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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO: Preparing to Apply for 2015
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects 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 Charlie Eleftheriou. You may begin.

Announcements and Introduction

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on preparing to apply to become an ACO. MLN Connects Calls are part of the Medicare Learning Network.

During this call, CMS subject-matter experts will provide information on what you can do to prepare for today's – I'm sorry, for the Shared Savings Program application process for the January 1st, 2015 start date. A question-and-answer session will follow the presentation.

Before we get started, there are a few items I'd like to quickly cover. You should have received the link to the slide presentation for today's call in an email today. If you have not seen the email, you can find today's presentation on the Call Details web page, which can be found by visiting www.cms.gov/npc, as in National Provider Call. Again, that's cms.gov/npc. Then select today's call – I'm sorry, then select "National Provider Calls and Events," then select today's call by date from that list. The slide presentation is located there in the Call Materials section.

And one last note, this call is being recorded and transcribed, and an audio recording and written transcript will be posted to the Call Details web page when it's available. And an announcement will be placed in the MLN Connect Provider eNews.

At this time, I'd like to turn the call over to Laura Dash, Director of the Division of Application, Compliance and Outreach in the CMS Performance-Based Policy Group. Laura?

Presentation

Laura Dash: Thanks, Charlie. Welcome, everyone, to our first call for the 2015 application cycle for the Medicare Shared Savings Program. As Charlie mentioned, my name is Laura Dash. I am the Director of the Division of Application, Compliance and Outreach in the Performance-Based Payment Policy Group in the Centers for Medicare & Medicaid Services.

Introduction

Today we will be going over with you information that will prepare you for the upcoming application cycle for the 2015 program performance year. We are now on slide 5.

On slide 5, you will find our agenda for today's call. In this session, we will introduce you to the Medicare Shared Savings Program; talk about what it takes to be an Accountable Care Organization; how your ACO should be structured, including the governance of the ACO; anti-trust issues associated with the ACOs, and how to successfully apply for the 2015 cycle. We have a robust agenda, so let's begin.

Slide 6. The 2015 application will be posted on the CMS website at the link provided on this web page on May 30th, 2014. We suggest that you take steps now to prepare yourself for the application phase.

This application requires several detailed narratives that you are required to submit explaining the details of your Accountable Care Organization, or ACO. Please do not 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. As part of the application, you must provide CMS with a sample of your ACO participant agreement, a template that we'll provide to you, where you will list all ACO participants, and a signed participant agreement that includes the first page and signature pages for all of your ACO participants. Also, you will need to submit − or you will need to establish your payment mechanism only if you have chosen track 2.

We strongly encourage you to 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 that you spend now preparing for the application process will save you time in the long run.

And also I wanted to let everybody know we'll be having a call on April 22nd to specifically discuss your ACO participant agreement. So please listen to that call for 2015 application cycle agreement guidance.

Before we discuss the application, we believe it's imperative that we define and describe what Medicare means by an Accountable Care Organization. Now I will turn the call over to Dr. Terri Postma, 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. Dr. Postma?

What Is an Accountable Care Organization?

Terri Postma: Thanks, Laura. Hi, everyone, and thanks for joining us today. I'm on slide number 7. My name's Terri Postma, I'm a medical officer in the Center for Medicare. I trained as a neurologist, but I've been privileged to spend the past several years here at CMS working on the development and implementation of the Medicare Shared Savings Program. And I've been asked to take some time today to give an overview of that

program and also emphasize some important elements that you should focus on as you develop your ACO and apply for participation.

Slide 8. By way of background, the concept of ACOs grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality. That body of work demonstrated that more care does not necessarily equal better care. In fact, often the opposite is true.

Additionally, CMS has prior experience with ACO-like efforts through the Physician Group Practice 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 $107 million in savings. Congress drew from these experts and from 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 and suppliers to join together into what are known as Accountable Care Organizations, or ACOs. Participating providers and suppliers in the ACO 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 overall. And 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 it generated for Medicare. In turn, the ACO will allocate those savings to improve its infrastructure and reward participating providers and suppliers.

Because the Shared Savings Program's 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 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 that we received.

Slide 9. Currently, over 330 organizations are participating in the Shared Savings Program. This map is a snapshot of where nearly 5 million Medicare fee-for-service beneficiaries are connecting with Medicare-enrolled providers and suppliers that are participating.

Slide 10. 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 pieces—so a hospital over there, a clinic over here, a post-acute care setting over there—without really 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. Don Berwick referred to as a three-part aim: that is, better care for individuals, better health for populations, and lowering growth in overall health care expenditures.

And we believe the ACO does this 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.

This program is built on the existing Medicare fee-for-service 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 of providers; rather, this is an incentive program for fee-for-service providers and suppliers to demonstrate that they can improve the quality and efficiency of care delivered to their fee-for-service patients.

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, ACOs should embrace the goals listed on this slide.

