings Program website is now updated with a Notice of Intent to Apply (NOI) and the complete Shared Savings Program application package. From the Shared Savings Program Web site at www.cms.gov/sharedsavingsprogram, select Shared Savings Program Application from the left side of the webpage and scroll down the page to the Downloads section for these documents.

Without further delay, I would like to introduce Dr. Donald Berwick. Dr. Berwick is the Administrator for the Centers for Medicare & Medicaid Services. As Administrator, Dr. Berwick oversees the Medicare, Medicaid, and Children's Health Insurance programs. Together, these programs provide care for nearly one in three Americans.

Before assuming leadership of CMS, Dr. Berwick was President and Chief Executive Officer of the Institute for Healthcare Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor of Health Policy and Management at the Harvard School of Public Health. He also served as a consultant in pediatrics at Massachusetts General Hospital and Adjunct Staff in the Department of Medicine at Boston's Children's Hospital.

Dr. Berwick is a pediatrician and holds a Master in Public Policy degree from the John F. Kennedy School of Government. He received his medical degree from Harvard Medical School, where he graduated cum laude. Now it is my pleasure to turn the call over to Dr. Berwick.

CMS Administrator Donald Berwick

Donald Berwick: Thank you very much. Thank you to the hundreds of you on the call, for your interest in the Medicare Shared Services Program, ACOs, and the topic of today: how to apply. I'm thrilled by your interest and excited by this program.

I'm going to take a few minutes for background. Before Tricia walks you through the actual application process, I want to go back to why we're doing this, and why this program was originally created by Congress in the Affordable Care Act.

As you know, American medical care delivery tends to be highly fragmented. Ask a person with chronic illness, and you'll find that they're sometimes lost between the slats as they go between the hospital and home, or between a specialist and a primary care doctor. We didn't build a system for truly coordinated and seamless care. That has to do not just with people with chronic illness, but with the simple deeds of effective prevention in health care, or the episodic challenges we face as well. People with intermittent illness still challenge the system to create seamlessness and coordination.

The consequences for patients are not good. People have complications they could have avoided, they get confused, and the consequences for cost are not good. When care isn't coordinated, efforts are duplicated, balls are dropped, and complications increase in frequency. So, one of the great and important solutions for the problem of America's health care value is to better coordinate care over time and space.

One way to do that is with traditional forms of managed care. Many beneficiaries in Medicare, those who choose Medicare Advantage, want that. They join health plans that have the job, under contract, of maintaining the health and taking care of people over time and space. They do that in network systems, where a person agrees to stay within the network of a Medicare Advantage plan in order to get the care they want and need.

But three out of four Medicare beneficiaries don't choose Medicare Advantage. They are in normal Fee-For-Service, what we call traditional Medicare, in which fees are paid for services, and those services do not normally include coordination. They are embedded in some of the primary care and evaluation and management payments, but coordination remains sort of an orphan challenge for care. Good doctors, good nurses, and good hospitals work hard on it, but the reward systems are inconsistent, and the supports and payment are not there, or not there well enough.

With the creation of the Affordable Care Act, Congress has put into play a number of changes in systems of payment and measurement for Medicare that are intended to encourage coordinated care. Some are not within the ACO realm, things such as bundled payments, which are now being tested through our Innovation Center and begun in the ESRD program; and supports to medical homes and health homes to pay for primary care to get invested in coordination of care.

One of the big ideas in the Affordable Care Act is the Accountable Care Organization. The ACO idea pedigree goes back I think to the work of scholars who have been very interested in seamless care. Elliott Fisher, Glen Hackbarth (the Chair of MedPAC), Mark McClellan, and others have invested their time and energy in helping to answer the question of how we can encourage more seamless and coordinated care in the country, especially within the Fee-For-Service environment of traditional Medicare.

The ACO was born as an idea to try to foster coordination of care and the benefits to patients and to costs that come from coordinated care in a Fee-For-Service payment environment. That's the edgy and interesting idea here.

The concept is to encourage the formation of organizations of providers who are willing to take responsibility for panels of attributed patients. Attribution means the functions through which we in CMS are able to decide that Ms. Jones apparently has chosen Dr. Berwick to be her primary care provider and therefore is "attributed" to Dr. Berwick.

The ACO, once formed, has such an attributed panel of patients, and we in Medicare have the data to predict what the costs of care for this group of people ought to be over, say, the subsequent year. This organization that's formed, the Accountable Care Organization, stands to gain in shared savings if the total costs of care for the attributed patients are less than predicted for the subsequent year. The sharing of savings varies with the amount of risk the organization is taking on the downside, but it's on the order of 50 or 60 percent.

In the Medicare Shared Savings rule, we have to attend to many variables that allow such a program to be effective and attractive, as well as safe and effective for beneficiaries. For example, if you're a beneficiary and you know your primary care provider has joined an ACO or formed an ACO, and therefore will share in savings, are you worried about skimping on care? Well, maybe not if you trust the provider as you should, but we also need to have some other forms of guarantee. In the ACO rule there are forms of accountability and surveillance of quality so that the shared savings don't exist. There can't be shared savings if quality deteriorates. We have quality metrics, then, in the rule that allow us to watch the quality of care obtained by beneficiaries and also to hear directly from beneficiaries, because some of the metrics are beneficiary driven.

