

**Centers for Medicare & Medicaid Services**  
**Medicare Shared Savings Program Application Process National Provider Call:**  
**Application Review**  
**Moderator: Leah Nguyen**  
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## **Announcements and Introduction**

**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. Thank you. You may begin.

Leah Nguyen: I am 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 MLN National Provider Call on the Medicare Shared Savings Program Application Process. MLN National Provider Calls are part of the Medicare Learning Network.

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 an overview and updates to the Shared Savings Program application process for the January 1st, 2014, start date. A question-and-answer session will follow the presentation.

Before we get started, I have a few announcements. A link to the slide presentation was e-mailed to all registrants earlier this afternoon. The presentation can also be downloaded from the CMS MLN National Provider Calls Web page at [www.cms.gov/npc](http://www.cms.gov/npc). Again, that URL is [www.cms.gov/npc](http://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 Dr. Terri Postma, who is the Medical Officer for the Performance-Based Payment Policy Group here at CMS.

## **Presentation**

### ***The Shared Savings Program: Key Dates***

Terri Postma: Great. Thanks, Leah. I've been asked today to continue our review of the application process to assist you with your upcoming submission, and I'm going to start on slide 6.

Slide 6 gives you the key dates for the Shared Savings Program application cycle for January 2014 starters. So I'm going to walk through each section of the process and the subsequent slides, but these are the deadlines for each step in the application process.

As you can see, the deadline to submit the Notice of Intent to Apply for the January 1st, 2014, program start date was May 31st, 2013. If you did not submit an NOI for this year,

we cannot accept an application for you – from you for January 1st, 2014. However, we invite you to consider submitting an NOI next year, so that you can apply for the January 1st, 2015, start date.

The CMS User ID application deadline has also passed. It was Monday, June 10, 2013. Please submit an application for a User ID immediately if you've not already done so. A CMS User ID is necessary to access our online application submission system. Delays in obtaining your CMS User ID may cause delays in your ability to submit your application. We'll accept your application to the program from Monday, July 1st, through Wednesday, July 31st. We'll send application approval or denial notices sometime in the fall of 2013 for the 2014 program start date.

Please do not wait to submit your application until July 31st. It is in your best interest to start your application submission as early as possible. And I really can't emphasize this enough. Preparation and organization on your part now is essential. We have a lot of information up on our Web site to help you prepare for submission, and the earlier you begin that process, the better it's going to go for you.

It's important to note that if you cannot complete your application submission by the 31st, you will have to wait until the next cycle to apply, which in this case would be for the January 2015 program start date. We cannot accept submissions later than that, regardless of circumstances. We sympathize if you have had, you know, systems issues and things like that, but there's no way we can accept after the 31st. So that's why it's really important that you start your submission process as soon as the application is available to you on July 1st.

### ***The Application Process***

All right, slide 7: We're going to discuss now the application process. Slide 8: I can't emphasize enough the importance of a timely application submission, and once again, please do not wait to the last minute to apply. We will not process any applications after July 31st. If your application is submitted after July 31st, we will not review it. You will, however, be able to apply for the next application cycle, for the start date of January 2015.

Any number of things could cause a delay—for example, not having your ACO participant agreements in place, or not having a CMS User ID, difficulty accessing the system, and things of that nature. So again, while we sympathize with those things, unfortunately, we will not accept applications after the 31st. So it's your best interest to start that process early and meet the deadlines and plan ahead. Make sure you build in time to account for delays that are out of your control, and submit early.

We will continue to update our Web site with information and key dates for subsequent Shared Savings Program cycles. For more information, please visit our Web site that's provided on the slide.

Please also send any application or application process questions to [sspaco\\_applications@cms.hhs.gov](mailto:sspaco_applications@cms.hhs.gov). It's important that you always include your ACO ID number and your ACO's legal name and the topic of your question in the subject line of that e-mail, so that we can route it quickly and appropriately to the subject-matter experts.

Now I'm on slide 9. Those of you who have submitted an NOI are eligible to submit an application for the January 1st, 2014, start date. If you did not submit an NOI, I'll briefly walk through these steps so that you know how to apply for the next year's start date.

First, navigate to the Shared Savings Program application Web site, and click on the link in step 1 called Submit a Notice of Intent to Apply. Once you click this link, you'll move down the Web page to step 1 instructions with a link to the online Web form at the Vovici Web site.

Fill out all the questions and click "Submit Survey" to complete your Notice of Intent to Apply, indicating your interest in participating in the Shared Savings Program. You will then receive an e-mail acknowledgment containing your ACO ID number and instructions on how to request a CMS User ID. Submitting a Notice of Intent to Apply, or an NOI, does not require you to submit an application, but it does reserve your eligibility to submit an application. Once again, the NOI deadline has passed for this application cycle, but there will be another opportunity next year.

Slide 10: After you receive your NOI acknowledgment letter via e-mail, your next step will be to obtain a CMS User ID. A CMS User ID is necessary to access the Health Plan Management System, or HPMS, the system that you'll use to complete and submit your ACO application. You'll also use your CMS User ID to access data if you're accepted into the Medicare Shared Savings Program. CMS User IDs are issued to individual people and should never be shared with another person. If you already have a CMS User ID, you don't need to get another one. If you do not already have a CMS User ID, follow the specific instructions on our Web site explaining how to fill out the CMS User ID application, and submit it to the address noted on the slide and the Web site directions.

At this time, you should have already submitted your request for CMS User IDs. As I mentioned before, that deadline has passed. But if you have not, we urge you to send it in as quickly as possible on form CMS 20037. It usually takes about 3 to 4 weeks to process the CMS User ID application, and that's why you should submit now.

Please do not call or e-mail us for your status. As you see on the slide, you'll be submitting your request to Adam, and when you submit calls or e-mails for status, it takes Adam's time away from processing and is not necessary because we'll notify you as soon as your CMS User ID has been approved. So please be thoughtful of that and give it about 3 to 4 weeks to be processed.

We're requesting that each ACO applicant submit up to three CMS User ID applications. We recommend that you submit two for your ACO's Information Technology contacts, and one for the person who will enter the application into the system.

Occasionally, personnel terminations occur. So, if one your IT contacts or the person submitting the application has terminated or dissociated from your ACO organization, it's a responsibility of the ACO applicant to notify CMS immediately so that the CMS User ID can be discontinued. To notify us, submit documentation including the ACO legal name, the ACO ID number, the user's full name, and his or her CMS User ID as soon as the relationship terminates.

Slide 11: While you're waiting for your CMS User ID, we strongly encourage you to take this time to visit our Web site and download the updated Medicare's Shared Savings application package. You can begin working on it offline immediately.

The updated package includes the following: the application; the toolkit, which includes in that, the Application Reference Guide, the link to the CMS Form 88 – 588 (which is the Electronic Funds Transfer Authorization Agreement), and the templates and instructions for the ACO participant list template, the governing body template, and the ACO participant agreement template.