First and foremost, there's a goal of patient-centeredness. Also, ACOs should consciously seek to remember beneficiaries over time and place, and attend carefully to care transitions as those patients move along the care continuum and through – and between those sites of care. ACOs should proactively manage the beneficiary's care and collect, evaluate, and use data to improve care delivery and patient outcomes. And 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, it shows the Medicare Shared Savings Program, implemented by the Affordable Care Act as a national program and developed through rulemaking by the Center for Medicare on the fee-for-service side of CMS. The rule finalized two tracks from which an ACO can choose to participate.

Track 1 is a 3-year agreement period where the ACO receives shared savings, if they're generated, and is not put at risk for losses. Track 2 is 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 creates an on-ramp for organizations in varying stages of readiness to take on performance-based risk.

On the right side of the slide, the bubble shows the Innovation Center model – 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 view the Shared Savings Program rules as a starting point for the 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 as it's evaluated and proven to be effective.

You also might have 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 rule-in 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 available 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 we have posted on our website.

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

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 and may lead to denial of your application.

For example, the ACO 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, which is defined as 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 are important for your understanding of assignment, which will be covered on the next provider call, so I won't go into detail here.

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.

Organizational Structure and Governance

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 for your application. Specifically, your ACO must have a formal legal structure. Your ACO must have a mechanism for shared governance in the leadership and management structure. Your ACO must have at least 5,000 beneficiaries assigned to it. And 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 your ACO. This slide illustrates the typical structure, but not the only structure, of a Shared Savings Program ACO, where a collection of ACO participants—that is, those Medicare-enrolled billing TINs—have joined together to create an ACO.

The ACO participants could be hospitals, multispecialty group clinics, primary care clinics, solo practices, or pharmacies and the like, that bill Medicare directly – or they could be virtually any legal entity that bills Medicare directly for services rendered to fee-for-service beneficiaries. The Medicare-enrolled billing TIN identifies and defines the ACO participant.

For the eligibility requirement that the ACO have a formal legal structure to receive and distribute shared savings and a mechanism for shared governance, this is found in our rule at 42 CFR 425.104. In particular, note that the legal structure of the ACO is evidenced by a taxpayer ID.

If an ACO participant wants to form an ACO by itself 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 may be able to qualify to be the ACO. But it also must meet all the other eligibility requirements. Most ACO participants, however, will not be able to meet eligibility requirements on their own. When this is the case, they may choose to join with other Medicare-enrolled TINs to form an ACO.

Note that if the ACO is formed by multiple ACO participant TINs, the ACO's legal entity must be separate and distinct from any of the ACO participants themselves. That is, the ACO organizational TIN has to be different than any of those ACO participant TINs that's listed in the application.

Slide 16. The statute requires that ACOs have enough primary care professionals for the assignment of at least 5,000 fee-for-service beneficiaries. We will be using the ACO participant TINs submitted on your application to determine whether the ACO participants bill for at least 5,000 – bill for the assignment of at least 5,000 beneficiaries.

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: The governing body. The ACO legal entity must have a governing body that is representative of the ACO participants that have joined together to form it and have meaningful beneficiary input. We've created requirements, such as 75-percent control over the governing body by ACO participants. However, if an organization is unable to meet certain criteria, we have built in some 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, ACOs 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 includes 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 that meet the goal of the ACO.

Some common errors that we see on the applications are not having enough ACO participant representation on the governing body—that is, not meeting the 75-percent requirement; not demonstrating shared governance among ACO representatives—that is, one ACO representative on the governing body is overweighted at the expense of the others; or 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. This beneficiary does not have to be a fee-for-service beneficiary that ultimately becomes assigned to the ACO.

Control of the ACO resides with a parent or subsidiary organization but is not with the ACO legal entity. This is the cause for many requests for information in the application review. The control of the ACO must reside with the ACO legal entity designated on your application.

One other common error we see on applications is that the applicant's governing body does not have a fiduciary duty to the ACO alone. This is particularly important. And the existing organizations that are particularly vulnerable to not meeting this are IPAs that attempt to apply with a subset of practices, rather than all.

I strongly encourage you to review the guidance on our website and 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 submitting your application.

Slide 18. As previously mentioned, in order to participate, the ACO must be willing to become 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, we're really talking about the operational necessity of defining a population unique to the ACO for purposes of determining whether the ACO has met the quality standard necessary during the performance year to receive an incentive payment for improving the quality and efficiency of care delivered. We'll be implementing a preliminary prospective assignment with retrospective reconciliation.

So what does this mean? This means that we will perform 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 upfront information along the way during their performance year to help them better understand the fee-for-service population their providers care for by providing a list of preliminary prospective beneficiaries.

This list is based on the previous 12 months of experience and gives the ACO an idea of the types of beneficiaries that the ACO practitioners are seeing and suggests what beneficiaries will likely be present and continue to receive care during the performance year, enough so that they're assigned during retrospective reconciliation for that year. We believe that this creates an incentive for ACOs to standardize care processes and treat all Medicare patients the same while aiding ACOs in understanding their patient populations and proactively redesigning care processes for them.