There are issues around thresholds for savings. We don't want to reward random variation in costs so we have to have rules that apply, which allow us to know and allow the providers of care to know when they've saved enough, that it's a non-random variation in savings.

There are issues of antitrust and market discipline, so that we're sure that the kinds of cooperative behaviors we want to encourage among clinicians and with hospitals occur, but without collusive effects on pricing and market forms. So there are issues concerning antitrust behaviors of ACOs.

There are issues around the burden of setting up an ACO—how to make it simple, but also make sure that it is truly responsive to patients, families, and communities. There are concerns around governance: Will the governing

structures be responsive to the interests and needs of the beneficiaries? Issues around marketing: How can appropriate disclosure occur so people know their doctor or hospital has joined an ACO?

There are issues around sharing of data. To properly help coordinate care, the Accountable Care Organizations of course want information that CMS has in our claims data. On the other hand, beneficiaries and others are justifiably concerned about privacy. So there are rules and procedures for how much data can be shared and when.

When we went out with our preliminary rule, the proposed rule in the spring of 2011, we received, as we expected, many comments on all of these and many other variables in describing what an ACO is. Over 1,200 comments were received formally, and many more ideas came in through listening sessions and dialogue with all stakeholders in health care. That led to the final rule, issued about a month ago, which has received, I think justifiably, a lot of positive response, because it was responsive. We crafted a better rule as a result of the incoming information.

Now the opportunity exists for organizations to form as Accountable Care Organizations—provider led, organized around primary care, with attributed populations. We've added increased flexibility to this rule, such that Rural Health Centers, Critical Access Hospitals, Federally Qualified Health Centers, and others can participate more effectively in the ACO world. Also, we've adjusted the saving percentages and other rules for savings essentially to make the business case a little more attractive than in the proposed rule.

In the final rule, as you will see, there are two tracks for possible participation in the ACO program.

Track one is more or less for newcomers, organizations not terribly experienced perhaps in coordinating care but confident they can do it, and they want a period of time to ramp up into the kind of risk bearing that an ACO might take at a mature level. Track one is three years (or because we're having rolling entry into the program, in some cases a little more than three years) of shared savings only, in which the organization only has upside

potential. That is, if the costs are lower than predicted, they share in the savings. But if the costs are higher than predicted, there's no downside risk for the ACO. Since there's no downside risk, the amount of shared savings is somewhat lower in track one than in track two.

Track two in the Medicare Shared Savings Program has both upside and downside risks. These organizations are a little more capable perhaps of bearing some of that risk because they may already have onsite care coordinators, or they may already have information systems that will allow them to better track and coordinate care with patients. Maybe they began by already being an ACO in the private sector, because there's a lot of private sector activity here. So track two has a little more gain but also some downside exposure for organizations that want to engage in this.

All this is to be done transparently with the beneficiary. Because this is traditional Medicare, in neither model does the beneficiary lose any choices at all. Beneficiaries still can go anywhere they want for their care, which means the ACOs that form under the Medicare Shared Savings Program will have to be organized around the notion of attraction instead of restriction as a way to keep beneficiaries involved with the work of the ACO, so the ACO can give them better care.

There is another ACO model out there that is already announced, and that's by the Innovation Center. The Center for Medicare & Medicaid Innovation began its Pioneer ACO Program application process a couple of months ago. Quite a large number of organizations came in as applicants, many more than we had thought—indeed, many more than the pioneer program can accept. We are now in the final stages of identifying the Pioneer ACOs. This program is for the much more advanced organizations, those able to take on the overall job of care coordination for attributed populations because they have the experience, data, cultures, and relationships that allow them to do this.

That's the basics, that's what the ACO program is designed to do. It's designed to do what now CMS is intending to do, which is to help improve American healthcare, to make things better for beneficiaries. And, at the same time, by improving care, to reduce the cost of care. Better care, better health,

and lower costs—that’s what we call the three-part aim here at CMS. There’s no better example of an attempt to foster new care delivery for the three-part aim than the ACO program itself.

It’s not the only game in town. There will be others interested in many other programs like bundled payment, primary care homes, and advanced primary care, but this ought to be of great interest to people ready to move into the era of coordinated care for Medicare beneficiaries.

Finally, let me say this has all been done with very much awareness and alertness about how much of the same activity is going on in the private sector. Major insurers in the country have moved aggressively into forms of Accountable Care Organizations that hopefully MSSP in CMS is well aligned with, but we know this is part of a much broader front of progress toward seamless care for all Americans.

I will stop there. I understand we can open the line for a couple of questions before I turn it over to Tricia to take us into a description of the application process. Operator, is it possible to take a couple of questions now?

Question and Answer Session with Dr. Berwick

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before asking the question to assure clarity.

Please note: Your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Jay Chowdappa.

Jay Chowdappa: As the Accountable Care Organizations mature, will the ACOs, like the Medicaid Advantage Plans, be able to enter into fee schedule arrangements with other providers attached to diagnostic centers or hospitals?

Donald Berwick: I'm not quite sure what you mean by fee schedule arrangements. The Accountable Care Organization can help guide beneficiaries toward providers of care it believes will do better for the beneficiaries, but beneficiaries retain absolute rights to go anywhere they want.

