

This document has been edited for spelling and grammatical errors.

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program Application Process National Provider Call:
Preparing to Apply
Moderator: Leah Nguyen
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Contents

Announcements and Introduction	2
Presentation I	2
Introduction to the MSSP Application Process	2
Accountable Care Organizations and an Overview of the Medicare Shared Savings Program ..	3
ACO Organization and Governance	6
Other Program Issues	9
Keypad Polling.....	11
Presentation II	12
Application Process for January 2014	12
Question-and-Answer Session	15
Additional Information	28

Operator: At this time, I would like to welcome everyone to today's 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. I will now turn the call over to Leah Nguyen.

Please, go ahead, ma'am.

Announcements and Introduction

Leah Nguyen: I'm Leah Nguyen from the Provider Communications Group here at CMS, and I will serve as your moderator today. I would like to welcome you to this National Provider Call on the Medicare Shared Savings Program Application Process.

Today's National Provider Call is brought to you by the Medicare Learning Network [MLN]—your source for official information for health care professionals.

On October 20th, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program. This initiative will help providers participate in Accountable Care Organizations to improve quality of care for Medicare patients.

During this National Provider Call, CMS subject-matter experts will provide information on what you can do now to prepare for the Shared Savings Program application process for the January 1st, 2014, start date. This National Provider Call will include information on key dates, the Notice of Intent to Apply submission, and the first steps in submitting an application. A question-and-answer session will follow the presentation.

Before we get started, I have a few announcements. Links to the slide presentation, additional guidance for Shared Savings Program ACO applicants, and the merger and acquisitions FAQ document for today's call were e-mailed to all call registrants earlier this afternoon. These presentation materials can also be downloaded from the CMS MLN National Provider Calls Web page at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the Web page, select National Provider Calls and Events, then select the April 9th call from the list.

This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the MLN National Provider Calls Web page.

At this time, I would like to turn the call over to Tricia Rodgers, Deputy Director of the Performance-Based Payment Policy Group here at CMS.

Presentation I

Introduction to the MSSP Application Process

Tricia Rodgers: Thanks, Leah. Welcome to our first call for the 2014 applicants for the Medicare Shared Savings Program. My name is Tricia Rodgers, and I'll be going over with you today

information that will prepare you for the upcoming application phase for the next cycle of the program. So if you want to move to slide 6 of the presentation, I'll start there.

The 2014 application will be posted on the CMS Web site. There's a link for this in the presentation, or you can get there by going to www.cms.gov/sharedsavingsprogram and choose the Shared Savings Program application link at the left-hand side, and we'll be posting that in June of this year. We suggest that you take steps now to prepare yourself for the application phase.

The application requires several detailed narratives that you are required to submit, explaining the details of your Accountable Care Organization. Don't wait until July 1st to begin preparing your application.

Prior to submitting an application, you should establish your organizational structure; establish your leadership and governance structure; ensure all agreements with your ACO participants meet our requirements, are finalized, and signed. This is very important because as part of the application, you must provide us with a sample of your agreement with the ACO participants, a template listing all participants, and signed signature pages for all ACO participants. You should also establish a repayment mechanism if you have chosen Track 2.

We strongly encourage that you work on these elements immediately. These issues have historically taken a significant amount of time for previous applicants to complete. By working on these topics now, you will likely avoid many of the issues previous applicants have encountered. The time you spend now preparing for the application process will save you in the long run.

Before we discuss the application itself, we believe it's important that you – that we define for you and describe what we mean by Accountable Care Organizations.

So, I will turn the call over to Dr. Terri Postma on – who is in our group and who will speak to you about the definition of an ACO and the important elements you should focus on in order to become an ACO in the Medicare Shared Savings Program. Terri?

Accountable Care Organizations and an Overview of the Medicare Shared Savings Program

Terri Postma: Thanks, Tricia. Hi, everyone, and thanks for joining us today. My name is Terri Postma. I'm a medical officer in the Center for Medicare and the Performance-Based Payment Policy Group. I trained as a neurologist, but I've been real privileged to spend the last 3 years here at CMS working on the development and implementation of the Medicare Shared Savings Program.

I've been asked to take some time today to give an overview of the program and also emphasize some important elements that you should focus on now, as you develop your ACO and apply for participation.

I'll start on slide 8. By way of background, the concept of ACOs grew out of a number of different lines of research. One that was real important in informing the project was the Dartmouth Atlas Project work on geographic variations in cost and quality. That body of work demonstrated that more care does not equal better care. In fact, often the opposite is true.

Additionally, CMS had prior experience with ACO-like efforts through the Physician Group Practice [PGP] Demonstration Project, which showed promise as a model for improving the quality of care delivered to a Medicare fee-for-service population, while controlling growth and expenditures.

In the first 5 years of the demonstration, all 10 PGP participants demonstrated quality improvement, and 7 of the 10 groups shared in over \$100 million in savings. Additionally, MedPAC featured the ACO concept in its June 2009 report to Congress.

Congress drew from these experts and the CMS experience to establish the Medicare Shared Savings Program through the Affordable Care Act.

The Medicare Shared Savings Program is a voluntary program. It's an opportunity for providers to join together in what are known as Accountable Care Organizations, or ACOs. Participating providers and suppliers in the ACO will continue to bill and receive fee-for-service payments as they normally do. But at the end of each year, CMS will evaluate the ACO's quality and efficiency. If the ACO as a whole has met the quality performance standard and has reduced the growth in per capita costs for its fee-for-service population, the ACO will be eligible to receive a lump sum portion of the savings that it generated for Medicare. In turn, the ACO will allocate those savings to improve its infrastructure and reward participating providers.

Because the Shared Savings Program is a national program, its rules were developed through the CMS rulemaking process, which involved issuing a proposed rule, accepting public comments during a mandatory public comment period, and then issuing a final rule, which we did in the fall of 2011. We believe that the policies of the final rule are both improved and responsive to the over 1,300 comments we received.

Slide 9: Anyone who has been involved in our health care system, particularly you as providers know that our health care system is fragmented. It's really developed in separate pieces—a hospital over there, a clinic over here, a post-acute care setting, et cetera—without any conscious or well-designed connections among those pieces.

Fragmentation of payment, particularly fee-for-service payment, often reinforces this fragmented care. We believe that the Medicare Shared Savings Program represents a new approach to the delivery of health care in the fee-for-service setting. Its goal is to meet what our former administrator, Dr. Berwick, referred to as a three-part aim: that's better care for individuals, better health for populations, and lowering the growth in overall health care expenditures by promoting accountability for the care of Medicare fee-for-service beneficiaries, improving coordination for services provided under Medicare Parts A and B, and encouraging investment in infrastructure and redesigned care processes.

The program is built on the existing Medicare fee-for-service payment platform; it is not a managed care program or plan. Providers continue to bill Medicare and receive fee-for-service payments as they normally do. There is no lock-in of beneficiaries or providers; rather, this is an incentive program for fee-for-service providers to demonstrate that they can improve the quality and efficiency of care delivered to their fee-for-service population.