Slide 12: As I mentioned earlier, you must submit your application electronically through HPMS. When you first log in, you'll notice that the information you provided during the NOI submission has been prepopulated in HPMS. If any of this information has changed since you submitted your NOI, you may request a change through the application mailbox—that is [sspaco\\_applications@cms.hhs.gov](mailto:sspaco_applications@cms.hhs.gov). We'll only honor change requests that come from the ACO executive or either the primary or secondary application contacts that you have designated. The subject line of the e-mail must include your ACO ID number, the ACO's legal name, and the term "Change to NOI Information" in the subject line. You will provide the information change in the bottom – in the body of the e-mail.

Slide 13: This shows a screen shot of our updated applications that you may download from our Web site.

Slide 14: If you've applied in the past, this slide highlights the **changes that have been made to 2014 application** that you might notice as you're going through this application cycle.

First, we added several ACO contacts. We now require that the ACO executive and CMS liaison and primary application contact and primary IT contact be designated. Financial contact, compliance contact, and authorized design contact must be identified at the time of application. Several other contacts are optional at the time of application but will be required upon CMS approval into the Shared Savings Program. These contacts will be the primary and secondary quality contacts, primary and secondary marketing contacts, and the public contact that you'll use as your public – as your – the contact that the public will be able to reach you.

In addition, the ACO should develop and submit its Web page address. The ACO's Web site will be used to post certain information that the ACO is required to make publicly available.

CMS also restructured the repayment mechanism, or Track 2 piece of the application, so that it now appears at the front of application in the exact same spot it appears in the health – in the HPMS electronic version. This was done to eliminate any confusion when applicants were comparing the paper copy with the electronic version.

Another new feature of the 2014 application is the use of textboxes for narratives. You will no longer have to upload your narratives as separate files when a question requires a more indepth explanation. Now you can simply type in your narrative directly into the textbox provided in HPMS.

We also found it necessary to add two additional questions: the application having to do with past participation in the Medicare Shared Savings Program, and an attestation regarding the ACO's accountability for assigned beneficiaries.

Finally, we combined elements of the participant list template and the executed agreement template found in previous cycles in order to develop the current participant list template. By doing so, we've reduced the number of templates you'll need to prepare.

Slide 15: This is a screen shot of the 2014 Application Toolkit. We suggest you use this toolkit as you work your way through the application. We developed it as a guide to help you complete every question in each section of the application. Specifically, the reference guide provides the question number, the application section number, and specific directions on how you can answer the question. It contains the page number on which the citation appears in the final rule, and the citation from the Code for Federal Regulations, and whether supporting documentation is required to answer the questions, and whether a narrative response is required, and the naming convention for the files that need to be uploaded, if any.

This is an adjunct to the application and a quick reference to the final rule for each pertinent section. It's in your best interest to keep this reference guide with you and to refer to it often when completing your application in HPMS. You may also find it useful when responding to a request for more information from the reviewer of your application.

Slide 16 displays the sections of the application. In this application, we ask you a variety of questions related to program requirements, including questions about your ACO participants, your ACO's leadership and management, your ACO's governing body, the required processes, and patient centeredness, and things of that nature.

Slide 17 displays question 22 in the January 2014 application, which asked for your ACO's banking information. In this section, we asked you to submit CMS form 588, also known as the Electronic Funds Transfer (EFT) authorization agreement. You will find instructions on how to complete this form in the toolkit. The signed CMS 588 is

necessary for you to have shared savings deposited directly to your ACO's account. It's due at the time of the application, and applications are not considered complete until CMS receives this form. Also note that the TIN that you put on the 588 must match the TIN of your ACO legal entity. If you have any questions about filling out CMS 588, follow a tutorial at the Web address found in – on the slide.

On slide 18, in section 12 of the application, you'll be asked to attest that all your statements made in this application are true, correct, and complete. It's imperative that you read and understand the program regulations before selecting "I Agree." By selecting "I Agree," you're certifying that everything that you've attested to is true and clear to the best of your knowledge. After selecting "I Agree," you will hit the Submit button to complete your application submission.

### ***Required Templates***

Slide 19: Next we'll discuss the templates that are required as part of the 2014 Shared Savings Program application.

Slide 20: There are three distinct templates that must be completed and uploaded as part of a complete application submission. These applications I mentioned before are the governing body template, the ACO participant list template, and the ACO participant agreement template.

Slide 21: On section 5 of the application, we asked you to provide us with information about your governing body. This slide shows a screen shot of the governing body template that you'll fill out and submit. You must indicate each member of the governing body, indicating the member's voting power, and what ACO participant that member represents on the governing body. Instructions for this template are found in the toolkit. By completing this template, you're providing us with the information necessary to ensure that the governing body meets the requirements for participation in the Shared Service Program as set forth in regulations.

Moving on to slide 22: Question 23 in the application asks you to submit a list of ACO participant TIN identification numbers, or TINs, and CMS Certification Numbers, or CCNs. The toolkit contains the ACO participant list template and instructions for completing this requirement. You must submit one ACO participant list for each ACO. Multiple ACO participant lists will not be accepted. HPMS will validate the format of your ACO participant list upon submission. It's important that you submit your ACO participant list early to allow you to correct any formatting errors. This is an area that can hang up your application submission. So again, it's just one more reason for you to submit early.

You must successfully submit your ACO participant list through HPMS in order for your application to be considered complete. Please note that ACO participant TINs that bill Medicare for primary care services may only be listed on one Medicare Shared Savings Program ACO's list. Once you have successfully submitted your application, if TINs or CCNs are found on multiple ACO participant lists, we'll notify you that they are not

eligible to participate in your Shared Savings Program ACO. This is done to ensure that each ACO has a unique patient population assigned in each year of the program. The ACO participant TINs that do not bill Medicare for primary care services may appear on the ACO participant lists of more than one Medicare Shared Savings Program ACO. An example of this would be an acute care hospital that only bills under Part A and does not bill for any Part B services.

Slide 23 displays question 27, which asks you to complete the ACO participant agreements template. The toolkit gives you instructions on how to complete this template. In summary, you'll be asked to send in a sample agreement that your ACO uses when an ACO participant joins or when contracting with other individuals or entities that perform functions or services related to ACO activities.

The agreements your ACO makes with each ACO participant and other entities must contain certain elements. You'll use this template to tell us where each of those elements is present in the sample agreement you submit. For a refresher on this, we've covered this in previous National Provider Calls, but you can look on our Web site under the guidance—and I think it's also in the toolkit, right, Carmen? Yes, it's in the toolkit as well, and there is guidance about the ACO participant agreements and the elements that they must contain. So, for example, your agreement with the ACO participant – one of the elements is that it must contain an explicit statement that the ACO participant agrees to participate in the Medicare Shared Savings Program and comply with program rules. So you'll use this template to indicate where that explicit requirement can be found in your sample agreement for the reviewer of your application.

### ***Narratives***

Slide 24: Next we'll discuss how you'll provide CMS with the narratives that are required as part of the 24 Shared Savings Program application.

Slide 25: For the first time, narratives required as part of the application will be submitted through textboxes found in HPMS. We developed this tool in order to make the process easier and more efficient for both applicants and reviewers.

