

Medicare Shared Savings Program Application Process National Provider Call

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Presented by CMS



Medicare Learning Network

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Agenda

This presentation will cover:

- Introduction
- What is an Accountable Care Organization?
- Organizational Structure and Governance
- Application Process for January 2014



Introduction

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Purpose of Today's Call

- 2014 Medicare Shared Savings Program (Shared Savings Program) application will be posted on the [Shared Savings Program Application](#) web page
- Prior to submitting an application:
 - Establish your organizational structure
 - Establish your governance and leadership structure
 - Ensure all agreements meet requirements, are finalized and signed
 - Provide to CMS:
 - Sample of agreement
 - Template listing all participants
 - Signed signature pages for all ACO participants
 - Establish repayment mechanism, **only if** you have chosen Track Two



What is an Accountable Care Organization?

Terri Postma, MD
Medical Officer
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Shared Savings Program: Background

- [Shared Savings Program](#) web site
- Mandated by Section 3022 of the Affordable Care Act
- Establishes a Shared Savings Program using Accountable Care Organizations (ACOs)
- 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



Shared Savings Program: Goals

- The Shared Savings Program is a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures by:
 - Promoting accountability for the care of Medicare Fee-For-Service (FFS) beneficiaries
 - Improving coordination of care for services provided under Medicare Parts A and B
 - Encouraging investment in infrastructure and redesigned care processes