Slide 10: Dr. Berwick also articulated his vision of a well-functioning ACO. He often described how he envisioned ACOs reducing fragmented care by creating what he called “journeys of care” for beneficiaries. He believed that to do this, ACO should embrace the goals listed on this slide.

First and foremost: a goal of patient-centeredness. Also, ACOs should consciously seek to remember beneficiaries over time and place, and attend carefully to care transitions as the patient moves along the care continuum. ACOs should proactively manage the beneficiary’s care and collect and evaluate and use data to improve health care delivery and patient outcomes. And finally, ACOs should continually innovate and reinvent care in the modern age.

Slide 11: This slide demonstrates CMS’s integrated ACO strategy that creates multiple pathways for organizations to engage in Medicare ACOs.

On the left side of the slide, you see the Medicare Shared Savings Program implemented by the Affordable Care Act as a national program, developed by rulemaking by the Center for Medicare, on the fee-for-service side of the CMS. The rule finalized two tracks from which ACOs can choose to participate.

In Track 1, this is a 3-year agreement period, where the ACO receives shared savings, if they’re generated, and is not put at risk for losses. In Track 2, this is also a 3-year agreement period, where the ACO receives shared savings but is also responsible for paying back losses, if the average per capita cost of their population increases. For taking on this higher risk, ACOs are rewarded with a greater share in savings. We believe that the option of different tracks in the program creates an on-ramp for organizations in varying stages of readiness to take on performance-based risk.

On the right side of the slide shows the Pioneer ACO model.

We were very pleased when our colleagues in the Innovation Center decided to take up ACO testing and develop the Pioneer ACO model. Unlike the national program, this is a demonstration, so it’s not subject to rulemaking. Since we viewed the Shared Savings Program rules as a starting point for the national program, we’re looking forward to learning from the results of the Pioneer ACO model testing, and anticipate folding the innovative payment design into the national program over time.

You might have also heard about the Advance Payment model. To complement the Medicare Shared Savings Program, the Innovation Center developed an Advance Payment Initiative to provide additional financial assistance for certain rural and physician-only ACOs that qualified

to participate in the Shared Savings Program. This option was available for early adopters of the Medicare Shared Savings Program. It is no longer being offered to applicants.

Slide 12: Before I get into the details of the program, I'd like to review some definitions. These definitions are critical to an understanding of the Shared Savings Program rules and the guidance that we've posted on our Web site.

First, an ACO is a legal entity. It's formed by ACO participants, which are Medicare-enrolled billing taxpayer IDs, or TINs. ACO providers and suppliers are NPIs; that is, they are individual practitioners that have reassigned their billings to the TIN of an ACO participant.

Please make sure you read and understand the differences in these terms. Lack of understanding can negatively impact your ACO's ability to complete required documentation in the application and may lead to denial of your application.

For example, the application asks you to list the ACO participants and to submit the agreement your ACO has with each ACO participant. That means the ACO must have an agreement between the ACO legal business entity and the ACO participant legal business entity, not with an individual practitioner that is an ACO provider/supplier, or NPI, that bills through the TIN of the ACO participant. If the agreement is not made between the correct parties, the agreement will be rejected, and the practitioner may not be included in your ACO.

Slide 13: Some other critical definitions are listed on this slide. In particular, these definitions will be important for your understanding of assignment, which will be covered on the next provider call in detail, so I won't go into it here.

ACO Organization and Governance

Slide 14: An ACO must meet several statutory criteria in order to be eligible. First, the ACO must agree to participate for at least a 3-year period. The ACO organization is evaluated after each calendar year to determine whether it qualifies for an incentive payment. The ACO must define certain processes and demonstrate that it meets patient-centeredness. The ACO will submit narratives in its application to support these criteria.

Today and at the next provider call, we're going to focus on the four eligibility criteria your ACO must focus on now to prepare your application. Specifically, your ACO must have a formal legal structure. Your ACO must have a mechanism for shared governance and a leadership and management structure. Your ACO must have at least 5,000 beneficiaries assigned to it. And finally, your ACO must provide information about the ACO professionals that are participating, including the agreements your ACO has with each ACO participant.

Slide 15: I mentioned earlier that this program is for groups of providers and suppliers to join together to form what are called ACOs. This slide demonstrates the typical structure, but not the only structure, of a Shared Savings Program ACO, where a collection of participants—again, that's the Medicare-enrolled billing TINs—have joined together to create an ACO. ACO participants can be hospitals, multispecialty group clinics, primarily care clinics, solo practices,

pharmacies that bill Medicare directly, rural health centers, and virtually any legal entity that bills Medicare directly for services rendered to fee-for-service beneficiaries. The Medicare-enrolled billing TIN defines the ACO participants.

I want to talk a little bit about the legal entity. The eligibility requirement, you'll recall, is that the ACO must have a formal legal structure to receive and distribute shared savings and a mechanism for shared governance. You can find details of this in our final rule at 42 CFR §425.104. In particular, note that the legal structure of the ACO is evidenced by a TIN, a taxpayer ID.

If an ACO participant wants to form an ACO and can meet the eligibility requirements, it may use its existing legal entity and governing body to form an ACO. For example, a very large multispecialty group clinic might be able to qualify to be an ACO. But it must meet all other eligibility requirements—for example, having 5,000 beneficiaries assigned to it. Most ACO participants, however, will not be able to meet the eligibility requirements on their own. When this is the case, they may choose to join together to form an ACO.

Note that if the ACO is formed by multiple ACO participant TINs, then the ACO's legal entity must be separate and distinct from any of the ACO participants. A common application error we see is that the ACO legal entity is already existing but does not meet requirements. So please read this carefully and look at our Web site and the guidance posted there to make sure that you understand the structure of an ACO.

Slide 16, please. The statute requires that ACOs have enough primary care professionals for the assignment of at least 5,000 fee-for-service beneficiaries. We'll be using the ACO participant TINs to determine whether the ACO participants bill for at least 5,000 – bill for the required number of beneficiaries to be assigned. This means that whatever ACO participants join together to form the ACO, they must be billing for primary care services as those are defined in the rule.

Slide 17: I want to talk about the governing body a little bit more. This is a real important point to understand. The ACO's legal entity must have a governing body that is representative of the ACO participants and have meaningful beneficiary input. We've created requirements, such as 75 percent control over the governing body by the ACO participants. However, if an organization is unable to meet these criteria, we've built in flexibility for the ACO to describe how it will ensure meaningful representation by the ACO participants and meaningful input from beneficiaries.

According to the statute, the ACO must also have a leadership and management structure that includes clinical and administrative systems. In the final rule, we stated that the ACO's leadership and management must demonstrate an organizational commitment to the goals of the ACO, must have an experienced leadership team, which would include a medical director, and a qualified health professional leading its quality assurance and improvement process. Consideration will be given to ACOs that have innovative leadership and management structures and meet the goal of the ACO.

Some common errors we see in applications are that not – are that the applicant doesn't have enough ACO participants – ACO participant representation on the governing body—that is, they don't meet the 75 percent control over the governing body.