When you come to a section that requires a narrative, you'll take your information directly into the textbox provided. This eliminates having to prepare a document, zip it up into a file, and upload it using the proper naming convention. However, if you believe your narrative requires additional supporting documentation, you still have the ability to upload companion pieces.

Narratives are limited to 4,000 characters per textbox. Be aware that certain characters are not recognized by the textboxes, specifically semicolons and the greater than or less than signs.

Slide 26: Here's an example of a narrative that we will ask you to write your answer in a textbox. As a general rule, please be sure that you answer each part of the question. You'll notice that this particular one has three separate parts to the question. It's very

important that you clearly answer each part, and making the distinction between those parts for the reviewer will be helpful to the reviewer when they're looking at your application.

### ***Participant List Issues***

Slide 27: Now we'll discuss ACO participant list issues. The ACO participant list is required as part of your application. It includes information about the ACO participants and in some cases the ACO providers/suppliers—that is, the practitioners that are billing through the TIN of that ACO participant. I'll discuss with information as required on the next slide, but for now, note that the ACO participant list is very important, and so it is very important that you submit it correctly.

We will use the ACO participant list you submit with your application to determine your eligibility to become an ACO in the Shared Savings Program. Additionally, the ACO participant list is the basis for allowing us to determine whether your ACO has achieved shared savings. We will use the ACO participant list to assign beneficiaries to your ACO. Beneficiaries' assignment is performed in order to establish the historical benchmark, perform financial reconciliation, and determine the sample of beneficiaries for quality reporting. The ACO participant list also allows us to coordinate participation in the PQRS system under the Shared Savings Program and will allow your eligible entities to qualify for a PQRS incentive or avoid the PQRS payment adjustment.

We covered the ACO participant list in great detail in previous National Provider Calls, as well as our assignment algorithm. So I strongly encourage you, if you weren't participating on that call, to go to our Web site and to get those slides—there's the audio available for you—and refresh yourself on these issues.

The ACO participant list is the basis for all program operations, so it's very important that you understand the definition of an ACO participant, and how to submit this correctly, and also understand how the assignment process is done.

Slide 28: On this slide, you see the fields that are part of the ACO participant list template. In the first column, you'll need to provide the TIN that the ACO participant uses to bill Medicare. You will also have to provide the TIN legal business name. We'll search for the TIN in the Medicare enrollment system to ensure that the legal name you've provided matches, and the legal name – matches the legal name in its enrollment file. We do this to verify that the TIN you gave us is actually the correct TIN. Sometimes there are transpositions, and so this is a way of crosschecking and making sure that that hasn't occurred.

Also indicate whether the TIN is Medicare enrolled, and indicate whether the TIN you are submitting is a merged or acquired TIN. I just note here that it's optional for you to submit merged or acquired TIN; it is not required.

Finally, you will need to provide the name of the individual who is authorized to sign the ACO participant agreement on behalf of that ACO participant TIN. We will be checking

to make sure that the name that you provided matches the signer on the executed participant agreement for the TIN that you submit along with your application. So make sure that those two things match.

Under certain circumstances, you'll be asked to provide information about ACO providers and suppliers or the NPIs that bill through the TIN of the ACO participant. And in some cases, we ask you to provide this information.

Although program operations are always based on the ACO participant TIN, it's part of the statutory and regulatory requirements that we have to ask for some additional information in some circumstances. Specifically, if the ACO participant is an FQHC or RHC, you'll need to provide us with the CCN that the facility uses for billing Medicare and the NPI of physicians who directly provide primary care to patients at that facility. We're still going to pull all the claims associated with that FQHC or RHC TIN. However, because of the statutory requirement, we need you to give us the names or list specifically the NPIs of the physicians that directly provide primary care to patients in those facilities.

By including an NPI on the ACO participant list, you're attesting that the physician directly provides primary care. You should not include other types of providers, such as nurse practitioners, certified nurse specialists, or physician assistants on the list. We – again, we capture all those billings associated with each ACO participant TIN, but the claims used by FQHCs and RHCs are different than the claim forms used by most Part B providers. And so it requires us to request the NPIs of physicians that provide direct patient care in those settings in order to comply with the statute.

If the ACO participant is a Critical Access Hospital billing under method 2, or is an Electing Teaching Amendment Hospital, you will only need to provide the CCN. If you have multiple CCNs or NPIs affiliated with the ACO participant TIN, then you will need to provide multiple rows of data where the TIN information repeats on every row. Think of the ACO participant list like a data set, and the computer will read every row of data separately, so all the information has to be present on that row.

It's not required, but you may choose to include TINs of practices that have been merged or acquired by other ACO participants in your organization. A merged or acquired TIN is a TIN that was acquired by an ACO participant through purchase or merger. A merged or acquired TIN may be added to the ACO participant list so that we can use the information for beneficiary assignment in setting your historical benchmark.

The merged or acquired TIN can be added to the ACO participant list if the ACO participant subsumed the acquired TIN in its entirety, including all the ACO providers/suppliers or NPIs that billed under that TIN. All the ACO providers/suppliers that billed through the acquired TIN must have reassigned their billings to the ACO participant TIN, and the acquired TIN must no longer be used. It is not required that applicants include merged or acquired TINs on their ACO participant list, but in response to comments in earlier cycles, we provided this way of accepting and evaluating these particular TINs so that your benchmark can be as accurate as possible.

Slide 29: We will use the ACO participant list submitted with the application to preliminarily assign beneficiaries to your ACOs for the benchmark years—that is, the 3 years prior to the start of the agreement period. And we use it to screen the ACO participants and the ACO providers/suppliers that have assigned their Medicare billings to ACO participants. So we actually use the ACO participant identifiers you submitted on the ACO participant list to lookup beneficiary claims, and we'll use those claims to assign beneficiaries to your ACO.

It's important to note that if we find that one of the TINs on the ACO participant list is already participating in another Medicare initiative involving shared savings, or was submitted on multiple ACO applications, we will exclude claims from that TIN until the overlap is resolved.

Your ACO participant list must include ACO participants that are sufficient for your ACO to have at least 5,000 preliminarily assigned beneficiaries in each of the benchmark years. We perform assignment on each of those 3 years independently, and your ACO must have at least 5,000 assigned beneficiaries in each of those 3 benchmark years in order to be eligible. CMS will also use the ACO participant identifiers you submitted on the ACO participant list to make sure that each of your ACO participants meets the definition of an ACO participant, and match information for the ACO participant in the Medicare enrollment system called PECOS.

We will use the ACO participant identifiers you submitted on the ACO participant list to review the ACO participant or any ACO providers/suppliers with regard to their program integrity history, including any history of Medicare program exclusions or other sanctions, and affiliations with individuals or entities that have a history of program integrity issues.

Slide 30: Soon after submission, applicants will receive a report that includes the number of preliminarily assigned beneficiaries and the results of our preliminary screening. We'll send this to you, to your application contacts, in an e-mail with an encrypted zip file attachment.