Slide 19. CMS assigns beneficiaries in a two-step process that will be described in detail on a subsequent National Provider Call. Note that not all fee-for-service beneficiaries in a practice's panel will be assigned. So don't think that if you have an ACO participant TIN listed and they've seen 5,000 beneficiaries in the last year, don't think that all 5,000 of those beneficiaries will be assigned to the ACO. That's not the case. The two-step assignment algorithm looks at where a beneficiary has received the plurality of their primary care services—all primary care services, regardless of whether or not they've been provided by providers in your ACO or outside your ACO—and assigns on that basis.

All right, slide 20. This next part of the talk, we'll focus on additional programmatic issues. Slide 21. The statute states that if a provider/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 for you and also in the applications. The ACO participants submitted by the ACO will be screened during application review. If any of the ACO participant TINs is in one of the programs identified or any other program identified by CMS as another Shared Savings Program initiative, the application will 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 contain a list of the beneficiaries used to generate the report. Beneficiary-identifiable claims data provided for patients seen by ACO primary care providers, who have been notified and have not declined to have data shared, will also be available.

Slide 23. Patient engagement and shared decision-making are important aspects of the Shared Savings Program. We believe this initiative really works 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 – in the Shared Saving Program. Beneficiaries will also receive general information about the Shared Savings Program through the Medicare & You Handbook. CMS has established certain marketing guidelines. And, of course, ACOs are required to refer – offer beneficiaries the opportunity to decline data sharing before requesting their claims data for CMS.

Monitoring of this program has taken on heightened importance, particularly in light of the relaxation of C&P referrals kickback rules through the OIG–CMS joint waiver.

Slide 24. Finally, quality is another very important aspect 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 the set of 33 measures that support this 3-part aim focusing on better care and better health dimensions. The four domains are preventive health, at-risk and frail elderly populations, patient or caregiver experience of care, and 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. They were also chosen in part because many of these measures align with other incentive programs, such as PQRS and the EHR Incentive Program.

Slide 25. 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. ACO reporting can also satisfy certain criteria for meeting the EHR Incentive Program requirements. This eliminates the necessity of duplicate reporting and reduces burden for participants. Note that that the value-based program modifier does not apply to claims of providers and suppliers participating in the ACO.

Slide 26. Consistent with statute, measures include process, outcomes, and patient experience of care measures and are derived and collected from claims data, survey data, and medical records. The quality performance standard itself 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, over half the measures will be pay-for-performance. And in the third and final year of the agreement period, 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 relative to the benchmark.

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

There's one tip I would give applicants: Some ACOs have met the requirements to enter the program, but because their ACO participants weren't well educated or committed to the program, those ACOs have 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 participants informed and educated and up to speed rather than risk failure because you rushed through the development process.

Slide 27. Details of the quality measures submission are provided to ACOs through webinars and other education materials developed by CMS. These can be found on our website, and I encourage you to review the quality reporting requirements before applying to ensure that your ACO can meet its obligations to the program and to the ACO's providers and suppliers that have joined to participate.

Slide 28. Meaningfully using EHR technology is an important skill for practitioners in the ACO to learn. To signal the importance of developing this capability, one of the measures in the quality performance standard counts twice that of any other measure. Specifically, ACO measure number 11 calculates the number of primary care providers participating in the ACO that earn an EHR incentive payment. Additional information about the EHR Incentive Program can be found by following the link on this slide.

Slide 29. Before applying to participate, your organization should review and understand the quality reporting requirements, clearly articulate the quality reporting requirements to ACO participants, including the alignment of other CMS quality reporting incentive programs like PQRS and the EHR Incentive Program, and develop a plan for quality reporting.

This is particularly important for organizations that are composed of more than one ACO participant TIN. Several of our ACOs – just anecdotally, several of our ACOs that are currently participating are made up of very small group practices that have joined together − small group practices and solo practices that have joined together. And those ACOs have met with the challenge of working across those practices to gather the information necessary for quality reporting.

Many of those ACOs report that they are working with practices that may or may not have EHRs and even when they do have EHR, they may be dealing with multiple different platforms, up to or exceeding 10 different kinds of EHR platforms.

So really plan ahead and think about how you're going to – how you're going to connect those and how you're going to get that information rolled up and submitted to CMS in a timely way.

Slide 30. The benchmark is established by taking the claims submitted by ACO participants – the financial benchmark, I should say, 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 of those benchmarking years, and then rolling it up to establish a 3-year average per capita cost for the ACO's average fee-for-service population.

The financial benchmark is risk-adjusted and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services. The performance year risk-adjusted expenditures are then compared to the benchmark. And 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 into account normal variation. The ACO then shares from first dollar from the benchmark.

As mentioned earlier, the ACOs have the opportunity to choose between one of two tracks. Under Track 1, the ACOs will 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 or MSR is variable depending on the number of assigned beneficiaries. Once met or exceeded, the ACO shares from first dollar.