Another common error is that applicants don't demonstrate shared governance among ACO representatives—that is, sometimes applicants submit a governing body template that's overweighted with one ACO participant at the expense of others.

Also, applicants sometimes submit applications not having a beneficiary designated or appointed to the governing body or having a suitable alternative. ACOs may designate any fee-for-service beneficiary served by the practitioners in the ACO. It doesn't have to be a beneficiary that ultimately becomes assigned to the ACO.

Another common error in applications is that the control of the ACO resides with the parent or subsidiary organization and not with the ACO legal entity. The control of the ACO must reside with the ACO legal entity and its governing body.

And finally, another common error that can set applicants back is that the applicant's governing body does not have a fiduciary duty to the ACO alone. Particularly vulnerable are existing organizations, such as IPAs, that attempt to apply with a subset of practices, rather than with all their practices.

I strongly encourage you to review the guidance on our Web site and our final – sorry, our final rule for more information on the requirements for your ACO's governance, leadership, and management, and to have this prepared and in place in advance of your application.

Slide 18: As previously mentioned, in order to participate, the ACO must be willing to be accountable for the Medicare fee-for-service population CMS assigns to it. Again, I want to emphasize that unlike a managed care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see, regardless of whether that practitioner is participating in the ACO or not.

Because of this, when we refer to *assignment*, what we're really talking about is the operational necessity of defining a population unique to the ACO for purposes of determining whether the ACO has met the standards necessary during a performance year to receive a shared savings payment for improving the quality and efficiency of care delivery.

We'll be implementing a preliminary prospective assignment with retrospective reconciliation. What this means is that we'll be performing a look-back at the performance year to determine what beneficiaries chose to receive a plurality of their care from the ACO practitioners, but we'll also be providing the ACO with information along the way—that is, a preliminary prospective list of beneficiaries—to help them better understand their fee-for-service population their providers care for. We believe this creates an incentive for ACOs to standardize care processes for all Medicare fee-for-service beneficiaries, treating them all the same, while also aiding ACOs in understanding their patient populations and proactively redesigning care processes for them.

I'm on slide 19 now. CMS assigns beneficiaries in a two-step process that will be described in detail on the next provider call. Note that not all the fee-for-service beneficiaries in a practice's panel will be assigned. The beneficiary must have received a plurality of primary care services by the ACO as a whole during the previous 12 months in order to be assigned.

Other Program Issues

Slide 20: This next part of the talk, I'll just focus on some additional programmatic rules and issues.

Slide 21: The statute states that if a provider or supplier is participating in another initiative involving shared savings, they may not also participate in the Shared Savings Program.

We've identified several existing initiatives involving shared savings. They're listed on the slide and also in your applications. The ACO participants submitted by the ACO will be screened during the application review. If any of the ACO participant TINs is in one of the programs, your application may be denied.

Slide 22: CMS will share data with ACOs under certain circumstances: 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 continue – contain a list of the beneficiaries used to generate the report. Also, beneficiary-identifiable claims data can be provided for patients seen by ACO primary care providers, who – once they've been notified and not declined to have their data shared.

Slide 23: Patient engagement and shared decisionmaking are important aspects of the Shared Savings Program. We believe this initiative will work best when patients are true partners with their practitioners.

To facilitate the transparency of the program, the ACO participants must notify beneficiaries that they are participating in the program. Beneficiaries will also receive general information about the program through the *Medicare & You* handbook. Marketing guidelines have been established. And, of course, as I mentioned previously, ACOs are required to offer beneficiaries the opportunity to decline data sharing before requesting their claims data.

Monitoring in this program has taken on heightened importance, particularly in light of the relaxation of CMP referral and kickback rules through the OIG–CMS joint labor.

Slide 24: Quality is another very important part of this initiative. The ACO cannot share in savings, even if they've been generated, without first meeting the quality performance standard. We've finalized a set of 33 measures that support this three-part aim focusing on better care and better health. The four domains are listed there: preventive health, at-risk and frail elderly populations, patient and caregiver experience of care, care coordination and patient safety.

Measures were chosen based on their ability to address high prevalence conditions, patient safety and prevention, chronic ambulatory conditions, care coordination, and patient experience of care.

Measures align with other incentive program such as PQRS and the EHR Meaningful Use Initiative.

Slide 25: Consistent with the statute, measures include process, outcome, and patient experience of care measures, and are derived and collected from claims data, survey data, and medical records. The quality performance standard is phased in over the course of the agreement period. In the first performance year, the quality performance standard is defined as full and complete reporting. If the ACO reports on all measures, it will qualify for the maximum sharing percentage. In the second performance year, about half the measures will be pay-for-performance. And finally, in the third year, nearly all measures will be pay-for-performance, and the ACO's sharing rate will be based on a sliding scale on how they perform.

I want to emphasize the importance of quality reporting and remind you that it's extremely important that the ACO participants joining together understand the program and commit to the ACO. The operations for a performance year are based on the list of ACO participants that is certified by your ACO at the beginning of each performance year, including beneficiary assignment, which is then used to generate the sample for quality reporting.

One tip I would give applicants is that we've seen some ACOs have met the requirements to enter the program, but because their ACO participants weren't well educated or committed to their ACO, they've had trouble implementing care processes and quality reporting. Don't let this happen to you. It may be better to wait a year and get your ACO's ducks in a row than risk failure because you rushed through the development process.

Slide 26: In any year that the ACO reports the GPRO measures fully, the eligible professionals in the ACO will automatically qualify for a PQRS incentive payment or avoid the PQRS payment adjustment. This eliminates the necessity of duplicate reporting and reduces burdens for the participants.

Slide 27: The benchmark is established by taking the claims submitted by ACO participants, assigning beneficiaries to the ACO in each of the three benchmark years, calculating the average per capita cost of the population for each benchmark year, and then rolling it up to establish a 3-year average per capita cost for the ACO's average fee-for-service population.

The benchmark is risk-adjusted and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services. Performance year risk-adjusted expenditures are then compared to the benchmark. ACOs may share in savings, if they qualify based on their quality performance, and the performance year per capita expenditures meet or exceed the minimum savings rate, or MSR, below the benchmark. The MSR is designed to take normal variation into account. The ACO then shares from first dollar from the benchmark.

As I mentioned earlier, the ACOs will have the opportunity to choose between one of two tracks. Under Track 1, the ACOs have the opportunity to share in savings but not be put at risk for losses. The maximum sharing rate under this one-sided model is 50 percent, with a 10 percent cap on shared savings. The minimum savings rate is variable, depending on the number of assigned beneficiaries. Once met or exceeded, the ACO shares from first dollar.

Under Track 2, the ACOs have an opportunity to share in savings and be put at risk for losses, but in return for a higher sharing rate, a maximum of 50 percent, and a higher sharing cap of 15 percent of the benchmark. Losses will be calculated to take into account quality performance, such that higher quality performance will protect ACOs from shared losses.

The MSR is fixed at 2 percent on both the up and down sides. Once met or exceeded, the ACO will share savings or losses from first dollar.