The internal arrangements within the ACO—and between the ACO and other providers who are not in or with the ACO—are up to the ACO to arrange. In the rule there are waivers from normal Stark and anti-kickback provisions, because we want to allow lots of flexibility and creativity on the part of the ACOs as relationships are built among providers, although this will be under extremely strong scrutiny. We are absolutely committed that if collusive behaviors begin to occur, the degree of permissiveness will decrease.

Other questions, Holly?

Operator: Yes. Your next question comes from Peter Aran.

Peter Aran: My name is Peter Aran; I'm with the Saint Francis Health System in Oklahoma. I have much the same question, Dr. Berwick, which is: If we're trying to design a health care system that would encompass care and provide care to our patients and their families, it would seem helpful to us if the patients would stay within our network of care. It's harder for us to track how their care is delivered when it's outside our network of care. I think you just touched on that, but it's an issue we are still grappling with.

Donald Berwick: That's a great question. That is the concept here. Let's be clear that what Congress contemplated in the ACO environment is that the beneficiary has lost no choice. They can still go anywhere they want, and that is the way we've written the rule. Now, it is a challenge. Unlike a pure managed care environment like Medicare Advantage, there are not the financial incentives now for the patient to stay within your network.

What are you to do about that? Well, for one thing, don't participate in an ACO. Find another framework where you think you can thrive more, like bundled payment, or maybe develop better relationships with the Medicare Advantage plan.

But if you think you can do it, this is a very thrilling idea. It means you will then be working with your patients, the ones attributed to you, to keep them by attraction with you, to convince them, to basically help them understand why you would be the best place to get their care from.

To make it easier to do that, a couple of changes were made in the final rule. For example, we will be providing ACOs upfront, when they become an ACO, with a list of the patients who are attributed to them at that point and who are likely to be attributed at the end of the reconciliation year. We will update those lists every three months so you'll have a pretty good idea of which patients are staying with you, and which ones, therefore, at the end of the year will be part of the settling up process as we decide whether there are savings to share or not.

We also are sharing beneficiary claims information with the ACO. The beneficiaries have an opt-out option—that is, they have to be informed that they can stop the sharing of CMS data with the ACO. But the claims data would include the experience of the patients no matter where they go. If they're seeing providers outside the ACO structure and Medicare is paying those claims, this would be in the data set, which, absent beneficiary opt-out, the ACO would have access to. So you can actually know quite a bit about the patients, where they're going, what's happening to them, and what the costs and experience of care are like. Hopefully, that will make it more attractive and more feasible to coordinate care even in an open-choice environment like the ACO.

Peter Aran: Thank you very much.

Operator: Your next question comes from the line of Clint McKinley.

Clint McKinley: My name is Clint McKinley, and I'm with Ability Prosthetics and Orthotics. My question is: Where in the ACO model do ancillary providers like our company, Prosthetics and Orthotics, fit, and to what degree can we participate?

Donald Berwick: Well, the ACO is a primary care model. The lead is the attribution. There are a few exceptions here. I won't go into the details, but the general lead is attribution of patients according to where they get their primary care services. Patients who cannot be attributed based on their primary service-seeking behavior can be attributed through certain forms of specialty care behavior, but that's a small matter.

The relationship between any other supplier of care and the ACO is between that supplier of care and the ACO. The ACO undoubtedly would be looking for providers of, in your case, equipment or other supplies that they would regard as favorable to the outcomes, quality of care, coordination of care, and cost for the beneficiaries attributed to it. This gives you a new business case, a new business model might be the way to think about it. But the lead in establishing an ACO is the provider of care, not another stakeholder in the system.

Clint McKinley: Can an ancillary provider participate in multiple ACOs?

Donald Berwick: Clint, I believe the answer is yes. I'm going to take that offline, though, and we'll check it. At the end of the call, we will give you a way to contact us, and we'll follow up with you if that's not the right answer.

Clint McKinley: Thank you.

The Medicare Shared Savings Program Application Process

Leah Nguyen: Thank you, Dr. Berwick. At this time I would like to introduce Tricia Rodgers, Acting Deputy Director of the Performance-Based Payment Policy Staff here at CMS, who will cover the Medicare Shared Savings Program application process.

Tricia Rodgers: Thanks, Leah. Good afternoon to all of you, and thank you for joining us for the call. This presentation is aimed at providers who are interested in participating in the Medicare Shared Savings Program Accountable Care Organizations. Today we will give you a brief background of Accountable Care Organizations, or ACOs, the various initiatives we have here at CMS, as well as specific information regarding the Shared Savings Program and the Advance Payment Initiative application process and key dates.

We will go step-by-step with you through the process, which begins with accessing the Notice of Intent to Apply on the Shared Savings Program website in order to obtain an ACO identification number and a CMS user ID. We will provide information to help you fill out and submit your Medicare Shared Savings Program application, and we will go over the acceptance or denial process. Lastly, Kelly Hall will review the Advance Payment Model application process.

The concept of ACOs grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality. Doctors Elliott Fisher of Dartmouth and Mark McClellan of Brookings have written extensively about the ACO model as a means of improving quality and decreasing costs. During the development of health care reform, Congress drew from these experts as well as the Physician Group Practice Demonstration project here at CMS. This work established the foundation for the Medicare Share Savings Program and indeed ACOs.