In the past, a few applicants have experienced issues with receiving this e-mail because their firewall has blocked the incoming e-mail with an encrypted attachment. You'll know if this happens to you because you'll receive a followup e-mail from CMS with a password in it referencing the report we just sent. If that happens, contact us right away so that you have plenty of time to review the information in that report. You should also consider working with your IT staff now to see if they can adjust your system to avoid this problem from occurring in the first place.

All applicants will receive this report at the same time, and will have a short window to make any changes necessary and resubmit. If you review the report and decide you do not have any changes to make, you do not need to resubmit the ACO participant list.

This would be your opportunity to drop or add ACO participants. But it's going to be a fairly short turnaround, so do plan ahead, be organized, and be ready for this.

Slide 31: Now I'll briefly go over how to submit the ACO participant list with your application. You must successfully upload an ACO participant list before the application system will allow you to hit "Final Submit" on your entire application. By successfully loading, I mean that you have uploaded an ACO participant list that meets basic formatting requirements.

Again, the ACO participant list is a data set, and computers read the information on that file, not humans. For example, a taxpayer identification number must be nine digits and not include any spaces, dashes, or other special characters.

Another example is that if you haven't indicated to us that the ACO participant is a FQHC, you must also provide the CCN and the NPI information. If the application system detects that you did not provide that required data, or did not provide data in the correct format, then it will give you an error report that describes the errors, and you'll have to correct them and re-upload the participant list.

This is, again, the reason why you should not wait till the last minute to try to submit an application. If you wait till the last minute, you may not have time to correct errors such as this, and it can cause you to miss the deadline. But starting early will give you time to correct formatting errors and re-upload.

Now I'm going to turn it over to Leah for keypad polling.

## **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. Victoria, we're ready to start polling.

**Operator:** CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone 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. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you, and this concludes the polling session. I would now like to turn the call back over to Ms. Leah Nguyen.

Leah Nguyen: Thank you, Victoria. I'll now turn the call back over to Dr. Postma, who will continue the presentation.

## **Presentation**

### ***Track 2, Repayment Mechanism***

Terri Postma: Thanks, Leah. I'm on slide 32 now. So the next few slides are going to be relevant to applicants applying to Track 2, which is the shared savings and losses model. So this won't apply to those of you who are submitting application under Track 1—only those who are applying to Track 2.

Slide 33: On your Notice of Intent, you elected to participate in the program either under Track 1, which is shared savings only, or Track 2, shared savings and losses. The “repayment mechanism required” applies to applicants entering Track 2 of the program.

If you wish to change your selection of track from what you indicated on your NOI, you would submit, in writing, a request to CMS, as I noted before, earlier in the presentation. Do this as soon as possible to avoid delays in application processing.

I'll now briefly review information on how to establish and submit an adequate repayment mechanism. Prior to application, please review the guidance document available on our Web site regarding requirements for each acceptable type of repayment arrangement. These are very specific, very detailed, and can take some time. So begin discussions with your bank now. Applicants should identify a preferred arrangement and institution to work with for establishing a repayment mechanism arrangement prior to the close of the application period.

Application – applicants should carefully review the following resources about repayment mechanism arrangements. First, review the repayment mechanism arrangement's guidance, which is available on our program Web site. Also, review the repayment mechanism arrangement FAQs, which are going to be distributed by e-mail soon to Track 2 applicants.

When you fill out your application, you must indicate which repayment mechanism arrangement you've selected. The following are available to you: first, funds placed in escrow; second, a line of credit, as evidenced by a letter of credit; three, a surety bond; four, reinsurance; or five, an alternative repayment mechanism. Anecdotally, most ACOs have chosen to set up an escrow account, letter of credit, or surety bond. ACOs have reported difficulty in getting reinsurance and establishing – sorry, we're getting a little bit of feedback.

Yes, that's good. Great, thanks, Leah. I think that did it.

So let me just repeat that. Anecdotally, most ACOs have chosen to set up an escrow account, letter of credit, or surety bond. Some ACOs have reported difficulty in getting reinsurance and establishing acceptable alternative repayment mechanisms. So just keep that in mind as you're thinking about which one you want to use.

Shortly after the application submission deadline, CMS will send each Track 2 applicant an ACO-specific repayment mechanism amount estimate and detailed instructions on submitting repayment mechanism documentation.

The applicant must use this estimate to establish the dollar amount of its repayment mechanism arrangement. We reserve the right to issue a revised repayment mechanism account estimate in the event that you have changes to your ACO participant list during the application review period, and indicate significant changes in the estimated number of beneficiaries to be preliminarily prospectively assigned to your ACO.

So it's very helpful to you to have established a working relationship with a bank, and know which mechanism you want to use in advance, and get that ball rolling, so that when you get that letter from us with the amount estimate, you can just pop that in, and you'll be good to go. Don't wait to get that estimate before you decide what payment mechanism arrangement you want to use.

Track 2 applicants will have several weeks to provide documentation of an established repayment mechanism arrangement. You must provide this documentation by the due date specified by CMS. The documentation must demonstrate the existence of an established repayment mechanism arrangement, and for some types of repayment mechanisms, such as escrow accounts, CMS must execute documentation before the arrangement can be established. In these cases the applicant must submit the repayment mechanism documentation for CMS execution by the date specified. So keep that in mind.

I'm on slide 34. CMS will review the documentation submitted, and as a result of this review, CMS may either determine that the arrangement is adequate as is, determine that revision is needed, or disapprove the arrangement altogether. If a revision to the initial documentation is required, the applicant will be expected to provide revised documentation within a very short timeframe. CMS will review the revised documentation and make a determination of its adequacy.

If we're unable to confirm the adequacy of your ACO's repayment mechanism, you will not qualify to participate in Track 2 of the Shared Savings Program. If we approve all other elements of your application, you will be considered for participation in the program under Track 1, which is shared savings only.

Again, it can be a time-consuming process for ACOs to establish a repayment mechanism arrangement, so it's very important to start considering the repayment mechanism required early in the application process. In fact, now is the time to start thinking about this and establishing your relationship with a bank.

### ***Application Review and Determination Process***

Slide 35: Now that we've discussed the details of the application submission process, I'll turn to the application review and determination process.

Slide 36: During the application review, your reviewer may need some clarification on parts of the application that you've submitted. Requests for information will be sent via e-mail to the ACO's executive and the primary and secondary application contacts. Each applicant will get an RFI—these are called Requests for Information, RFIs—early in the process, to provide information about the application's reviewer name and contact information, the count of your beneficiaries, and, if Track 2, the repayment mechanism of the estimated amount. It's very important to make sure that the contact information in your application is correct so that you don't miss any of these important communications about your application.

Moving on to slide 37: During your application review, we may request that you submit additional information because a portion of portions of the application are incomplete or require clarification. You must upload the additional information into HPMS. If you do not submit the information in a timely manner, we will not accept the submission.

I'm on slide 38 now. After we review your application and supporting documents, we'll send you an e-mail either accepting or denying your application sometime in the fall of 2012. If you're approved, you'll be asked to sign and date the Medicare Shared Savings Agreement and sign and date the DUA. They're posted on our Web site now, so you can look at them in advance, but please don't submit these documents with your application. If your application is denied, you'll receive an e-mail giving you the reasons for the denial, and you'll have an opportunity to request a reconsideration review.