Slide 28: I want to remind folks that this was part of a coordinated interagency effort. CMS worked with FTC and DOJ antitrust agencies as well as the IRS and the OIG to bring this program to fruition. The antitrust agencies have concurrently released an antitrust policy statement that complements that final rule. It addresses stakeholder antitrust concerns and offers a voluntary expedited antitrust review and guidance on avoiding running afoul of antitrust laws for newly formed ACOs that wish to participate in the program.

The IRS released a response to comments for those tax-exempt entities that wish to participate. And the OIG jointly with CMS issued an interim final rule with comments regarding CMP, kickback, and referrals for ACOs. These documents can all be found on our Web site, and I encourage you to review them closely.

With that, I'll turn it back over to Leah.

Keypad Polling

Leah Nguyen: Thank you, Dr. Postma. At this time we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note: There will be a few moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office using only one line.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Thank you. And this does conclude the polling session of today's conference call. I'll now turn the call back to Leah Nguyen.

Lean Nguyen: Thank you, Holley. I will now turn the call back over to Tricia Rodgers, who will discuss the application process for January 2014.

Presentation II

Application Process for January 2014

Tricia Rodgers: Thanks. So, we're going to move forward starting with slide 30.

So in order to get started with your application, you must be aware of the key dates of our – for our process. Understand that we are required to start each new cycle on January 1st, so it's imperative that we meet all of our deadlines to be in compliance with the law.

I will go through each of the steps more thoroughly in a moment. But before then, you need to focus on the key dates for submitting an application.

So before you submit an application, you must first submit a Notice of Intent to Apply, or NOI. We will make this available on our Web site, and we will accept online submissions from May 1st to May 30th.

Following the NOI submission, you should submit your CMS user ID forms for all individuals who may submit an application and for those who may utilize CMS data if your ACO is approved.

These forms must be submitted by June 10th, 2013. We would like to emphasize that this step should be taken immediately upon receiving your ACO ID number, which is included in your NOI receipt notice e-mail. Directions on completing the CMS user ID access are also included in this e-mail. Since it can take 3 to 4 weeks for us to process user ID requests, we again stress the importance of completing this step as soon as possible.

Additionally, if you previously submitted an application for the Medicare Shared Savings Program and your application was either denied or withdrawn, you must complete the process again from the beginning. This means that you must submit a 2014 NOI and receive a new ACO ID. After this has been completed, you must submit a 2014 application using the templates and responding to the questions in this application. We will not evaluate any previous submission.

We will accept applications from July 1st through July 31st, and we will issue application dispositions in the fall of 2013. If an applicant is denied and would like to seek re-consideration, the applicant will have up to 2 weeks after the final determinations are issued to request a review of that denial.

Moving on to slide 31: In order to make the application process easier and more efficient, we developed the application toolkit. This toolkit gives you precise directions and examples of supporting documents that are integral parts of the application. The toolkit includes a regulation

reference page, additional guidance, and FAQs for each question in the application, [and] a form CMS-588, which is the Electronic Funds Transfer, or EFT, Authorization Agreement. It includes the ACO Participant List Template, the Governing Body Template, the ACO Participant Agreement Template, and the Executed Agreements Template. And Terri talked about those earlier in the presentation.

On slide 32 now: As I mentioned before, your first step in the application process is to prepare and submit your Notice of Intent to Apply. Once we post that, and we expect to do that soon, you may access the NOI on our Web site at the – there's a link in your – on your slide, or you can go to the www.cms.gov/sharedsavingsprogram and choose – select from the Application link at the left-hand side. And then Step 1 on that page will direct you to the link for the NOI. Again, we will post this soon, and we will accept NOIs from May 1st through May 31st.

After you submit your NOI, you will receive an NOI receipt notice by e-mail. We will send this e-mail to the primary and secondary application contacts listed on the NOI. The NOI receipt notice e-mail will include your ACO identification number, or ACO ID, and instructions on obtaining CMS user IDs. It's important to know that submitting a Notice of Intent to Apply does not bind you to submit an application; however, you must submit an NOI prior to submitting an application.

Slide 33: Your NOI receipt notice will provide you with detailed instructions about how to access and fill out the CMS Form 20037 for the application for access to CMS computer systems. This is the form you need – you will need to fill out to get a CMS user ID. Follow the instructions exactly as they appear in the NOI receipt notice. This step is critical in order to process your request successfully.

If you are applying for a new CMS user ID, you must fill out the specified form in your Notice of Intent receipt notice and return the completed form to CMS via tracked mail, such as FedEx, within 3 business days of receiving your NOI receipt and no later than June 10th.

The form should be sent to Centers for Medicare & Medicaid Services, Attention: Adam Foltz, 7500 Security Boulevard, Mail Stop C4-18-13, Baltimore, MD 21244.

Please note that your ACO must have at least four CMS users. Each individual's form must include the requestor's Social Security Number, ACO ID, date, and original signature on that form. Again, we stress it takes up to 3 to 4 weeks to process the CMS user access request, so it's critical that you do this step as soon as possible. CMS user IDs are necessary to submit your final application.

On slide 34, we talk about if one of your – if your CMS user IDs – that your CMS user IDs are unique to an individual, not to the ACO applicant. And if one of your contacts has an existing CMS ID, that person should submit an e-mail to the application mailbox and – to the mailbox and indicate that CMS user ID is affiliated with an authorized applicant ACO ID.

If your – one of your contacts is a consultant, please include an authorized letter from the ACO applicant, which authorizes the consultant to request, receive, and submit access – and gain

access to the ACO's data maintained in our CMS system. The letter should include – the information there on the slide including submitted – being submitted on your ACO's official letterhead indicating the consultant's name and the State that he/she will be serving as a consultant on behalf of the ACO, the authorized ACO ID number that the consultant would have access to, and it must be signed by the ACO's authorizing official.

If a consultant is working with multiple ACOs, you may send a single e-mail. Please send any of these e-mails—that is, for consultants, or if you have someone who already has a CMS ID—please send all of these e-mail requests to the hpms_access@cms.hhs.gov. And again, you would – you could send multiple PDF attachments for each separate ACO. These instructions will be included in your NOI receipt confirmation e-mail.

Slide 35: It is fraudulent to use another user's CMS access or to allow someone else to use your CMS access, and we will terminate individual CMS user's access if we find this is happening, so please request access for each individual.

Slide 36: So this – everything comes down to this slide. It's the money slide. In order to get paid, you must submit a completed CMS Form 588, Electronic Funds Transfer Authorization Agreement with your application. This form – you might hear us talk about it as the EFT form, Form 588, or the banking form.

Slide 37 goes into more detail, and we validate the banking information before any EFT deposits are made, and we recommend that as soon as your ACO is formed and prior to submitting a Shared Savings Program application, you should establish a validated account and set up an active checking account using your ACO's legal business name and TIN. Your ACO legal business name and TIN must match the information we have on file with your application, the CMS Form 588, and that of your financial institution. You will not receive any funds if this information does not match. If there are any errors, our office of financial management will notify the contact person on the CMS Form 588 to ask for corrected information. If your ACO's TIN or legal business name changes, you must notify us as soon as possible through the sspaco_applications@cms.hhs.gov e-mail box. That – there's information on that in the presentation as well.