Under Track 2, the ACO has the opportunity to share in savings and be put at risk for losses, but in return for a higher sharing rate, a maximum of 60 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 the ACO from sharing maximally. The MSR is fixed at 2 percent on both the up and down sides. Once met or exceeded, the ACO will share in savings or losses from first dollar.

Slide 31. As part of a coordinated interagency effort, CMS worked with the FTC and DOJ antitrust agencies as well as the IRS and the OIG. The antitrust agencies concurrently released an antitrust policy statement that complements the 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. And you're going to hear from Rob Canterman shortly.

The IRS released a response to comments for those tax-exempt entities that wish to participate. And finally, the OIG jointly with CMS issued an interim final rule with comment regarding C&Ps, kickback, and referrals for ACOs. All this information and links to those documents can be found on our website.

So with that, I'll conclude this overview and turn it over to Rob Canterman from the FTC, who will give a brief overview of the antitrust policy statement. Rob?

Antitrust and ACOs

Rob Canterman: Thanks, Terri. Good afternoon, everyone. I'm please to have the opportunity to talk with you about antitrust and ACOs. As Terri mentioned, I'm an attorney in the Health Care Division of the Bureau of Competition of the Federal Trade Commission.

First, I just need to give the standard disclaimer that the views I'm sharing with you are my own and not necessarily those of the FTC. I also note that the FTC coordinates with the Antitrust Division of the Department of Justice on these issues, including this antitrust portion of today's program.

I'm going to very briefly give you a high-level overview of the key antitrust issues you should be aware of, and point out some available antitrust guidance. The key takeaway from my talk is this: As you form and operate an ACO, remember to consider potential antitrust issues. Guidance from the antitrust agencies is available, which I will talk about in just a moment. Also under certain circumstances, you may want to consider seeking antitrust counsel.

On the next slide, slide 33, are key antitrust issues relating to ACOs. First, the antitrust agencies recognize that many ACOs do not raise any antitrust concerns, and they actually benefit patients by improving quality of care and lowering cost. But, under certain circumstances, which I'll talk about in just a moment, the formation or operation of an ACO may raise antitrust issues. Keep in mind there's no antitrust immunity just by participating in the Shared Savings Program.

So there are three potential antitrust concerns ACOs should be aware of: first is price-fixing, second is monopolization, and the third, certain mergers or acquisitions. First, price-fixing agreements among competing providers, including joint and negotiations with commercial payers, are considered per se or automatically illegal under the antitrust laws if not part of a legitimate joint venture such as an ACO participating in the Shared Savings Program.

So if an ACO participates in the Shared Savings Program and uses the same governance and leadership structures and clinical and administrative processes to service patients in commercial markets, then there's not going to be a per se or automatic violation of the antitrust laws. Instead, the antitrust agencies will evaluate the ACO under what we call a rule of reason. That simply means that we weigh the efficiencies created by the ACO against any potential anti-competitive effects.

Under the rule of reason, a potential concern is what we call monopolization. And that includes whether the ACO has market power. More specifically, monopolization is the power to raise prices above a competitive level and some conduct to maintain or achieve that power. A starting point that we usually look at to determine whether or not an ACO has market power is examine an ACO's market shares in a particular geographic market.

Ultimately, whether an ACO has market power will depend on the size of the ACO, that is, how many providers are participating in the ACO, and how many other providers compete with those providers in the particular geographic market.

The third potential antitrust concern to keep in mind is an ACO formed through a merger or an acquisition of a competitor that lessens competition in a particular market. In looking at a merger, the key question is whether that merger creates or enhances market power. One other point on mergers is that although providers may form an ACO through a merger, it's not required under the Affordable Care Act or under the Shared Savings Program regulations.

On the next slide, slide 34, I want to point out some guidance that is available to ACOs in this area. And that is the FTC−DOJ Antitrust Enforcement Policy Statement regarding ACOs participating in the Shared Savings Program. This policy statement provides guidance for collaborations among otherwise independent providers and provider groups that are eligible and intend or have been approved to participate in the Shared Savings Program. Keep in mind that if the ACO is formed through a merger that that merger will be evaluated on a separate set of guidelines issued by the antitrust law − antitrust agencies. And that is the horizontal merger guidelines.

Very briefly, I've pointed out on these – this slide some of the key features of the policy statement. As I mentioned earlier, there's no per se or automatic violation for jointly negotiating with commercial payers if certain conditions are met. There's also a Safety Zone for ACOs that are unlikely to raise any significant competitive concerns. And if the ACO falls within the Safety Zone, the antitrust agencies will not seek an antitrust enforcement action against the ACO.

Just because an ACO does not fit within the Safety Zone doesn't mean there's necessarily a problem. It just means we need to take a closer look. And the policy statement provides guidance for those particular ACOs.

For ACOs that want further guidance beyond the policy statement, there's an opportunity to seek a voluntary expedited review from the antitrust agencies, which is spelled out in the policy statement. The policy statement and other guidance for ACOs are available at the links that are provided on the slide.