In October 2011 we issued our final rule on the Medicare Shared Savings Program, which added to the menu of options for providers looking to better coordinate care for patients. Anyone who has been involved in our health care system, whether as a provider, a patient, or a family member of a patient, knows that our health care system is fragmented. It has developed in pieces—hospitals, clinical practices, home health care, etc.—without conscious or well-designed connections among those pieces.

Fragmentation of payment, especially of Fee-For-Service payment, reinforces this fragmented care. ACOs are a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering

the overall growth in health care costs. As shown on slide 4, ACOs are designed to meet these goals by:

- Promoting accountability for the care of Medicare Fee-For-Service beneficiaries
- Improving coordination of services provided under Medicare Parts A and B, and
- Encouraging investment in infrastructure and redesigned care processes.

While many providers are embracing these changes, the process of establishing the program will take time. As noted on slide 5, many Medicare provider organizations throughout the country are in various transitional phases. In order to facilitate a move toward participating in ACOs, CMS has developed several initiatives that meet providers at their level of readiness, including the Shared Savings Program, the Advance Payment Initiative, the Pioneer ACO Model, and the ACO Accelerated Development Learning Sessions. Information on these initiatives is available on our Web site at www.cms.gov/sharesavingsprogram and at www.innovations.cms.gov.

Slide 6 describes the origins of the Medicare Shared Savings Program. The Shared Savings Program was enacted by Congress through section 1899 of the Social Security Act and amended by section 3022 of the Affordable Care Act. The final rule addressed over 1,300 comments, went on display in the Federal Register on October 20 of this year, and was published on November 2.

This final rule established the Medicare Shared Savings Program for Accountable Care Organizations. The Medicare Shared Savings Program is a voluntary program for health care providers that agree to become accountable for the quality, cost, and overall care of Medicare beneficiaries in the traditional Fee-For-Service program. By focusing on the needs of patients and linking payment rewards to outcomes, the program's goals are to improve the health of individuals and communities while lowering the growth in costs.

ACOs may accomplish this by carefully coordinating patient care in order to eliminate duplication, medical errors, and mismanagement. Ultimately, we

believe that changes in infrastructure and redesigning care will increase our beneficiaries' quality of care while also reducing time and cost.

We will now walk through the Medicare Shared Savings Program application process with you, beginning with the Notice of Intent to Apply through receiving your denial or acceptance letter. Slide 8 gives the key dates for the Shared Savings Program application cycles for both the April 1 and July 1 start dates. As you can see, this is an ambitious schedule. I will walk through each section of the process in subsequent slides, but these are the deadlines for each step in the application process.

This month we posted the Notice of Intent to Apply, or NOI, and the Medicare Shared Savings Program application on our CMS Web site. NOIs are currently being accepted through January 6, 2012, for an April 1 start date, and now through February 17 for a July 1 start date.

After the NOI is received we will send you an e-mail with instructions on how to apply for a CMS User ID. We are accepting these forms until January 12 for an April 1 start date, and until February 23 for a July 1 start date.

As soon as you receive your CMS User ID you may begin working on your application. We will begin accepting applications on December 1 and continue through 5:00 p.m. eastern standard time on January 20, 2012, for an April 1 start date, and from March 1 through March 30, 2012, for a July 1 start date. Approval or denial e-mails will be sent by March 16 for an April 1 start date, and by May 31 for a July 1 start date.

If your application is denied and you would like a reconsideration review, the review deadline is March 23 for April 1, and June 15 for a July 1 start date. It is important to note that if you cannot complete a requirement by a specified date, you must wait until the next cycle to apply.

Now let's get to the application process. On slide 10, the first step in the application process is the Notice to Intent to Apply, or NOI. Submitting an NOI does not require you to submit an application, but you must complete the

NOI process to receive an ACO Identification Number. The ACO ID is required throughout the application process.

On slide 11: Once you are on the Shared Savings Program website, scroll down to the Downloads section. Click on the link called “ACO NOI Memo – Application,” and on page 2 of the memo, click on the link in the first paragraph, “How to Submit a Notice of Intent to Apply.” This will take you to the online web form at the Vovici website. Fill out all eight questions and click “submit survey” to complete your Notice of Intent to Apply, indicating your interest in participating in the Shared Savings Program.

You will receive an e-mail acknowledgment containing your ACO ID number and instructions on how to request a CMS User ID. We are only accepting these NOI applications electronically, and although you have until 5:00 p.m. Eastern Standard time on January 6 to submit an NOI for an April 1 program start date, we encourage you to complete the NOI process as soon as possible.

Slide 12: After you receive your NOI acknowledgment letter via e-mail, your next step is to obtain a CMS User ID. As noted on your NOI acknowledgment notification, you will need to download the CMS access request form at www.cms.gov/InformationSecurity/Downloads/EUAaccessform.pdf.

I am going to walk through the specific instructions on filling out the CMS user ID application, and we will also post these instructions on our Shared Savings Program Web site for your reference. We are requesting each pending ACO to submit up to three applications for a CMS User ID. This should include two information technology contacts, and if the person who will enter the electronic application for the Medicare Shared Savings Program is different from the information technology contact, please submit an additional application for a CMS User ID for this person.