During the application process, you must submit the CMS Form 588 to us via tracked mail at the same time you are submitting the application. Please send your form to the Centers for Medicare & Medicaid Services, Attention: Jonnice McQuay, Location C4-02-02, 7500 Security Boulevard, Mail Stop C5-15-12, and that's Baltimore, MD 21244.

Our applications – your applications are considered incomplete without that CMS Form 588, so please remember to send that in - in addition to submitting your application online. The information and instructions are also in the application toolkit, which you can find online.

I'm on slide 38 now. We've been through a lot of information and I will recap some of the important things. The first thing is to act early. Submit and complete all of the steps as early as possible according to the timeframe provided. List at least four contacts, the secondary – the primary and secondary application, contacts, and primary and secondary IT contacts for your

ACO's application. These contacts must be available through the entire process, starting with the NOI and through the disposition. So that is from May until late fall of 2013 we need to be able to contact these folks.

All correspondence between the ACO applicant and CMS must include your ACO ID and your legal business name. Remember to never share any CMS user IDs or passwords, and please contact us with applications questions at the sspaco_applications@cms.hhs.gov.

I'm on slide 39 now. And we have some upcoming application calls. Terri mentioned a couple. On Tuesday, April 23rd, please join us for our next Shared Savings Program Application Process National Provider Call. Complete details and registration information are available on our Web page, and also on the National Provider Call Web page that Leah mentioned. There are slides in the back – or there – on the slide in the back of the presentation there's information on how to get to those.

On the call on the 23rd we will address specifically more intricate issues associated with your application, focusing on beneficiary assignment, your participant list, and the agreements between ACOs and the providers. Our subject-matter experts will explain these topics so that you can better prepare for the application process. Since these have been the most complicated issues in past cycles, we believe that this information we provide on the call, coupled with lead time that you have now, will give you the opportunity to have a successful and efficient application process. Please mark your calendars for the upcoming application calls that we plan to provide throughout your application cycle for 2014.

Again, April 23rd is the second part of the application preparation. On June 20th, we will have an application overview, and the application will be posted by that time, and we will go through the steps of completing it. Then on July 9th we will have a call on our HPMS submission. We will walk you through using the HPMS and how to successfully submit an application online. And then July 18th will be an open Q&A time. It will be in the middle of our application cycle, and we will answer your questions that you have about the application at that time. In addition, you could send questions through the application mailbox.

Slide 40 shows who to contact for assistance. You can certainly go to the Shared Savings Program Application Web page and monitor that, as we will be putting new information up there, and that is where you can go to download and start your process with the Notice of Intent to Apply, and then back to that for any questions or future updates. If you have questions regarding the application process, you can contact us at the sspaco_applications@cms.hhs.gov mailbox, or you can leave a voicemail message at 410-786-8084.

So this concludes the preparation – or the prepared portion of our application call. Thank you for your attention. I will turn it back over to Leah to open the lines for questions.

Question-and-Answer Session

Leah Nguyen: Thank you, Tricia. Our subject-matter experts will now take your questions about the Shared Savings Program application process. Before we begin, I would like to remind

everyone that this call is being recorded and transcribed. Before asking your question, please state 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. If you'd like to ask a followup question, or have more than one question, you may press star 1 to get back into the queue, and we'll address these additional questions as time permits. All right, Holley, we're ready to take our first question.

Operator: All right. 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 remember to pick up your handset before asking your question to ensure clarity. And please note: Your line will remain open during the time you're asking your questions, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

Again, please continue to hold while we compile the Q&A roster.

Again, if you'd like to ask a question, press star followed by the number 1 on your touchtone phone.

And your first question comes from the line of Family Caregiving.

Family Caregiving: How important is Electronic Health Reporting to becoming partners with an ACO?

Tricia Rodgers: I'm sorry. Can you repeat the question one more time?

Family Caregiving: How important is Electronic Health Reporting, EHR, to becoming partners with an ACO?

Tricia Rodgers: Is the question more like – more about “Must you have Electronic Health Records in order to be an ACO?”

Family Caregiving: Yes. Yes.

Terri Postma: This is Terri. EHR is important for ACOs to develop, but they're not a requirement, although it is highly encouraged in the rule and there is – one of our measures measures the number of providers that qualified for an EHR Meaningful Use incentive payment as part of our evaluation of quality for the ACO.

Family Caregiving: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jan Gillespie.

Jan Gillespie: Hi, this is from Northern Colorado IPA, and I was wondering if you could clarify the – if IPAs can function as the ACO? And what would exclude them from that role?

Terri Postma: Yes, this is Terri. I'd like to refer you to – in particular, anyone who's thinking about using an existing legal entity as their ACO legal entity, and existing governing body as the ACO's governing body—I'd like to refer to our Web site guidance. It's at www.cms.gov/sharedsavingsprogram (all one word, forward slash). And on the left-hand side, you'll see a tab that says – or a link for “guidance,” and the first guidance that we have there on that page is a memo that we issued last year in March, where it talks about additional guidance for Shared Savings Program ACO applicants. And in particular, it talks about a number of the issues that I touched on today, about the legal governing body – sorry, legal entity of the ACO and the governing body.

One thing that I flagged for your attention in particular (I think this is what you're referencing) is that we're finding that existing organizations are having trouble, in some cases, meeting the requirement that the governing body have fiduciary responsibility to the ACO alone and not to any other individual or entity. So if an existing – if there's an existing entity such as an IPA that represents many group practices that wants to apply as an ACO using its existing legal structure and governing body, each group practice represented by the ACO must agree to be an ACO participant, and each provider and supplier within each of those group practices must agree to be ACO provider/suppliers.

So if only some of the representative groups – group practices want to become ACO participants, then the IPA cannot use its existing legal structure and governing body for the ACO because it can't meet the regulatory requirement including the fiduciary duty requirement. If only some of the group practices, providers, and suppliers agree to be ACO providers and suppliers, then that group practice can't be an ACO participant.

So, in summary, the ACO's governing body decisions have to be independent from influence of interests that may conflict with the ACO's interests, including the interests of group practices that are not participating in the ACO but continue to be represented by the IPA for other purposes, such as commercial contracting.

So take a look at that guidance. Look it over real carefully. We have a number of IPAs or organizations that are subsidiaries of IPAs that were developed solely for purposes of participating in the Shared Savings Program. So often the IPAs, though, are contracting with the ACO legal entity as another entity—that is, they are providing or performing services, rendering services on behalf of the ACO, but the IPA itself is not the ACO.

Leah Nguyen: Thank you.

Jan Gillespie: The specialists in the IPA, since they can't be a part of the ACO, does that automatically create a conflict?