***Clarification: The date in the previous paragraph should be "fall of 2013"***

If you chose to see – if you choose to seek a reconsideration review, we must receive a request within 15 days of the date of your denial. If you do not meet this deadline, you will not be considered – reconsidered for the January 1st, 2013, start date. However, you always have the option of reapplying for the next cycle which in this case is January 1st, 2015.

Please note that there are several statutory reasons for denial that are not subject to judicial or administrative review. For example, if your ACO is denied because it failed to meet the 5,000 assigned beneficiary threshold, your application will be denied. But again, denials don't mean that – don't prevent you from reapplying during the next application cycle. And we encourage you to use the time to get more ACO participants to join your ACO so that when you do reapply, you can meet this 5,000 assigned beneficiary requirement.

Slide 39 outlines **how to withdraw an application**. If you decide to withdraw an application, you must send us an e-mail prior to the date in which CMS issues final dispositions. So you can – you can withdraw at any point in time and withdrawals don't – don't prevent you from reapplying in a future cycle. The request must be made on a PDF in your organization's letterhead and signed by your ACO executive or authorized official. Please include the following information in the request: your legal entity name, your ACO ID number, the ACO's complete address, point-of-contact information, and

the reason why you're withdrawing. You may submit the request in PDF format via e-mail to the ACO applications e-mail box.

### ***Lessons Learned***

Slides 40 and 41 represent the lessons we've learned over the past application cycles. In our experience, these issues have repeatedly caused challenges for ACO applicants. Fortunately, you can benefit from these lessons learned so you don't repeat these mistakes.

First, it's imperative that you have the information required by the application—specifically, that you have your ACO participant agreements all in place, required processes and structures also in place, in order to apply for participation.

Disorganization on your part makes it very difficult for reviewers to assess your application and increases the probability of a denial. The application period is not the time to get organized. Organize before you apply. Some of the most successful applicants and participants spent a lot of time in the year leading up to application getting buy-in from ACO participant TINs and designating their current processes, and things of that nature.

Some of the least successful applicants and participants spent little time organizing upfront. Good advance organization not only assists in a smooth application, but also allows the ACO to hit the ground running and not spend the first performance year getting organized or losing ACO participants, and so on.

[Feedback noise.] Sorry about that. Maybe can we turn those two off? OK, sorry. I know we're getting a little bit of feedback.

All right, the next lesson learned is: It will benefit you greatly if you start the application process early. I know I've been pounding on this a lot during this presentation, but if – we really can't overemphasize the importance of getting started early. Getting started early will allow you to ask questions and thoroughly get answers to those questions as you go through the submission process. And once again, applications received after July 31st will not be processed.

If you're a Track 2 applicant, it's critical that you establish your repayment mechanism as soon as possible, so start now. Start that relationship with your bank and – and designate what – what mechanism your ACO would like to use. It's also in your best interest to use the toolkit provided as the reference throughout your application process. In addition, if a problem arises in your ACO during the application review period that could negatively affect your application or eligibility, contact us immediately at the Shared Savings Program Application e-mail box. The sooner we know about an issue, the better we can work with you to resolve it.

I'm on slide 41 now. It's in your interest to pay particular attention to the regulations having to do with legal structure, governing body, and agreements between ACOs and

their participants. If you do not meet the requirements set forth in the regulations, you will encounter significant delays in the application process and increase the probability of denial. In previous National Provider Calls—which can be found on our Web site, the audios, and the slides—we covered this particular – these particular issues in great detail. So I encourage you to review those – those presentations.

Also, be sure to avoid the appearance of conflict of interest when selecting a beneficiary to serve on the ACO’s governing body. For example, the beneficiary representative that is also an ACO provider/supplier would appear to set up a conflict between beneficiary input and provider input into the governing body decisions, and your application may be denied for this reason.

Also, your application must specifically address the remedial processes that will – that you will take against any of your ACO participants or providers and suppliers who are noncompliant with the requirements of ACO regulations. Having these processes in place ahead of time is – is important, and allows your ACO to function properly during the agreement period.

Finally, you must comply fully with the requirement that your ACO participants have at least 75 percent control of the ACO’s governing body.

### ***Resources***

Slide 42: We anticipate that you’ll have questions throughout this process. So when questions arise, please call or e-mail the appropriate contact, as indicated on the slides. We’d like to reiterate that it’s critical to meet all deadlines in order for your application to be accepted. Any applications or supporting documents received after the scheduled times will not be considered for the current cycle.

We also encourage you to submit your applications as early as possible—don’t wait for July 31st—to give yourself plenty of time to complete any request for further information.

Leah Nguyen: Hold on for one moment.

Terri Postma: All right. Thanks for your patience. We’ll be providing some valuable information for you in the upcoming weeks. Please make plans to have representatives for your ACO attend these important sessions. On Tuesday, July 9, we’ll be providing applicants with HPMS trainings. This is specifically in how to use HPMS to submit your applications. The person in your ACO who’s responsible for submitting the application should definitely attend the sessions so that they’re familiar with HPMS and don’t encounter issues during their application submission.

We’ll go through the entire application process including answering attestation questions, using textboxes for narratives, uploads for additional supporting documents, and the required templates.

Our call on Tuesday July 16 will provide all ACO applicants with the opportunity to ask questions about the application a full 2 weeks before the application is due. We urge you to go over the application thoroughly so that we can address important questions in this section – in this session that may affect a large portion of applicants.

***Clarification: The call will take place on Thursday, July 18***

So, sometimes during previous cycles, applicants have informed us of inconsistencies or things that are unclear to them, and so that format is a really good format to raise those issues and address those with us before the application is due. We stress the importance of being familiar with the application prior to the call, so it's in your best interest if you've already been in HPMS and started applying, and you come with very specific questions that we can answer on the call. So, really, that call is only going to be helpful to you if you've already read and attempted to complete the applications.

Slide 43, this concludes the prepared portion of the Shared Savings Program 2014 Application National Provider Call. We're happy to accept any questions, but right now I'm go turn it back to Leah.

## **Question-and-Answer Session**

Leah Nguyen: Thank you, Dr. Postma. 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 your name and the name of your organization.

In 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, Victoria, we're ready to take our first question.

**Operator:** 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. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q & A roster.

And your first question comes from the line of Alexis Isabelle.

Alexis Isabelle: Hi, my name is Alexis Isabelle from Athenahealth, and I have a question about just the general notification of intent to apply. Is that a required step in the process? Or can providers who would like to participate, or ACO participants, can they still apply during this July 1st through July 31st application period?

Terri Postma: Thank you for the question. This is Terri. The Notice of Intent to Apply is a required piece. You may not submit an application for the July 1st, 2014, start date—that is, during this application cycle, if you did not complete a Notice of Intent to Apply. So if you did not, we invite you to continue organizing your ACO and consider applying for next year.

Alexis Isabelle: Thanks.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Debra Baverman.

Debra Baverman: Good afternoon. This is Deb Baverman from Collaborative Health. I just want to clarify what I think I heard in regards to the textboxes in support of the narratives, that they're limited to 4,000 characters, and that we could also upload a companion piece?