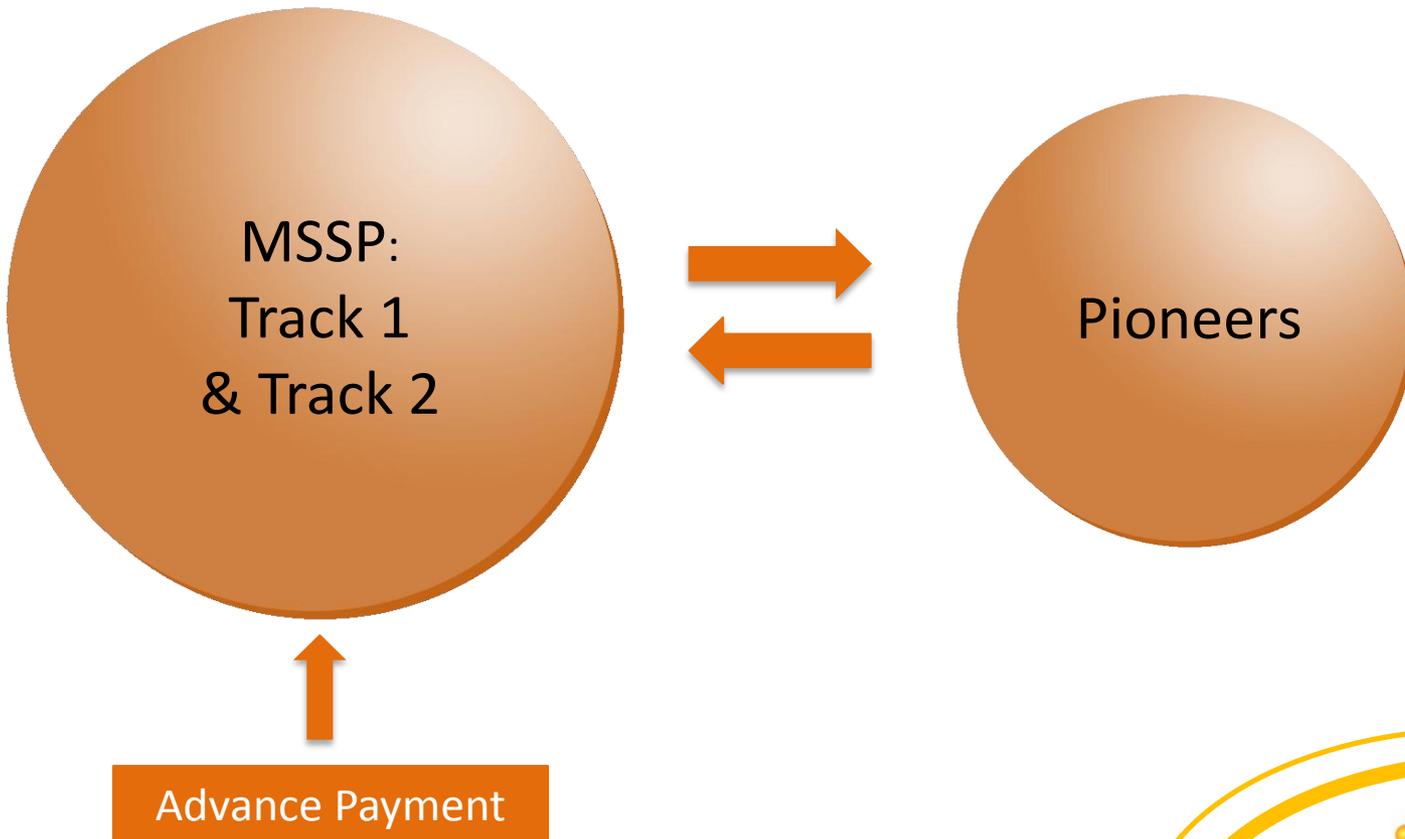


Shared Savings Program: Vision

- 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
 - Proactively managing the beneficiary's care
 - Evaluating data to improve care and patient outcomes
 - Using innovation 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:

(1) A provider or (2) A supplier and
(3) 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



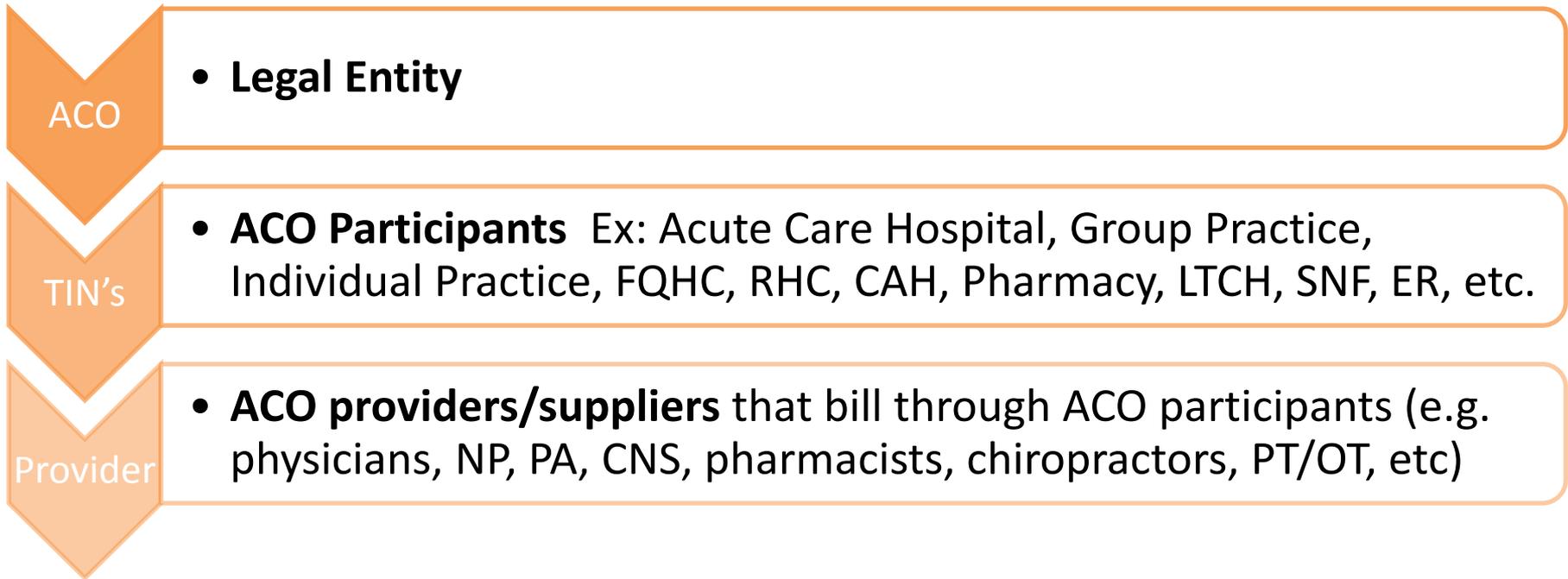
Shared Savings Program: Statutory Requirements

- 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

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 75% control of governing body
 - Partners with community stakeholders
 - 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
- Finalizing 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

- No longer participating in other 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

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



Quality Measure & Performance

- ACO Quality Performance Standard 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



Quality Data Reporting

- Quality data collected three ways:
 - Claims data
 - ACO Group Practice Reporting Option (GPRO) tool
 - Survey
- Complete and accurate reporting in the first year qualifies the ACO to share in the maximum available quality sharing rate
- Pay for reporting is phased in for the remaining performance years
- Shared savings payments linked to quality performance based on a sliding scale that rewards attainment
 - High performing ACOs receive a higher sharing rate



Incorporating Other Data Reporting Requirements

- Reporting on GPRO quality measures through the Shared Savings Program qualifies each eligible professional within the ACO for the PQRS payment incentive.