Terri Postma: Specialists can be part of an ACO. So any Medicare-enrolled entity, any Medicare-enrolled TIN, such as a group practice or multispecialty group practice, or a hospital, et cetera, can be an ACO participant. So any entities that the IPA – let's say that the IPA sets up a separate legal entity to be the ACO – to be the ACO legal entity and – because a subset of the practices that the IPA contracts with wants to be an ACO. So that separate entity, then, would become the ACO legal entity. And it would have direct contract with the practices, the ACO participants, right? And it would also have a contract with the IPA perhaps, if the IPA is rendering services on behalf of the ACO. But the point is that the ACO legal entity and governing body have to have a fiduciary duty to the ACO, and that means that anyone contracting with the ACO has to agree to participate in the program and comply with the program regulations.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Marie Ramirez.

Marie Ramirez: Yes. Hi, good afternoon. In the first portion of the presentation, the comment was made by the presenter that the Advance Payment, which was a complement to the MSSP—it is no longer to be offered. Is this for sure?

Tricia Rodgers: Yes. The Advance Payment application cycle, the last one was for 2013 – for a 2013 start date, so they're no longer offering that extra startup fund for the Shared Savings Program.

Marie Ramirez: So the 2014 will have to fund their own ACOs? Is that what you're saying? They will not be . . .

Tricia Rodgers: Correct. There is no application for this year – for the Advance Pay – Advance Payment model in 2014.

Marie Ramirez: For 2014? All right. Thank you.

Tricia Rodgers: Thank you.

Operator: Your next question comes from the line of Marcellis Pena.

Marcellis Pena: Hi. I'm calling in regards to the – trying to understand the ACO structure that you have on the slide—the ACO participants and the ACO providers/suppliers. Where would home health fall in any of that?

Terri Postma: This is Terri. If the home health organization has a Medicare-enrolled TIN and bills Medicare for services rendered to fee-for-service beneficiaries, then the home health organization would be considered an ACO participant, and any practitioners that billed through the TIN of that home health agency would be considered ACO providers/suppliers.

Marcellis Pena: OK. All right, great. Thank you.

Terri Postma: Thank you.

Operator: And your next question comes from the line of Francisco Trilla.

Francisco Trilla: I'm with Redwood Coalition. It's an FQHC ACO. My question is on attribution, and I know you're going to address that in the future. What is the exact time period for attribution that you'll be utilizing for this year, for 2014?

Tricia Rodgers: For 2014 starters, assignment will occur for benchmarking purposes in—let's see, I have to work this backwards—2011, 2012, and 2013, the 3 prior calendar years. And then beginning in 2014, the first performance year will be calendar year 2014, and the retrospective reconciliation and assignment will occur on calendar year 2014. Similarly, with performance year 2 being 2015, and performance year 3 2016—same thing, it will be retrospective reconciliation and assignment based on calendar years 2015 and 2016.

Francisco Trilla: And that's helpful. And just a comment, not a second question: A lot of the FQHCs have many nurse practitioners and PAs. I understand that a physician needs to see them for attribution. So, as we're moving towards 2014, we want to make sure that we're complying with that.

Tricia Rodgers: OK. Thank you.

Francisco Trilla: Thank you.

Operator: Your next question comes from the line of Michael Andrews.

Michael Andrews: Hello and good afternoon. As a consultant, what would you recommend the first – or the primary steps be to assist small physician practices in becoming an ACO or developing an ACO?

Terri Postma: This is Terri. Just anecdotally, what I have observed is that small group practices that want to join together to form an ACO often are very enthusiastic but lack the infrastructure to be able to participate. So that's where consultants can really come into play and be very helpful in helping them set up the infrastructure necessary to participate, helping them get organized, understanding the rules, understanding the – financial aspects, the quality reporting aspects, all those things. Helping to educate them on the program rules is all – are all places where consultants can assist.

The same thing goes for existing structures like IPAs or existing health structures or systems that want to bring in providers or join providers together to participate. I find that that education piece is very, very important. Most providers, like I said earlier in the talk, understand how fragmented the system can be and frustrating for beneficiaries, and so giving them the infrastructure that they need to better coordinate their beneficiaries' care and engage with them as partners is something that, at least with my physician hat on, speaking, is something that I always enjoy doing, and I have been hearing from other providers that they enjoy that as well.

Leah Nguyen: Thank you.

Operator: And your next question comes from the line of David Brady.

David Brady: Hi, this is – I'm calling from Northwestern Memorial in Chicago. My question regard – is in regards to the application toolkit. You mentioned on there, there's forms, and it spells out the electronic funds transfers, but what other forms are included in the toolkit? And where is the toolkit – can it be found?

Tricia Rodgers: Thank you for that question. The toolkit—we have not posted the toolkit for the 2014 cycle; however, the toolkit for the 2013 cycle is posted on the Shared Savings Program Web page under the Application link, and it has things such as how to fill out the – helpful hints on filling out the application. It has information about the other forms that you need to complete the application, some of the templates that you will need to complete the application. It has the 588 form for the EFT, the Participant List Template, the Governing Body Template, the Executive Agreement Template, and all of the FAQs and guidance for referencing our regulations to help complete your application.

We will – we intend to post that soon, so please keep checking that on the Web site, but you can look at the 2013 kit that's there now. The 2014 kit won't be changing significantly from that.

David Brady: Great. Thank you very much.

Tricia Rodgers: You're welcome. Thank you.

Operator: Your next question comes from the line of Paul Kitchen.

Paul Kitchen: Hi. Yes, I wanted to ask if you'd refer to—and I'm looking specifically on slide 6, some of the sample agreements and templates, and it was a little bit addressed in the last question. Do you have any – if they're not included, could you think about including some of these boilerplate-like agreements to help? I mean, I think it would help you to assess some – if it works for us without having to generate one-off things trying to accomplish the same purpose. And also if it would serve your purpose and we don't need to change for our purposes, again, it would seem like it would help. Anyway, that's a request.

Tricia Rodgers: Thank you for that. We will talk about that and see if we can put something up to help folks out.

Paul Kitchen: Great.

Terri Postma: The next call, we are going to be going over the requirements, specifically the things, the elements that must be present in the agreement, and providing some helpful hints for what the agreement should include.

Operator: And your next question comes from the line of Susan Harrington.

Susan Harrington: Yes, hi, Can you tell me if you have a current association with the ACO, how soon after stopping that association can you start another one with this shared savings?

Tricia Rodgers: If an ACO terminates or if CMS terminates an ACO, that ACO would need to wait until the end of the first agreement period, which is either 3 – or if it's in the April or July starters, a little bit longer than 3-year agreement period. If a participant TIN comes out of an ACO, they can go – they can form or join another ACO without waiting. But an actual ACO, a full ACO termination or withdrawal would have to wait the full agreement period time before they can apply again.

Susan Harrington: Thank you.

Tricia Rodgers: You're welcome. Thank you.

Operator: And your next question comes from the line of Fernando Mata.

Fernando Mata: Hi, my name is Fernando Mata. I'm from Kings Home Healthcare. I have a question regarding home health. Someone had spoke – or asked a question regarding the ACO participants. But how does that – how are we associated with the ACO organization? Do we have to sign an agreement with these organizations? Or what is the role regarding home health?