Terri Postma: Hi, Deb. It's Terri.

Debra Baverman: Hi.

Terri Postma: Yes, that's right. There's a limitation to the characters that can be put in the narrative textboxes. But if you have additional supporting information that you'd like to submit such as, you know, in the required processes do you know that we ask – we ask about your individualized care plans? And so, in previous applications, some applicants have actually submitted that care plan as part of the narrative. So, supporting documentation and things like that—there will be a mechanism for you to submit that additionally – in addition to what you put in the narrative textbox.

Debra Baverman: Great. Thanks so much.

Terri Postma: Sure.

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

Paul, your line is open.

Your next question comes from the line of Gale Biederman.

Mickey Duke: Hi, this is Mickey Duke with Silver State ACO. Wanted to know if there's a place we can go to find additional information regarding past, current, and future potential involvement of ACO participants in other ACOs. I'm a little confused as to exactly what we need to provide in what kind of a format.

Leah Nguyen: Hold on for one moment.

Terri Postma: So—hi, this is Terri—so I think that I – if I hear the question correctly, are you asking how one might determine whether an ACO participant TIN is already participating in an ACO?

Mickey Duke: No. I'm more – directing my question to the documentation that needs to be provided if a participant has formerly participated in another ACO and wishes to now participate in a different ACO going forward.

Terri Postma: Oh, I see, OK. So, first of all, the ACO participant needs to dissociate from the other ACO, and the other ACO needs to inform the program of that dissociation, and we have to have processed that. There is an effective date that they can put in. And then, there's a question on the application about – are you referring to the past participation question 18, “Has your ACO, ACO participants, or ACO providers/suppliers ever been voluntarily or involuntarily terminated from” the program? And also ...

Mickey Duke: Yes.

Terri Postma: ... the current participation—that section?

Mickey Duke: Yes, that's the section that I'm kind of curious about.

Terri Postma: OK.

Mickey Duke: And of course involuntary participant – you know, being – leaving one and going to another voluntarily on the part of the provider.

Terri Postma: Right. So, if they have participated in another Shared Savings Program before, if they've voluntarily or involuntarily terminated, then you would check “yes” to that question, and you would provide a narrative identifying the cause of the termination and what safeguards are now in place. And that would just require you talking with your ACO participants and – and getting that information from them.

Mickey Duke: OK. And if there was more than one, then we would just need to kind of do them separately, each one?

Terri Postma: You could do them separately, or you could identify similar reasons for their termination.

Mickey Duke: Got it.

Terri Postma: Yes. Either way.

Mickey Duke: OK.

Terri Postma: Thanks.

**Operator:** Your next question comes from the line of Mike Melnyk.

Mike Melnyk: Hi, yes. My name is Mike Melnyk, and for reasons of confidentiality, I'm going to leave my organization out of this, but do you have any context for those who are Pioneer ACOs that will be transitioning into MSSP, with how we answer 18, 19, and 20? Is there any specific guidance for the Pioneers?

Terri Postma: Well, these questions are specific to – well, the first question, past participation, number 18, is specific to the Shared Savings Program. So if you – if a Pioneer is leaving the Pioneer ACO model and applying to the Shared Savings Programs, question 18 would be “no,” because you were participating in Pioneer, not the Shared Savings Program. And then for current participation, you would answer question number 19 “yes” and check the Pioneer Accountable Care Organization model—that is, *currently* participating in the Pioneer Accountable Care Organization model. And then under future participation, the next question is 20, “Will participation in the program or programs in question 19 be complete by the start date for which you are applying?” you would answer “yes,” certifying that neither the ACO nor any of the ACO participants will participate concurrently—that is, participation in the Pioneer model will end, and you will begin the Shared Savings Program participation, and there won't be any overlap in time.

Mike Melnyk: Great. Thank you.

Terri Postma: You're welcome.

**Operator:** Your next question comes from the line of Tracy Brewer.

Tracy Brewer: Hi, my name is Tracy Brewer. I'm with Presbyterian Healthcare Services, and we were reviewing the regulations, and we just had a question. Would a multi-hospital system that uses one TIN be disqualified from being a Medicare Shared Savings ACO if one or more of its hospitals that bill under that TIN are Critical Access Hospitals but do not bill using method 2?

Terri Postma: No. You would not be – no, you wouldn't be knocked out of eligibility for that reason, but you would have to make sure that all the entities that bill through the TIN of that Medicare – that health systems Medicare-enrolled TIN – agree to participate and comply.

Tracy Brewer: OK. Thank you.

Terri Postma: You're welcome.

**Operator:** Your next question comes from the line of Jennifer Schwartz.

Jennifer Schwartz: Hi, this is Jennifer Schwartz from Lourdes Health System. My question is, I understand that the ACO participants need to be exclusive, and that you

need to submit that with your July – ultimately with the July 31st application. Is there an opportunity at any point after July 31st and before January 1st to add additional ACO participants?

Terri Postma: Yes, this is Terri. So, once you submit your application, we're going to give you a feedback report fairly soon thereafter. And it will – it will tell you if there are any overlaps in ACO participant TINs, it will tell you if there are any issues with your ACO participant list that will give you your number of assigned beneficiaries, and you will have that opportunity, and it's going to be a fairly quick turnaround, to make corrections to that list, including adding or subtracting ACO participant TINs from the list.

Jennifer Schwartz: OK. So does that end up approximately in a timeframe? Are you talking about, you know, in the month of August that you could do that? Or can you give me a sense of timeframe, although I know it probably varies?

Terri Postma: Yes. It'll be the August–September timeframe.

Jennifer Schwartz: OK. Thank you.

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

Marie Hooper: Hi, this is Marie Hooper from Northern Physicians Organization. Could you restate the portion – I was – it was not clear to me when you have ACO – if you – about ACO participants who may only be billing Part A, they *can* be in more than one ACO? But if they're Part A and B, they *can't* be in more than one ACO?

Terri Postma: Yes, the basic rule is, go to your ACO participant TIN and ask them if they bill Medicare for any of those primary care services that we reviewed in the first Provider Call. And so, ask them if they bill for any of those primary care service codes. If that ACO participant TIN bills Medicare for any of those primary service codes, that ACO participant TIN may only be on one ACO's list of ACO participants.

If the ACO participant TIN doesn't bill for any of those primary care service codes, then – and an example might be an acute care hospital that bills under the DRG, they don't bill primary care service codes – then that ACO participant does not have to be a part of only one ACO's list. The reason is because we use the primary care services to develop the assignments for the – for each ACO. And so, that – that list of beneficiaries has to be unique to each ACO, and it – or it should ensure that – then it's – the ACO participant that bill for primary care services can only appear on one list. Does that help clarify it?

Marie Hooper: Thank you. Yes, it does. Thank you.

Terri Postma: OK.