In section 1, select “NEW (Issue a CMS UserID).” In section 2, select the third checkbox, “Medicare Advantage/Medicare Advantage with Prescription Drug/ Prescription Drug Plan/Cost Contracts - Using Other Systems.” Enter your information in the following fields only: your first name, middle initial, and last name; the company or organization or department name; the mailing

address; the city, state, and zip code; and the phone number and e-mail addresses.

In section 3, enter your ACO ID. It will begin with the letter A, followed by four digits under “Contract Number(s).” In section 4, select the third “Connect” checkbox and write “HPMS_P_Comm1User”. The textbox will not accept all the typed characters, so we are requesting that you hand write the job code.

In section 5, enter “I request a CMS user ID to access the Medicare Shared Savings Program ACO application.” On page 3, enter the requested information—name, Social Security Number, and date of birth. Print the form, sign and date it, and send it to CMS via tracked mail as soon as possible, but no later than January 12, 2012, to begin the program on April 1.

You will send it to the Centers for Medicare & Medicaid Services, Attention: Greg Buglio, Mail Stop C4-18-13, 7500 Security Boulevard, Baltimore, Maryland 21244.

I know I went through this very quickly, but, as mentioned, we will be posting this information on the Medicare Shared Savings Program website.

Now that your Notice of Intent to Apply is complete and you’ve received your ACO ID, let’s move on to slide 13 and step 2, which is the application itself. The Medicare Shared Savings application package is available for download on the Medicare Shared Savings Program website in the Downloads section. The application package includes: the application itself; the Electronic Funds Transfer or EFT Authorization Agreement, which is known as CMS form 588 and is our Appendix A; the Participant List Template (Appendix B); the Data Use Agreement, or DUA (Appendix C); and the Application Reference Guide (Appendix D).

Slide 15 contains a screen shot of Appendix D, the Application Reference Guide. We suggest you use this reference guide as you work your way through the application. We developed the guide to help you complete each section in the application. It references the regulation citation, the page on

which the citation appears in the final rule, whether supporting documentation is required, and the naming convention for files that need to be uploaded. It is an adjunct to the application for a quick reference to the final rule for each pertinent section.

Slide 16 displays the Table of Contents of the application, and you can see that the application follows the outline of the final rule. It covers the organization overview, legal requirements, governance/leadership, participation in other Medicare initiatives involving shared savings, financial section, provider information, data sharing, the required clinical processes and patient centeredness, and the application certification.

As you make your way through the application questions, you will see that in some cases, depending on your answer, you may need to submit a narrative in addition to responding to the question. For example, on slide 17 you will see the screen shot of page 13 of the application. Here you are asked about your operations management structure. If you respond in the negative, we ask you to describe how you intend to manage the operations of the ACO, and how this alternative leadership and management structure can accomplish the ACO's mission.

The Reference Guide provides instructions on how to submit your supporting documentation. Once you complete your application, you will proceed to the Upload screen. Please combine all supporting documents into a single zip file and click the submit button on the Upload screen to complete your application.

For those submitting by tracked mail, please provide your supporting documentation on an encrypted CD or DVD to include as part of your application package. You will send a password including your ACO ID to the SSPACO_Applications@cms.hhs.gov mailbox.

Slide 18 displays the banking information section of the application, where you are asked to submit CMS Form 588, or Appendix A. The signed CMS 588 is essential for you to get a shared savings payment. Shared savings will

be deposited directly to this account. This form is due at the same time as the application, and applications are not considered complete until CMS receives it.

If you have any questions about filling out the CMS 588 Form, a tutorial is available at the Highmark Medicare Services link shown on the slide and available in Appendix A. You will submit CMS form 588 at the address noted in the application.

Moving on to slide 19: Page 17 of the application asks that you submit a list of participant Tax Identification Numbers, or TINs, and CMS Certification Numbers, or CCNs. Appendix B is the participant list instructions and templates. You must submit one participation list for each ACO. Multiple participation lists will not be accepted. Please indicate all ACO participant TINs and CCNs that are part of your ACO.

Because beneficiary assignment is based on primary care services rendered by ACO participants, each ACO participant TIN that bills Medicare for primary care services must be exclusive to a single Medicare Shared Savings Program ACO. ACO participant TINs that do not bill Medicare for primary care services may apply for participation in more than one Medicare Shared Savings Program ACO. Please note that this exclusivity requirement applies only to the Medicare Shared Savings Program and does not apply to arrangements the ACO might make in the private sector.

Slide 20 depicts Appendix C, or the Data Use Agreement. If you responded that you will request beneficiary-identifiable data and Medicare-specific data, and you are accepted into the program, you will be required to sign and return a Data Use Agreement before receiving CMS data.

After you respond to all application questions, you must certify on page 19 of the application that the information you provided is true, correct, and complete. Slide 21 depicts this question on the application. You are also agreeing that CMS will share your completed application with the Federal Trade Commission and the Department of Justice if your ACO is newly formed according to the Antitrust Policy statement definition.

Slides 22 and 23 describe the two options for submitting applications: either through tracked mail or electronically through our online automated system in the Health Plan Management System or HPMS. While we strongly encourage ACOs to submit applications through the automated system, we will accept paper submissions.