Financial Performance

- ACOs demonstrate savings if 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



Application Process for January 2014

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Application Cycle: Key Dates

Start Date	January 1, 2014
2014 applications posted on CMS Web site	June 2013
Notice of Intent to Apply (NOI) forms accepted	May 1, 2013 – May 30, 2013
CMS User ID forms accepted	May 1, 2013 – June 10, 2013
2014 applications accepted	July 1, 2013 – July 31, 2013
2014 application disposition	Fall 2013

Application Toolkit

- The Toolkit provides direction and examples:
 - Regulation reference page, guidance, FAQs
 - Forms
 - 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 Shared Savings Program.
- The NOI memo is available on the [Shared Savings Program Application](#) web page.
- NOI Process:
 - You will get a confirmation notice e-mail containing your ACO ID and instructions on how to complete the CMS User ID application.
 - Submitting an NOI **does not** require you to submit an application for 2014. 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 2014 application.



Step 2 - Obtaining a New CMS User ID

- The second step in the application process is to obtain a CMS User ID.
 - Use the CMS guidance available on the [Application](#) web page.
 - Send the completed CMS User ID form by tracked mail (e.g. FedEx) to CMS. The due date submitting this form is **June 10, 2013**.

Centers for Medicare & Medicaid Services
Attention: Adam Foltz
Mail Stop: C4-18-13
7500 Security Boulevard
Baltimore, MD 21244
- You must have at least four (4) CMS Users.
- It takes 3-4 weeks to process the requests. **Submit the form immediately upon receiving your NOI confirmation notice E-mail.**



Existing CMS User IDs

- CMS User IDs are unique to the individual, not the ACO
- If a User already has a CMS ID, he or she must submit an email including:
 - Attached PDF on ACO's letterhead
 - Indicate user's name and User ID for which the affiliated ACO is providing services
 - Authorized ACO ID number for the specific ACO
 - Letter is signed by the ACO's authorizing official
- If a Consultant already has a CMS ID, he or she must submit an email including:
 - The information listed above
 - The consultant's company name
 - If multiple users are authorized, 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.



Fraudulent Use of CMS User ID

- It is considered fraud if you use another person's User ID and password or, conversely, allow someone else to use your User ID and password
- This activity is strictly prohibited and will result in the termination of the individual's CMS User ID and password



Banking Information: CMS Form 588

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Application: Banking Information

BANKING INFORMATION

21. You must establish a relationship with a banking partner that meets the Internal Revenue Service (IRS) requirements (a bank, insurance company or other entity) as set out in the Treasury Reg. Secs. 1.408-2(e)(2) through (e)(5).
This account associates with the TIN designated for the ACO. Shared savings will be deposited directly to the account you indicated.

MEDICARE SHARED SAVINGS PROGRAM 2013 APPLICATION

- Complete the Electronic Funds Transfer (EFT) Authorization Agreement form (CMS Form 588; Use this CMS Form 588 tutorial for further guidance).
- We will not consider your application as complete until we get this form. Send your completed CMS Form 588, with your original signature and a voided check using tracked mail, such as certified mail, Federal Express or United Parcel Service, to:

Centers for Medicare & Medicaid Services
OFM/YSG/DFSE Mail Stop N3-04-07
7500 Security Blvd
Baltimore, MD 21244-1850
Attention: Ed Barands



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
- 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 23: Tips on Completing a Successful Application National Provider Call
 - Topics
 - Beneficiary assignment
 - Participant List
 - Agreements between ACOs and providers
 - [Registration information and complete call details](#)
- Save the date:
 - June 20: 2014 Application Overview National Provider Call
 - July 9: HPMS Submission
 - July 18: Application Process Q&A National Provider Call



Who to Contact for Assistance

- [Shared Savings Program Application](#) web page
- Questions related to your NOI submission or application process
SSPACO_Applications@cms.hhs.gov or Call: (410) 786-8084
- Questions related to your access to HPMS, Form CMS-20037, and/or CMS User ID (e.g. new access to HPMS, trouble finding the HPMS Web link)
HPMS_Access@cms.hhs.gov or (800) 220-2028
- Questions related to HPMS Log-In assistance (e.g., trouble logging into HPMS, password reset)
CMS_IT_Service_Desk@cms.hhs.gov or 1-800-562-1963



Questions?



Evaluate Your Experience with Today's National Provider Call

To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.

To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call from the menu.

All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

We appreciate your feedback!



Official CMS Information for
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Thank You

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

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



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