**Operator:** Your next question comes from the line of Noah Nesin.

Noah Nesin: Hi, thank you. My question is something that was stated during the presentation, which is that that overlapping participation in another Shared Savings Program has to be resolved before a participant can be considered for assignment of beneficiaries and that – so during the application process, I'm sure there are others in the same boat, that we're currently in a Shared Savings Program and have given notice of withdrawal, which will take place at the end of the year. Is that going – is that going to be a barrier to the application? Does that withdrawal have to occur more immediately?

Terri Postma: The withdrawal should occur as soon as possible because we have to at this end process that. And so, you know, if it was done earlier in the spring, chances are good that it won't cause a problem, but there may – you may get a report back showing an overlap. If that's the case, then – and you know that the withdrawal has already occurred and been submitted to CMS, then you would want to reach out to us immediately and – so we can go back and take a look and make sure that it's not really an overlap.

Leah Nguyen: Thank you.

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

Marie Ramirez: Yes hi. This is Marie. I'm with Yasmin Maldonado, M.D., P.A., and my question is this: that when we start putting in our information into the HPMS, are we able to go in and do a couple of sections and then get out and then go back the next day, say, and add additional into the other sections? Will it save the information?

Terri Postma: Yes, thanks for your question. There is a mechanism for you to go in and save, and come back at another time to complete it, and we'll be going over those types of details in the next Provider Call.

Marie Ramirez: Excellent. Thank you very much.

**Operator:** Your next question comes from the line of Dale Key.

Dale Key: Good afternoon and thank you. I'm calling from Physician Quality – Quality Partners. My name is Dale Key. Question I have involves slide number 41.3 that says, "Specifically address the remedial processes your ACO will levy if an ACO participant is non-compliant with the requirements." Once those remedial processes have been worked through, and at some point the ACO determines that that particular position is one the ACO chooses, or would wish to not be a provider in the ACO, does that then mean the entire group that that provider is a member of has to be excluded?

Terri Postma: Yes. So, if that provider is Medicare enrolled and one of several that are underneath the participant TIN, if that – so that provider would have to be either terminated from the group in order for that TIN to continue participating, or – but there's no way of separating out some TINs – or some NPIs from other NPIs within a TIN.

Dale Key: OK, thank you.

Terri Postma: You're welcome.

**Operator:** Your next question comes from the line of Dr. Singh.

Dr. Singh: Yes, hi there. Dr. Singh. I called earlier to your department, and they told me that people who are forming an ACO now won't be getting \$20 per patient, that administrative fee. Is this correct?

Terri Postma: I think you're referring to the advance payment model, which was available to provide an upfront payment to certain types of ACOs. This was something to the innovation center for certain types of ACOs that qualified to participate in the Shared Savings Program. That model is closed. It was only available to 2012 and 2013 starters; it is no longer available.

Dr. Singh: What if the issue is based in a very rural area?

Terri Postma: Yes, unfortunately it was only available to 2012 and 2013 starters.

Dr. Singh: OK, thank you.

Terri Postma: You're welcome.

**Operator:** Your next question comes from the line of Deborah Baitinger.

Mack Gorsakov: Hello, this is Deborah Baitinger and Mack Gorsakov, ABS Managed Care Administrators. We're asking specifically around the timeline of withdrawal. We have a participant in another ACO who would like to create their own ACO, and they were wondering how long the withdrawal process actually is, from when submission occurs to when they're actually able to apply for another ACO?

Leah Nguyen: Hold one moment.

Terri Postma: So, the earlier the better, so that once you submit your application, it doesn't come back as an overlap, and if it occurs earlier this year and the ACO has submitted that TIN to us to delete that TIN from their list, then an effective date is given to us, and then we know about it. So, if it occurs after the ACO applicant – it occurs after the timeframe in which no more changes can be made to their list of ACO participants, then it's – you know, we wouldn't be able to process it for this year.

So, I mean, if those overlaps persist, then the – you know, your ACO runs a risk of being denied on that basis, that it's – the list still contains overlaps. But if it's – if it's something that has not been done yet—basically, if it hasn't been done yet, it's going to be really difficult to get those changes done for this application cycle.

So, like, do it today and hope that it gets processed quickly. But, remember, you always have the opportunity, once the ACO is accepted, to make changes during the first performance year, to include them for the second performance year.

Mack Gorsakov: Understand. Thank you.

Terri Postma: Yes.

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

Paul Silva: Hi, this is Paul Silva, Holyoke Medical Center. I was just wondering if there is a phone number that I could use to speak with somebody about an issue with the Notice of Intent?

Leah Nguyen: Hold on one moment.

Terri Postma: Hi, this is Terri. So, could you just send us an e-mail to the applications mailbox, and – asking somebody to contact you? And we'll arrange that.

Paul Silva: I have sent several e-mails over the last couple of weeks to that e-mail and have not received a response.

Leah Nguyen: Hold on a moment.

Terri Postma: So, I apologize if it's gotten lost in the cracks, but if you wouldn't mind sending it today and, like, maybe in the subject line put that you are the person on the National Provider Call.

Paul Silva: OK. And just so that – since I have sent that to several e-mails, can I get...

Terri Postma: Well, just send it to the applications e-mail box.

Paul Silva: The application's e-mail? OK, and that's the one that's on the slide?

Terri Postma: Yes, yes.

Paul Silva: OK, I will send it again. Thank you very much.

Terri Postma: Thank you, sir.

**Operator:** Your next question comes from the line of Randy Hamilton.

Randy Hamilton: Yes, my question is, after you've completed the application and had it approved, if another provider or provider group wants to join, is there a process for that? And, if so, how do you get the agreements that are completed to CMS?

Terri Postma: Yes, once your application is approved and you get started on January 1st, 2014, there is a process in place for you to add or subtract ACO participant TINs. And so, basically, when you're accepted to the program you'll certify your ACO participant list that you submitted as part of your application, and that will be the basis for operations for performance year 1.

During performance year 1 you can add or subtract ACO participant TINs—and we'll let you know how to do that (it's also through HPMS)—and in fact you're required to notify us of any changes within 30 days, and the guidance for adding and subtracting is on our Web site.

So then, once you do that and we run the process and let – and inform you—I mean, there's a whole series of screens and things—and then once they're accepted, then they'll be added to your certified list of ACO participants for performance year 2, and all performance year 2 operations will be based on that new list.

Randy Hamilton: Great, thank you very much.

Terri Postma: You're welcome.

**Operator:** Your next question comes from the line of Ricardo Johnson.

Ricardo Johnson: Hi, this is Ricardo, Ricardo Johnson, and I have a question similar to the gentleman who just asked his. I know that the regulations say that to give 30 days' notice, so does that apply – I'm sort of trying to figure out what happens before January 14th. If the report that you send out, and that we're supposed to correct our ACO participant list, is in August or September, and then we resubmit, let's say, at the end of September, beginning of October, and then another ACO participant wants to be added, could we still do that up to November 31st? Because that's the way I read the regulations.

Terri Postma: So, if you're an applicant, then you're going to submit the list, and we're going to have it all cleaned up by September. There's sort of a blackout date after which it can't be changed anymore because we have to complete our screening processes, et cetera, and the certification will occur of that list that you submitted before sometime in December.

And then as of January 1st, when you start, if there have been changes or you want to add or subtract ACO participant TINs that, you know – changes that occurred between September and December, you would just submit them to us in January.