To submit an application using tracked mail such as FedEx, UPS, or certified mail, we must receive your application on or before January 20, 2012, for an April 1 start date. Send the completed application with the original signature and supporting documents to the Centers for Medicare & Medicare Services, Attention: SSP ACO Applications, Mail Stop C5-15-12, 7500 Security Boulevard, Desk Location C4-07-01, Baltimore, Maryland 21244.

As mentioned, we strongly encourage you to submit your applications through the automated system in HPMS. Slide 23 shows how you can access the automated application through our website. Technically, you will access the system through the link provided in your CMS User ID e-mail notification, rather than going through the information provided on the slide.

The information you provided during the NOI submission will be pre-populated in the online electronic application. If you need to change any of the pre-populated information, you must request the change through the application e-mail box at SSPACO_Applications@cms.hhs.gov.

Moving on to slide 24: During your application review we may request that you submit additional information because a portion or portions of the application are incomplete. If you applied electronically, you must upload the additional information into HPMS within five days from the date of the request. If you submitted a paper application, send the additional information through the mail within five days from the date of the request. If you do not submit the information in a timely manner, we will not accept the submission and may defer your application to the following application cycle.

After we've reviewed your application and supporting documents we will send you an e-mail either accepting or denying your application by March 16,

2012, for an April 1 program start date. If you are approved, you will be asked to sign the Medicare Shared Savings Agreement, and sign and date the DUA, and return both items to CMS within five business days of the acceptance letter. April 1 start dates are due by March 23, 2012.

Slide 25: If your application is denied, you will receive an e-mail to this effect, and you will have the opportunity to request a reconsideration review. If you choose to seek a reconsideration review, we must receive your request within 15 days of the date of your denial e-mail. If you do not meet this deadline, you will not be reconsidered for the April 1 start date. However, you may resubmit your application with supporting documents for the next cycle, which in this case begins July 1.

If you decide to withdraw your application, you follow the process described on slide 26. You must submit a written request before March 16, 2012, if you were applying for an April 1 program start date.

The request must be on your organization's letterhead and signed by your CEO. Please include the following information: your legal entity name, your ACO ID number, complete address, point of contact information, and the exact description of the nature of the withdrawal. You may submit the request either in PDF format via e-mail to SSPACO_Applications@cms.hhs.gov, or by mail to CMS, Attention: SSP ACO Applications, Mail Stop C5-15-12, 7500 Security Boulevard, Baltimore, MD 21244.

We anticipate that you will have questions throughout this process. When questions arise, please contact us as indicated on slide 27 at SSPACO_Applications@cms.hhs.gov.

We would like to emphasize that it is critical to meet all deadlines in order for your application to be accepted. Any applications or supporting documents received after the scheduled times will not be considered for the current cycle.

This concludes the Medicare Shared Savings Program portion of the call. If we have time remaining at the end of the next presentation, we will accept questions. For now, I will turn it back to Leah.

The Advance Payment Model

Leah Nguyen: Thank you, Tricia. Our next presenter is Kelly Hall from the CMS Innovation Center, who will cover the Advance Payment Model.

Kelly Hall: Thank you, Leah. The Advance Payment Model is sponsored by the Center for Medicare & Medicaid Innovation. It is designed to test whether the prepayment of a portion of expected shared savings to ACOs participating in the Shared Savings Program will increase participation and enhance performance in the program, particularly by physician-based ACOs and ACOs that include rural hospitals.

The initiative was first announced in May 2011 when we asked for public comments, and those comments then shaped the model that was announced alongside the Shared Savings Program in October 2011.

Slide 30 begins the discussion of program details. (Please note that the information in this slide presentation is also available in the formal solicitation for the Advance Payment Model, which is available on the Innovation Center Web site.)

Participating ACOs, meaning ACOs that are participating in the Shared Savings Program and have also been selected to participate in the Advance Payment Model, will receive three types of payments: (1) an upfront fixed payment that will be the same for all ACOs participating in the model, (2) an upfront variable payment based on the number of Medicare beneficiaries attributed to that ACO, and (3) a monthly payment of varying size, again depending on the size of the ACO as determined by the number of attributed beneficiaries. CMS will recoup all advance payments through an ACO's earned shared savings at the end of the first performance period.

Slide 31 details the eligibility requirements for the model. The Advance Payment Model is only open to participants in the Shared Savings Program that come into the program on the April 1, 2012, start date or the July 1, 2012, start date. It is also only open to two types of organizations within the broader

scope of the Shared Savings Program. The first type consists of organizations that do not include any inpatient facilities as ACO participants and have less than \$50 million in total annual revenue. The second type of organization that is eligible to participate consists of ACOs in which the only inpatient facilities are either Critical Access Hospitals or Medicare low-volume rural hospitals, and which have a total annual revenue of less than \$80 million.

Moving on to slide 32: Organizations must complete separate applications for the Shared Savings Program and the Advance Payment Model. The Advance Payment Model will not require a Notice of Intent or a CMS user ID. For ACOs that intend to enter the Shared Savings Program on April 1, 2012, applications will be accepted between January 1 and February 1, 2012. For ACOs intending to enter the Shared Savings Program July 1, 2012, applications will be accepted between March 1 and March 30, 2012.