Terri Postma: Regardless of whether your organization is a home health entity or another Medicare-enrolled entity like a hospital or a SNF or something like that, if that entity is Medicare-enrolled and bills Medicare directly for services rendered to beneficiaries, then that entity would be considered an ACO participant. ACO participants are the ones that join together to form the ACO. If there are multiple ACO participants, there must be a separate legal entity as the ACO. If there's only one ACO participant that's large enough and bills enough that can be the ACO on its own, that's possible, but it's got to be pretty large and meet all the requirements in the rule and they're – most of the ACOs are formed by multiple ACO participants joining together and forming that separate ACO legal entity.

There have to be agreements some place; there must be an agreement between the ACO and the ACO participant directly. The agreement must contain certain requirements in the agreement, and we'll go over those more on the next call. But – so if the entity is Medicare-enrolled and has a Medicare-enrolled billing TIN, and bills Medicare directly for services, then that entity can be considered an ACO participant and join together with ACO participants and have an agreement with an ACO.

Fernando Mata: OK. Thank you.

Operator: And your next question comes from the line of Charles Duncan.

Charles Duncan: Hi, I'm with Cumberland Healthcare PPO. We are interested in knowing what we need to have our board and attorneys addressing to prepare for the Notice of Intent, the first step. Could you tell us what is required on the Notice of Intent?

Tricia Rodgers: The Notice of Intent is eight questions, and it has the ACO legal name, the address, the TIN, the date of formation, and the application contact, and your tax status. And again, we expect that . . .

Charles Duncan: There is a . . .

Tricia Rodgers: . . . we expect to have that posted soon on the Web site. And then, May 1st through 31st, you can complete that.

Charles Duncan: All right. Thank you so much.

Tricia Rodgers: Thank you.

Operator: Your next question comes from the line of Eric Bouchard.

Eric Bouchard: Yes, hello, this is Dr. Bouchard from Tallahassee and Southern Medical Group. I have a question. I'm trying to grasp this infrastructure and the participant list. Now, I'm a primary care provider, and you say anyone who's got a Medicare TIN can be a participant. Does this ACO have to make agreements between cardiologists, urologists, a home health agency, hospitals? Or is it just the primary care physicians that have these, say, these 5,000 Medicare patients that are the required participants? I'm just trying to grasp what is the participant list?

Terri Postma: Yes, thanks for that question. We're going to go over this in a great amount of detail in the next call. But to just give you a little preview, we talked in this talk about who – the definition of an ACO participant and then the ACO providers/suppliers, or the NPIs, are the practitioners that bill through the TIN of the ACO participant. And as far as the agreements go, ACOs must have an agreement in place between – *directly* between the ACO legal entity and the ACO participant legal entity.

So let's say you're part of a multispecialty group practice where there's some primary care practitioners and some specialists. The multispecialty group practice would be the ACO participant. And so the clinic would make an agreement directly between itself and the ACO legal entity. Now, in order to do that, every one of the practitioners that bill through that clinic's TIN also have to agree to participate and comply with the program rules.

And part of the reason that it's structured this way is because operationally what happens here is that we take all the billings associated with each ACO participant and put them in a pool and create the assignment for the ACO. So operationally, everything is keying off the ACO participant list, and that's why it's so very important for you all to understand the definition of an ACO participant and make sure that the contracting structure is correct for that.

So thanks for asking that question, and we're going to go into a great amount of detail on that particular point on the next call.

Eric Bouchard: Now, the next call you mean is April 23rd?

Terri Postma: Correct.

Eric Bouchard: OK. And when you say “assigned,” so that means – so, if the primary care is taking care of the patient beneficiary and the cardiologist does a billing, does the cardiologist get rewarded in that process?

Terri Postma: So, again, the ACO is formed by the ACO participants. So, let’s say again it’s that multispecialty group practice. And all the providers and suppliers – all the practitioners, whether they are primary care or cardiology, that bill through the TIN of the ACO participant have also agreed to participate and comply, then we’re taking all those billings into account regardless of who is providing the service.

And then, all the ACO participants that have joined together were taking the billings of all of those participants together, considering them as a whole, because they’re what form the ACO. And then the assignment is based on a plurality of the primary care services rendered to the beneficiaries that are seen by the ACO as a whole—that collective pool of billings from each of the ACO participants.

Eric Bouchard: But what if the beneficiary goes outside those patients in the participant list? Like, say, they go to another hospital or another person that hasn’t had a contract made? Or can we make a contract and book them in the future as they pop up? I don’t know.

Terri Postma: Yes. And they do. Because, remember, these are fee-for-service beneficiaries. The ACO isn’t a – it’s not a managed care plan, there’s no lock in of the beneficiaries, there’s no requirement that the beneficiaries have to stay within that group of practitioners. So it is very likely that those beneficiaries will be seeing practitioners or getting health care services outside of the ACO practitioners.

And so part of the challenge of the ACO is to coordinate care for that beneficiary, regardless of whether that beneficiary is getting services from the practitioners within the ACO or frequenting a hospital that happens not to be part of the ACO. And that’s part of the care coordination strategy that your ACO’s going to have to think about.

So – but remember that the beneficiary ultimately gets assigned based on where they chose to receive a plurality of their care, and the reason that we’re looking at that is because we want to hold the ACO’s accountable only for beneficiaries that they had the opportunity to impact their care during the course of the year.

Eric Bouchard: Thank you very much.

Operator: Your next question comes from – comes from the line of Peter Brawer.

Peter Brawer: Hello. This is Peter Brawer from SSM Health Care. We are a multistate health care organization, and so could you address the possibility of creating a multistate ACO? And what are the potential barriers to going cross-state?

Terri Postma: Yes, thanks for that question. The rule doesn't address geography. So there isn't – from the rule's perspective, there's no reason why and ACO can't cross States. But I would point you to a part of the rule where we talk about the ACO legal entity, which says “an ACO must be a legal entity, formed under applicable State, Federal, or Tribal law, and authorized to conduct business in each State in which it operates” [42 CFR §425.104(a)]. So, as you're thinking of forming your ACO, be aware of that, and – but otherwise, the final rule doesn't address geography.

Peter Brawer: Thanks so much.

Operator: Your next question comes from the line of Vicki Bloom.

Vicki Bloom: We're a solo practitioner, and I was just want – making sure that you have mandatory participation in an ACO?

Tricia Rodgers: No, this is completely a voluntary program.

Vicki Bloom: And it will be forever?

Tricia Rodgers: It's – it's voluntary in statute. So unless Congress changes that, then it's up to you whether you want to participate in an ACO or not.

Vicki Bloom: OK. Thank you.

Tricia Rodgers: You're welcome, thank you.

Operator: Your next question comes from the line of Mickey Duke.

Mickey Duke: Good afternoon. There are quite a few ACOs that are underway. Do we have access to best-practice examples of governance agreements, or provider agreements, or compliance plans, for example? How public are our submission documents?