I've quickly gone through a lot of information. So if you remember nothing else, just remember to consider potential antitrust issues when forming or operating an ACO. I'll be happy to try to any – answer any antitrust questions at the end of this presentation.

And now I will turn the program over to Laura Dash, who will go over with you the 2015 application process. Laura?

Application Process for January 2015

Laura Dash: Thanks, Rob. All right. We're now on slide 36, the application process. So together let's walk through the actual application process for program year 2015 as well as the key deadlines that you must meet.

Slide 37 is our application cycle. These are deadlines to apply for program year 2015. And unfortunately the slide got cut. You should have received via email a corrected version of this timeframe, and it's also on our Medicare Shared Savings Program website, on the Application page.

So in order to get started, you must be aware of the key dates in the application process. Understand that we are required by statute to start each new cycle on January 1st of each year. So it's imperative that all of the deadlines are met in order to be in compliance with the law. I will go through each of these steps more thoroughly later in the slide presentation, but for now, know that before you can submit an application, you must first submit a Notice of Intent to Apply, or NOI. Note the NOI memorandum was posted to our website on April 1st, 2014. And that NOI memorandum contains a sample of the NOI questionnaire.

You will now be able to view the NOI memo, and the NOI − actual NOI questionnaire will be posted on our website May 1st. NOIs will be accepted online from May 1st to May 30th, 2014. Please note that the deadline for NOIs is 8:00 PM Eastern time on Friday, May 30th, 2014. We will not accept late NOI submissions. If you fail to meet the deadline, your next opportunity to apply for the Medicare Shared Savings Program will be for the 2016 application cycle.

Following the NOI submission, you are required to submit a CMS User ID form for all individuals who will submit an application and for those who may utilize CMS data if your ACO is approved.

These forms must be submitted to us by June 9th, 2014. I 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 email. Directions on completing the CMS User ID access are also included in that email. Since it takes 3 to 4 weeks for CMS 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 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 2015 NOI and receive a new ACO ID. After this has been completed, you must submit a 2015 application using the appropriate 2015 templates and naming conventions, as well as responding to attestation questions in the application.

CMS will not evaluate any previous submission. We will accept applications from July 1st through July 31st, 2014. Again, the deadline for application submissions will be 8:00 p.m. Eastern Time on July 31st. We plan to issue application dispositions in fall 2014. If an applicant is denied and would like to seek reconsideration, the applicant will have up to 2 weeks after the final determinations are issued and – to request a review of that denial.

Slide 38. In order to make the application easy and efficient, we developed the Application Toolkit. This Toolkit gives you precise directions and examples of the supporting documents that are integral parts of the application. It is important that you use the templates we provide in order to complete the application. Do not alter the templates. Only fill in the cells where applicable to your ACO.

We would also like to reiterate that it is important to use the naming conventions that we provide. The naming conventions were developed to make the application and review process more efficient.

Our Toolkit includes regulation reference page, additional guidance, and FAQs for each question in the application; Form CMS-588, which is the Electronic Funds Transfer, or EFT, Authorization Agreement; the ACO Participant List Template; the Governing Body Template; the ACO Participant Agreement Template; and Executed Agreements Template.

Slide 39: Step 1—Notice of Intent to Apply. Your first step in the application process is to prepare and submit your Notice of Intent to Apply, or NOI. You may access the NOI questionnaire on our website beginning May 1st at the web link provided. Step 1 on this page will direct you to the links for the NOI. NOIs will be accepted from May 1st to May 30th – from May 1st, 2014 through May 30th, 2014, and due on May 30th no later than 8:00 p.m. Eastern Time.

After you submit your NOI, you will receive an NOI receipt notice by email. We will send this email to the primary and secondary application contacts listed in the NOI. The NOI receipt notice email will include your ACO identification number, or ACO ID, and instructions on obtaining CMS User IDs. Please make sure the email addresses are accurate prior to submitting your NOI. It is important to note that submitting a NOI does not bind you to submit an application. However, you must submit an NOI prior to submitting an application.

Slide 40: step 2. Your NOI receipt notice will provide you with detailed instructions about how to access and fill out CMS Form 20037, Application for Access to CMS Computer Systems. This is the form you need to get a CMS User ID. Follow these directions 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 found at cms.hhs.gov/informationsecurity/download/euaaccessform.pdf. This is also in our Toolkit. Return the completed form to CMS via tracked mail, for instance FedEx, within 3 business days of receiving the NOI receipt. The forms must be sent to Adam Foltz at the address shown on this slide.

Please note that your ACO must have at least four CMS users. Each individual's form must include the requester's Social Security Number, email address, ACO ID number, and must be dated with an original signature. Again, please make sure the contact information is accurate.

Again, we stress that it takes 3 to 4 weeks to process CMS user access requests, so it is critical to do this step as soon as possible. CMS User IDs are necessary in order to submit your final application.