Ricardo Johnson: And then they would count for the performance year of 2014?

Terri Postma: 2015. It would be included on your new certified list going into 2015, your second performance year.

Ricardo Johnson: So, '15. So if it happens – so after we give you that second submission, that's the blackout period where, even if we give you 30 days' notice from then, the participant still can't be there for the 2014 performance year.

Terri Postma: Correct, and the regulations don't apply to applicants, because applicants aren't in the program yet.

Ricardo Johnson: I got you, OK, that makes sense.

**Operator:** Your next question comes from the line of Jonas Varnum.

Jonas Varnum: Yes, I know for the 2013 MSSP ACO application, CMS administered and paid for the first year of the Patient Experience of Care Survey. I'm wondering: Will CMS administer and pay for this survey during that 2014 year? Or will ACOs be responsible for selecting and paying for the CMS for vendors during 2014 to accommodate the survey requirement?

Terri Postma: That's a great question. So, the regulations state that CMS will pay for the first 2 years of the Patient Experience of Care Survey administration, and that applied to folks that started in 2012 and folks that started in 2013. So the first time that CMS paid for it was for the 2012 reporting period; the second time we'll pay for it is for the 2013 reporting period. And so ACOs beginning in January 2014—that is, ACOs that are applying now—will be responsible for choosing a vendor and administering the Patient Experience of Care Survey.

CMS is going to be determining who those vendors are towards the end of this year. And so, you'll have – you'll have plenty of time to choose the vendor and get prepared to do that.

Jonas Varnum: OK, will the – will CMS issue additional guidance on when they – when the ACOs accepted into the program will have to submit those requirements along with their – when they release the list of certified vendors, then?

Terri Postma: Yes, we'll be notifying you about – about the vendors, and who they are, and how to contact them.

Jonas Varnum: Right. Thank you very much.

Terri Postma: You're welcome.

**Operator:** Your next question comes from the line of Gene Farber.

Gene Farber: Hi, this is Gene Farber from Reliance ACO. My question is, if a TIN joins the ACO, how long are they committed to stay with a particular ACO, if any period of time at all?

Terri Postma: Well, the regulations sort of envisioned that the ACO participants that joined to form the ACO would be collectively agreeing to a 3-year agreement period.

Gene Farber: Right.

Terri Postma: And it's always best for the ACO if that commitment is strong. It can create problems for the ACO if that commitment isn't there. That being said, we did recognize that there are may be reasons why ACO participants might join in the middle of an agreement or might have to leave, and so that's why we developed a process to handle that. But, you know, this is something that you might consider talking with the ACO participants about and putting in your agreement with the ACO participants.

Gene Farber: OK. Thank you very much.

Terri Postma: Sure.

**Operator:** Your next question comes from the line of Lori Borkowski.

Lori Borkowski: Hi, this is Lori from Greater Genesee County. I was calling regarding the slide 41, the second bullet there. I just wanted to clarify that the beneficiary on the governing body cannot be any beneficiary that's in any – with any of the TINs that belong with the ACO.

Terri Postma: Yes, this is Terri. Thank you very much for the opportunity to clarify that. The regulations say that the beneficiary on the governing body cannot have a conflict of interest. So, what we are trying to say there is that we've seen in past application cycles where ACOs have submitted a beneficiary for the governing body, but that beneficiary also happens to be a provider within the ACO. And what we were trying to say here was that that can be perceived as a conflict of interest because then – because then on the governing body you're not sure if the beneficiary is speaking on behalf of ACO – or speaking on behalf of Medicare beneficiaries, or if they're speaking on behalf of the – of the providers that are participating in the ACO.

And so, that – the beneficiary needs to speak on behalf of fee-for-service beneficiaries, not on behalf of any participating provider in the ACO. Does that makes sense?

Lori Borkowski: Yes, it does. Thank you.

Terri Postma: Sure.

**Operator:** Your next question comes from the line of Toni Natchez.

Toni Natchez: Hi, this is Toni with Greater Genesee County ACO (how funny, Lori). And I was just wondering if there was any more information available on the narratives—any more specific guidelines for maybe how detailed the answers should be? I understand

the 4,000 character limit, but – or if there might be any examples or samples available to look at?

Terri Postma: Hi, this is Terri. This is a pretty common question. You know, some people take a lot of words to say next to nothing, and some people can say things very succinctly. And so, I think that when you're filling out these narratives, the – you should try to strike a balance where you're really answering each part of the question, and you can do that very succinctly.

We're not – there's nothing that requires you to completely use all the characters of narrative. But just so long as you're answering the question, and, you know, those answers are going to be unique from ACO to ACO. So we don't have any templates or examples, but the toolkit can help guide you in answering some of these questions. And also, you might want to talk to other ACOs that are up and running; that information and their contacts can be found on our Web site. And folks who have experience in the program might be able to help guide you a little bit, too.

Toni Natchez: That's great. Can you direct me where on the Web site I could find – how to contact the other ACOs?

Terri Postma: Yes, it's – the Web site is [www.cms.gov/sharedsavingsprogram/](http://www.cms.gov/sharedsavingsprogram/), and then on the left-hand side there's a tab that says something like "News and Announcements." And so, click on that, and then on that page we have a section for each of the rollouts that we've done—so, April 2012, July 2012, and January 2013—and you'll see a link to a list of ACOs and their public contacts.

Toni Natchez: Wonderful, thank you very much.

Terri Postma: You're welcome.

Leah Nguyen: Thank you. Victoria, we have time for one final question.

**Operator:** Your final question comes from the line of Allison Miller.

Lawrence Cappel: Hi, Allison just stepped out. This is Lawrence Cappel.

When you're looking at a method of attribution for the members to a physician, what really constitutes a primary care physician? How do you actually attribute a patient who, for example, is seeing an internist, a cardiologist, and a ENT—how does that work?

Terri Postma: Thanks for your question, and it's actually a pretty involved and detailed answer, probably too much time than we have right now. So I will direct you to the previous National Provider Calls, where we went over assignment in detail and how assignment is done. There is a very nice section in our most recent Provider Call, I believe that was April 26th or ...

Female: 23rd.

Terri Postma: 23rd. April 23rd. So, go on our Web site and look for that, look for those slides and the audio, and it steps through the assignment process, exactly what the definition of a primary care provider is, and exactly what codes constitute primary care services, and gives examples of how assignment is done—very, very detailed information.

Additionally, we have a specification document that walks through the assignment algorithm, as well as beneficiary exclusions and things like that, and that can also be found on our Web site.

Lawrence Cappel: Great. Thank you very much.

Terri Postma: You're welcome.

## **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 42.

I'd like to thank everyone for participating in this Medicare Shared Savings Program Application Process National Provider Call.

On slide 44 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 the CMS MLN National Provider Calls Web page.

Again, my name is Leah Nguyen, and it has been my pleasure serving as your moderator today. I would also like thank our presenter, Dr. Terri Postma.

Have a great day, everyone.

**Operator:** This concludes today's conference. Presenters, please hold.

**END**