Tricia Rodgers: So right now we're working on providing information each ACO needs to report certain information about their ACO. And we're in the process of getting that set up with the 220 ACOs that are currently in operation. And that information will be – most ACOs are putting it on a Web site. And if you look in our final rule—it's section 425.308—and you'll see everything that they need to provide under that reporting requirement. It's things like the ACO, the participant TIN, the governance, body, and structure, things of that nature. And then you could check on the ACO's Web site for that. There's also a contacts listed for each ACO on our Web site – each current ACO. And if you feel compelled to reach to one of those – a few of those ACOs, they might be interested in sharing some information with you. It's certainly not a requirement but it doesn't ever hurt to ask.

Mickey Duke: All right. Thank you very much.

Tricia Rodgers: Thank you.

Operator: Your next question comes from the line of Theresa Burkhart.

Theresa Burkhart: Hi. Thank you. Just a quick question about the participant list that we submit in the application: What if the participants change after the application is submitted between – if we are approved – between that point and January? Would there be a point in time we could update the list? And would the patient attribution be re-run?

Tricia Rodgers: Thanks for that question. So, we would hope that any agreements that you make with participant TINs would be firm and final, but we understand that some things might change. And, there is process for you to change that – to delete and/or add participant TINs in the future. There's actually information on our Web site. There's guidance there on adding and dropping participant TINs. I would encourage you to look at that. It's on the Shared Savings Program Web site.

And then our assignment lists, our preliminary prospective assignment lists are updated quarterly for each ACO. So you get a running list each quarter that takes into account deleted TINs. Any new TINs that would come on – participant TINs that would come on during a performance year would not be included until the following performance year. And all of that information is in the guidance.

Theresa Burkhart: So if the new TINs came on between, say, July and January, would we be able to add those on?

Tricia Rodgers: We will be looking at what is in your application to start for January 2014.

Theresa Burkhart: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Dr. Barkat Jaferi.

Dr. Jaferi Yes, one second. Here, it's for you.

Barkat Jaferi: Hello?

Tricia Rodgers: Hi. Go ahead.

Barkat Jaferi: Yes. This is Dr. Barkat Jaferi from New Jersey. I'm solo practitioner. I was just wondering, once we make a giant ACO from the hospitals in the local area, how does it work out for the solo practitioners who keep their costs down, while the hospital and the major groups will have higher costs? So how much it comes out with the distribution? And would the CMS protect the payments from them? Or they will get the global payment and whatever they decide, they will give it to all else?

Tricia Rodgers: So thanks for that question. CMS would make any shared savings payment to the ACO TIN. And then it's up to the TIN to distribute to the ACO's participant TINs based on the agreement that it has with each of the – with the ACO participant TINs. So, I would just encourage you to review your agreement – any agreement carefully with the potential ACO and have them explain to you how that distribution would happen.

Barkat Jaferi: Is there any regular percentage you are looking at that they will charge as an administrative fee? Like 10 percent, 20 percent, 15 percent? Or it is up to their – I mean, discretion that whatever they want?

Tricia Rodgers: It's up to the ACO to manage that – their ACO agreement with their participant TINs as they want to.

Barkat Jaferi: OK.

Tricia Rodgers: Thank you.

Barkat Jaferi: Thank you. Bye.

Operator: Your next question comes from the line of Cris Pertiarra.

Male 1: She had to go to the bathroom.

Leah Nguyen; Can we have the next question, please?

Operator: Thank you, your next question comes from the line of Dr. Patel.

Jitendra Patel: Hi, can you hear me?

Tricia Rodger: Yes, go ahead.

Jitendra Patel: Hey, I'm a single specialty solo practitioner. How many ACOs can a single specialty person join?

Terri Postma: Hello, this is Terri. ACO participants on – so, as a solo practitioner, you would have a Medicare-enrolled billing TIN. You would be the only practitioner billing through that TIN. So you would be both an ACO participant as well as an ACO provider/supplier.

So, as an ACO participant, any ACO participants—and this just isn't for solo practitioners, this is for any ACO participant that bills Medicare for primary care services as we've defined those in the rule—must choose to be a part of only one ACO.

The reason for this is because, like I mentioned before, the ACO participant list is critical for the program operations such as assignment, and we must – we must be ensured that we're making a unique assignment for each ACO, that beneficiaries aren't getting assigned to multiple ACOs. So

that's why the ACO participant TIN that bills for primary care services must be a part of only one ACO.

Now, there is – there are some QAs or facts that we have on our Web site that you might look at, where we talk about other entities that are performing services or rendering services on behalf of an ACO. Other entities might be Medicare-enrolled entities that don't want to be an ACO participant. So other entities can contract with multiple ACOs. But take a look at those facts; it's on our Web site, it's under our QAs, inside that document, and it talks about ACO participant TIN exclusivity and opportunities to use that other entity as a way to contract with multiple ACOs.

But, that being said now, if the ACO participant TIN – or if that solo practitioner goes the direction of another entity, and is not an ACO participant TIN, then they're not going to qualify for the PQRS incentives, for one. They may not qualify for shared savings, depending on how their ACO has structured that. The ACO may only want to share with ACO participant TINs who are contributing to assignment and quality.

So, think those things through. Take a look at our FAQ, and we'll probably touch on this a little bit on the next call.

Jitendra Patel: A quick followup on that: As a specialist, can you join more than one ACOs?

Terri Postma: The same rules apply. It doesn't matter who's billing through that ACO participant TIN—specialists, primary care. It's all dependent on whether the ACO participant TIN is billing Medicare for primary care services as they're defined in the rule. Primary care services aren't dependent on what – the practitioner type that's billing them. So they're largely E&M and HCPCS codes that are office-space kinds of codes. Those might be rendered by a specialist; they might rendered by a primary care practitioner.

Leah Nguyen: Holley, we have time for one final question.

Jitendra Patel: Thank you.

Operator: All right. Your final question will come from the line of Jordan Anderson.

Jordan Anderson: Hi. I'm representing – or I'm a consultant representing Willamette Valley Health Solutions. And, as a consultant, I'm wondering: For the NOI, the contacts that are listed, who should be sort of the primary and the secondary contacts? And on the IT contacts side, what sort of roles are those usually, or what sort of people usually fill those roles?

Tricia Rodgers: So a lot of folks who have consultants will have a primary contact from the ACO and then a secondary contact as a consultant in that case. Sometimes it's the ACO executive; sometimes it's a doctor who is very in the know of how the ACO is going to run. Sometimes it's someone else who's interested in standing up the ACO, some sort of member who might be on a board or something within the ACO structure. But it's possible to have the consultant as the secondary contact. Just follow those – follow that information on getting your

CMS user IDs that we discussed, about the consultants having that extra information from the ACO itself.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can e-mail it to one of the addresses listed on slide 40. I would like to thank everyone for participating in this Medicare Shared Savings Program Application Process National Provider Call.

On slide 42 of the presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box within 2 business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. Please note: Evaluations will be available for completion for 5 business days from the date of today's call. We appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to CMS MLN National Provider Calls Web page.

Again, my name is Leah Nguyen. It has been my pleasure serving as your moderator today. I would also like to thank our presenters Tricia Rodgers and Dr. Terri Postma. Have a great day everyone.

Operator: Thank you for your participation on today's call. You may now disconnect.

END