We will release an application template for the Advance Payment Model later this fall, and then applications will be accepted online in the timeframe I just mentioned. When the application template is available, it will be posted on the Advance Payment Model website, which is on the Innovation Center website. If you'd like to be notified when that application template is available, you can sign up for the Innovation Center listserv, which is an option available to you on the Innovation Center website, www.innovations.cms.gov.

I'm happy to take any questions about the process along with Tricia.

Questions and Answers on MSSP ACOs and the Advance Payment Model

Leah Nguyen: Thank you, Kelly. We have now completed the presentation portion of this call and will move on to the question and answer session. Our subject-matter experts will now take your questions about the Shared Savings Program and the Advance Payment Model application process. If you have other questions about the Shared Savings Program, please send them to ACO@cms.hhs.gov. Questions about the application can be sent to SSPACO_Applications@cms.hhs.gov. This e-mail address is also listed on

slide 27 of the presentation. Questions about the Advance Payment Model can be submitted to advpayaco@cms.hhs.gov, which is shown on slide 34.

Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking a question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible we ask that you limit your questions to just one. Alright, Holly, you may open the lines for questions.

Operator: Again, as a reminder, to ask a question, press star 1 on your telephone keypad. Your first question comes from the line of John Raya.

John Raya: Hi. What are the criteria for approving an application, or what are the reasons that an application can be denied?

Tricia Rodgers: That's a good question. If the application is incomplete, we would ask for more information to be submitted. If you do not submit that requested information, the application could be denied. If you do not meet the qualifications in the final rule that are set out by statute and in the rule, that is a possible reason for being denied. The best place to look is in the reg-text of the final rule. It depicts in a very concise manner all that will be required and expected of the ACO participants.

John Raya: Alright, thank you.

Operator: Your next question comes from the line of Beth Fleming.

Beth Fleming: Good afternoon. My questions are related to the exclusivity of providers in Shared Savings Programs. Specifically, are primary care physicians still limited to only one type of Shared Savings Program? Do the same limitations apply to non-PCPs? Also, as a follow up, are physicians participating in patient-centered medical homes excluded in any way?

Tricia Rodgers: Let me start with the definition of an ACO participant. An ACO participant must be a Medicare-enrolled TIN that bills Medicare directly for services, and that a subset of those billed directly for primary care services are used for

assignment, and they must be exclusive to a single Medicare Shared Savings ACO so that we can determine a unique patient population.

Beth Fleming: Are those physicians participating in an ACO limited to participating in any other type of Shared Savings initiatives, and what about specifically patients that are in medical homes?

Tricia Rodgers: If the participant is a primary care provider on which assignment is based, then he or she would be limited to participating in the Medicare Shared Savings Program or, in this case, in the Medicare Shared Savings Program ACO. If it is not a TIN upon which assignment is based, the exclusivity requirement is not there.

Beth Fleming: OK, thank you.

Operator: Your next question comes from the line of Josh Mast.

Josh Mast: Hello. I had a question about the Advance Payment Model. I saw that CMS will recoup monies paid out on the Advance Payment Model from the shared savings. What if an ACO signs up but doesn't achieve shared savings?

Kelly Hall: In that case, CMS would not recoup the advanced payments in full.

Josh Mast: Would there be any recoupment?

Kelly Hall: If the ACO does not achieve shared savings, then, no, there would not be any recoupment of those advance payments.

Josh Mast: I have one other quick question if I can, please. Can the States require any kind of certificate of authority from the ACO, or is all of this preemptive?

Tricia Rodgers: We are not preempting State law through the Medicare Shared Savings Program.

Josh Mast: There would be no certificate of authority that you would have to file with the States to be a participating ACO?

Tricia Rodgers: Any State requirements would be through the State. We are not requiring anything for the Federal program.

John Mast: OK, thank you.

Leah Nguyen: Just as a reminder, we're going to limit questions to just one per caller, please.

Operator: Your next question comes from the line of Barbara Newton.

Barbara Newton: I have a question about the patient dropping out or opting out. Does that mean the patient will not be included at all in the data, or does that mean that you just won't be able to share their data?

Tricia Rodgers: The beneficiary has the opportunity to decline to have their data shared. They would not be opting out of any type of program. Their claims costs would still be calculated in the reconciliation. If the beneficiary opts out of having their data shared, you would just not have access to that information, but their costs would be calculated in the final reconciliation.

Barbara Newton: Thank you.

Operator: Your next question comes from the line of Scott Hines.

Scott Hines: Do you have to have a CMS User ID before you can start filling out the application?

Tricia Rodgers: You must have a CMS User ID in order to submit the application electronically through our HPMS, but you may begin looking and forming your answers based on the application posted on our Web site. The questions and format are exactly the same. You would just submit your responses through the automated system once you receive your CMS User ID.

Operator: Your next question comes from the line of Amanda Cassidy.

Amanda Cassidy: Could you expand a little more on the role of the IT contact, and what functions you would expect them to perform?

Tricia Rodgers: The IT contact is for testing of data transfers between the ACO and CMS. We would like to have that information to get that process started as quickly as possible.

Amanda Cassidy: Do you expect that person to be an employee, or could they be a contractor of the ACO?