Slide 41. If the contact is a consultant, include an authorization letter from the ACO which authorizes the consultant to request, receive, and submit access – excuse me – request, receive, and gain access to the ACO's data maintained in CMS's system. The letter must have the following: It must be submitted on the ACO's official letterhead, it should clearly indicate the consultant's name and State and that he or she will be serving as a consultant on behalf of the ACO. Authorized ACO identification number or the ACO ID must be listed, and it must say that the consultant can have access to that ACO ID. And the letter must be signed by the ACO's authorized official.

If a consultant is working with multiple ACOs, a single email may be sent to hpms_access@cms.hhs.gov with multiple PDF attachments for each separate ACO. Again, all of these instructions will be included in your NOI receipt confirmation email.

Slide 42. If you are a consultant and already have a CMS User ID, please follow the directions found on this slide. Your CMS User ID is unique to you, not the ACO or ACOs that you represent. Therefore, if you currently have a CMS User ID, you do not need to apply for a new or a different one. Instead, you will need to make us aware of which ACO or ACOs you are representing by sending us the information found on slide 42, on the ACO's letterhead.

It is important that the ACO's authorizing official, who would be the ACO Executive or the Authorized to Sign, are the people who sign the letter. This letter should be made into a PDF and emailed to us at hpms_access@cms.hhs.gov. Please do this necessary step as you receive your NOI receipt confirmation email.

Slide 43. Just a quick reminder that it's fraudulent to use another user's CMS access or to allow someone else to use your CMS access. This activity is strictly prohibited and will result in the termination of the individual CMS user access if found in violation of this policy.

Slide 43 − Excuse me, slide 44. We will post the 2015 application to our website on May 30th, 2014. We suggest that you review this application thoroughly at that time. The more familiar you are with the application and its requirements, the more likely you will have fewer problems. Please do not wait to begin the application process.

Slide 45. In order to get paid, you must submit a completed CMS Form 588, EFT Agreement. This form may also be referred to as EFT Form 588, the 588, or the banking form. CMS validates the banking information before any EFT deposits are made. We recommend that as soon as your ACO is formed, you should establish a validated account and set up an active checking account using your ACO's legal business name and TIN.

We would like to emphasize that your ACO's 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. We will not receive your EFT if this information does not match. If there are errors, CMS's Office of Financial Management will notify the contact person on the form and ask them to make corrections. If your ACO's TIN or legal business name changes, you must notify CMS as soon as possible. You can email us at SSPACO_Applications@cms.hhs.gov.

During the application process, the CMS form must be submitted to OFM via tracked email or – excuse me – tracked U.S. mail to the address on this slide.

Slide 47. Just a quick recap: Act early; time is of the essence. Educate your ACO participants about quality reporting. Include at least four contacts for your ACO. All correspondence between the ACO and CMS must include your ACO ID number and the legal business name. Never share any CMS access user IDs. And contact CMS with application questions at the email address on this slide.

Resources

Slide 48: Upcoming application calls. So we have some upcoming application calls that you can see on this slide. And in the interest of time we're going to keep moving. Contacts for assistance—so again, another slide. So let's open it up for questions and answers.

Keypad Polling

Charlie Eleftheriou: I just want to pause for one quick second before we move into Q&A. We're going to pause for a moment 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 short moment of silence on the line while we tabulate the results. We're now 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.

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. 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. I would now like to turn the call back over to Charlie Eleftheriou.

Question-and-Answer Session

Charlie Eleftheriou: Thank you very much. Now our subject-matter experts will take your questions. Because this call is being recorded and transcribed, please state your name and the name of your organization before asking your question. And in an effort to hear from as many callers as possible, we ask that you limit your questions to just one at a time. If you have more than one question, please press star 1 after your first question has been answered to get back in the queue. We'll address additional questions as time permits.

Just one more quick note: We'll be correcting an – the error on slide 37 and should have a revised slide deck posted on the Call Details web page tomorrow. At this point, we're ready to start taking 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 into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Jennifer Teeter.

Jennifer Teeter: Yes. I'm with Frederick Regional Health System in Frederick, Maryland.

Charlie Eleftheriou: Hi, how are you?

Jennifer Teeter: Hi, I'm fine. I thought I heard Dr. Postma mention that the beneficiary does not have to be a fee-for-service participant of one of the participant TINs. Did I hear that correctly? Could someone repeat that?

Terri Postma: This is – yes. This is Terri Postma. So I think that perhaps what you're recalling, there's a requirement that a beneficiary be on the governing body of the ACO. And that fee-for-service beneficiary should be a patient of one of the ACO participants but does not necessarily have to get assigned to the ACO. Does that make sense?

The assigned beneficiaries are a subset of the patients that are seen by practitioners that are participating in the ACO. And you won't know ahead of time because those

beneficiaries are retrospectively assigned at the end of each performance year. So your – the ACO's not going to know which fee-for-service patients are going to end up getting assigned to the ACO.