Tricia Rodgers: That's a good question, Amanda. We will have to get back to you on that. If you can send that question to SSPACO_Applications@cms.hhs.gov, we can research it and let you know for certain.

Amanda Cassidy: OK, thanks.

Operator: Your next question comes from the line of Janice Anderson.

Janice Anderson: It's confusing to me in the regulations as to whether or not the ACO participants have to be owners of the ACO if they're not related, or can they be contractors?

Tricia Rodgers: I'm a little confused by your question.

Janice Anderson: There's some commentary that seems to suggest that non-related ACO participants can't participate simply by a contract with the ACO. That's what I'm trying to clarify.

John Pilotte: This is John Pilotte. What we have indicated in the final rule is that ACO participants need to have a 75-percent representative on the governing structure and the organizational structure of the ACO. We've also provided some opportunities for ACOs to describe how they are provider controlled and provider driven if they can't meet that specific level of provider participation. But we haven't been exactly prescriptive in terms of the exact organizational structure and the relationships there; rather, we are looking for organizations that are provider directed, provider driven, and have representative participation and control of their governing entities by the ACO participants.

Janice Anderson: Alright, thank you.

Operator: Your next question comes from the line of Mohinder Ahluwalia.

Mohinder Ahluwalia: I am part of the Heritage Provider Network. We'll be part of the Pioneer ACO. The question is: We have physicians who don't admit to the hospital, and when a patient goes to the hospital they just have a primary physician as an outpatient. Who will bill CMS for the admission to the hospital? How will that work out for the primary care physician, if the patient is under his name and his list, but he's not admitting to the hospital?

Kelly Hall: Mohinder, this is Kelly Hall. Because this call concerns the Shared Savings Program and the Advance Payment Model, we would be happy to answer your question regarding the Pioneer ACO Model through the Pioneer ACO e-mail inbox, which is pioneeraco@cms.hhs.gov.

Mohinder Ahluwalia: OK, thank you.

Operator: Your next question comes from the line of Brian Choi.

Brian Choi: As an organization that's trying to determine our capabilities to participate in the Shared Savings Program, I think that track one probably would be the track we would be aiming for. But I was wondering: If we do the capability assessment and determine that we're not ready at this time, how long will track one be available?

Tricia Rodgers: The final rule made track one available for all newly entering ACOs into the Medicare Shared Savings Program.

Brian Choi: So if we're not ready this year, it will still be available the following year?

Tricia Rodgers: That's correct.

Brian Choi: OK.

Operator: Your next question comes from the line of Stephanie Barnett.

Stephanie Barnett: Hi. I was wondering if ACOs could outsource some of their patient engagement and. . . .

Tricia Rodgers: I'm sorry. I think you asked if you could outsource some of your patient engagement material, is that correct?

Stephanie Barnett: No. Patient engagement support staff as well as quality management, utilization management staff—to a third party.

Tricia Rodgers: That would fall under agreements between the ACO and its participants. As long as it meets all the other criteria, then it's an agreement between the ACO and its participants.

Stephanie Barnett: Instead of hiring their own staff, I guess.

Tricia Rodgers: It's a subcontract of the ACO, and so it would just be treated as such.

Operator: Your next question comes from the line of Susan Thompson.

Susan Thompson: I was curious if you could further elaborate on an applicant ACO. If they meet the final rule requirements, what would the logic be in further determining the award of the Advance Payment Model and participation in the Shared Savings Program? Is it based on geographics, the number of beneficiaries covered?

Kelly Hall: Regarding selection into the Advance Payment Model, the primary criterion is first that you have to be selected to participate in the Shared Savings Program. You have to be eligible and be approved to participate in the Shared Savings Program. The review for your Shared Savings Program eligibility will be done concurrently with the Advanced Payment review of your application.

We have a detailed list of the selection criteria for the Advance Payment Model in the solicitation for that model, which is available on the Innovation Center Web site. There are eligibility criteria for the Advance Payment Model, which I went over on this call. In addition to those, in order to select down to the number that we'll be able to fund, there are criteria based on total revenue, the number of providers that are participating who practice in rural locations, and the percentage of the total patient revenue that comes from Medicaid and Medicaid managed care lines of business. Other criteria relate to

the description of how you intend to invest the funds that CMS would be providing, and what type of activities you would undertake to improve care coordination and achieve the goals of the Shared Savings Program. An evaluation of all of these criteria, then, would determine which organizations within those that are eligible for both the Shared Savings Program and the Advance Payment Model actually get selected to receive the funds.

Susan Thompson: Alright, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Tom Jendro.

Tom Jendro: Good afternoon. Just a quick question on the billing: Once the application is accepted, will the ACO be assigned its own unique billing identification number to place on Medicare bills, or will the ACO components continue to bill and get paid as they are right now?

Tricia Rodgers: The ACO participants will continue to bill and get paid under the regular fee-for-service program as they do currently.

Tom Jendro: OK, thank you.

Operator: At this time there are no further questions.

Leah Nguyen: We would like to thank everyone for participating in the Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application National Provider Call. An audio recording and written transcript of today's call will be posted to the CMS Teleconferences and Events section of the Shared Savings Program Web site at www.cms.gov/sharesavingsprogram.

I would like to thank our presenters, Dr. Berwick, Tricia Rodgers, and Kelly Hall. Have a great day, everyone.

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