So that's why the requirement is that if the – Medicare beneficiary's that a patient of one of these field practitioners but does not necessarily have to be an individual that ends up being assigned.

Jennifer Teeter: OK. And if it turns out after the first year that the person is not assigned, do you then have to pick an assigned beneficiary?

Terri Postma: No. Not at all.

Jennifer Teeter: OK. Thank you.

Terri Postma: You're welcome.

Operator: Your next question comes from the line of Alexis Isabelle.

Alexis Isabelle: Hi, this is Alexis from athenahealth. And I'm sorry if I missed this. I had to kind of jump off for a second. But for the quality measures for 2014 reporting period, had they changed at all, or are they still the initial ACO quality measures that were sent out at the beginning of the program?

Terri Postma: For 2014, which is the performance year we're in now, the quality measures are the 33 measures that are posted on our website and part of the rules that were published in 2011.

Alexis Isabelle: OK. So there haven't been any measure updates, or if there are, they would be on that site.

Terri Postma: Correct.

Alexis Isabelle: Thank you.

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

Barbara Lillemon: Hello, this is Barbara Lillemon with Capital Medical Extended Care. When you are going through the PowerPoint slides, I just wanted to point out that there is the missing slide 45 as well. And I was wondering if you'd be able to send that out. It was the banking slide.

Laura Dash: Yes. Hi, Barbara. It's Laura. I think there might be a numbering issue. So yes, that correction it will be included on the revised version that's posted tomorrow, as Charlie mentioned.

Barbara Lillemon: OK. Thank you.

Operator: Your next question comes from the line of Mary Thomas.

Mary Thomas: Hi, my name is Mary Thomas. I'm with Nebraska Methodist Health System. We are currently part of an ACO, but we are also a large independent multi-practitioner specialty group. And I'm wondering if we can participate, even though we are part of an ACO, independent of the ACO as a large group.

Terri Postma: So this is Terri. So I think what you would have to do is dissociate from your current ACO and then apply as that group practice, that being your ACO. So you could do it but you would have to work with your current ACO to terminate from them and be removed from their ACO participant list. You would have to apply this year if you wanted to start in 2015. And your group practice would have to meet all of the eligibility requirements …

Mary Thomas: OK.

Terri Postma: … to be able to do that.

Mary Thomas: OK. Thank you.

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

Jordan Anderson: Hi, I work for – Jordan Anderson, I work for MissionPoint. And I'm wondering about a, if an ACO that is already an existing – an MSSP ACO that's already in existence would like to go into a new geographic region and expand the MSSP into that area. From a governance standpoint, how does – how would that work from – the existing ACO already has a governing board but then the new ACO in a different geography, could you set up sort of like an advisory – an advisory committee that would have 75 percent of the participants on it?

Terri Postma: So this is Terri. If your ACO is already participating in the Shared Savings Program and you want to invite Medicare-enrolled entities from a different geographic area to join your ACO, you could do that through the drop/add process. I would suggest that you talk with your ACO's regional coordinator to talk about what modifications should be contemplated for your governing body.

Jordan Anderson: OK, thank you.

Operator: Your next question comes from the line of Bomi Parakh.

Bomi Parakh: Yes, I'm calling from Brookdale Senior Living. I was wondering if you could comment on what kinds of discounting or payment arrangements an ACO can request of its participants or providers and suppliers.

Terri Postma: So this is Terri. So all normal fee-for-service rules apply because the program is an incentive built on top of regular fee-for-service. So the providers and suppliers that join together to form the ACO would continue billing Medicare fee-for-service as they normally would. There aren't any discounts or anything like that. And then the ACO as a whole is evaluated at the end of each performance year to see whether it met the quality performance standards and reduced cost compared to its benchmark. And if it has, then CMS will share a lump sum incentive payment with the ACO. So I just want to make sure that that's clear.

There are some other incentive programs through the Innovation Center that you might want to look at if you're looking for innovative changes to fee-for-service payments and that sort of thing. But that's not part of the Shared Savings Program.

Charlie Eleftheriou: I think we'll take the next question.

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

Tom Boggs: Good afternoon, I was – I'm from Aultman Hospital and I was calling regarding slide 17. With respect to the governance roles, ACO participants have at least 75-percent control of the governing body. Is there a minimum number of participants, does it include voting-only or ex-officio members? If you can give me a little more detail about that.

Terri Postma: Yes, this is Terri. So I think the Toolkit has some further instructions on this, and we do look at voting power, so when you fill out that template as part of your application, you're going to be listing the ACO participants − or each member of the governing body, what ACO participant that member is representing and what that portion of the member's voting power is. So it's 75-percent voting power.

Laura Dash: And Tom, this is Laura. We do look at those lists very closely. So, for example, having one participant would not be sufficient. We want to make sure that there is a decent − a fair representation. So if you have specific questions, we can even address those to the SSP mailbox, which we have listed in the slide show.

Tom Boggs: And one other question if I may. On slide 21, are you still eligible to participate in the CMMI Bundled Payment initiative and a shared savings initiative?

Laura Dash: Yes.

Tom Boggs: OK. Just want to make sure that, thank you.

Laura: Mm-hmm.

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

Jennifer Touse: Hi, this is Jennifer Touse from BayCare Health System. My question is, if my company would like to use our existing clinically integrated network, which currently services only commercial payers, as the corporate structure for a Medicare ACO: Assuming we meet all the other structure and governance requirements, do all of our existing physician groups that − who are contracted under the clinically integrated network − have to agree to be participants in Medicare ACO, or can you have a legal entity that services both Medicare ACO participants and non-Medicare ACO participants?

Terri Postma: So this is Terri, and I think that that question's probably complicated enough that we would need some more detail. So it would be good to submit that through the Shared Saving Program mailbox, and we can maybe work with you on it. But generally speaking, if you look at the March 16 guidance that's on our website, and it talks about fiduciary duty, there are a number of governing body requirements that the ACO has to meet.

So look in our rule at those and look at the March 16 guidance, and generally speaking, if an existing organization wants to be the ACO legal entity, then all the Medicare-enrolled providers – that entity as a whole has to participate in order not to violate the fiduciary duty requirements. So just take a look at that and if you have followup questions or more, you know, we can get more information from you on what exactly you're thinking, then, you know, email through the mailbox and we'll work with you on that.

Laura Dash: And as a reminder the mailbox is …

Laura Dash: Sorry, Victoria, as a reminder, that mailbox is on slide 49. That's SSPACO_applications@cms.hhs.gov. We also refer to it as the applications mailbox. Thanks. Victoria?

Operator: Certainly. Your next question comes from the line of Teresa Jenewein.

Teresa Jenewein: We're dealing with some post-acute providers that have received contracts from other ACOs. So the example is it's a SNF that we were in conversations with about joining our ACO, but they're a part of another ACO. They do not have beneficiaries per se. But as a post-acute provider, we were trying to work with them. And one of the contracts they received from a large hospital organization that does have − that is an ACO said that they could not participate with any other ACO.

I couldn't find something that said you had to be proprietary as a post-acute provider to a specific ACO. I don't know if this would fall under antitrust that – maybe if someone could address that.

Terri Postma: Yes. This is Terri. So for purposes of the Shared Savings Program operations, it's really critical that we be able to assign a unique patient population to each ACO. So our assignment algorithm is based on primary care services rendered by the − and submitted by the ACO participant TINs. So the rule is that if you're an ACO

participant TIN that bills for primary care services as they're defined in our rule—that's a certain set of E&M and CPT codes, so take a look at those—but if that ACO participant TIN billed Medicare for any of those codes, then that ACO participant TIN can only be a part of one ACO's ACO participant list.

We also have some facts on our website about this so-called exclusivity rule that you might want to look at, that sort of walks through what that exclusivity is and what it is not. It does not apply to individual doctors; it is only for purposes of the Shared Savings Program. It's not for purposes of other private contracting or anything of that nature, referral of patients, nothing like that. So it's only for purposes − operational purposes for the rule. So take a peek at those facts and see if they kind of walk you through what that rule is, OK?

And I think that some SNFs do bill Medicare for those primary care services, but some do not. So I think you'd have to talk to that, you know, look at that TIN billing in particular and see if they do or not.

Teresa Jenewein: So if you're not, they would be eligible to participate with multiple ACOs?

Terri Postma: Yes, if the TIN does not bill for primary care services—so let's say it's an acute care hospital or something that only bills DRGs, they don't fill those outpatient services—then that TIN could be a part of more than one − it could be an ACO participant on more than one ACO's list.

Teresa Jenewein: Thank you.

Operator: Your next question comes from the line of Jeanne Shirshac.

Jeanne Shirshac: Hi, I'm from UMass Memorial, and I just had a question about the data sharing. So the data reports that you'll be sending us I assume are on TME benchmark information and beneficiary information. Says on the slide they'll be – 22, they'll be provided at the start of the agreement period. So is that January 2015 or is it prior to that when we first are, you know, are approved for the program?

Terri Postma: This is Terri. Those − the data reports start to be shared after the first of the year, or as soon as we've nailed down the assignment list and as soon as the contract has been signed for participation. So we try to get it out as quickly as possible to you, and those would be things like the benchmark report, and then the quarterly aggregate report will follow and then finally the reconciliation report, which happens at the end of each year. So there are a number of reports that have both aggregate as well as beneficiary-identifiable data. But those are only provided after the ACO has signed the agreement to participate.

Jeanne Shirshac: OK and then, in turn, do you folks provide a beneficiary listing that we would use to do the beneficiary communication, or is that – how does − when is that provided?

Terri Postma: Yes, there's a preliminary perspective list that is generated in conjunction with your benchmark report as well as each quarterly report.

Jeanne Shirshac: OK, thank you.

Operator: Your next question comes from the line of Jennifer Gasperini. Jennifer, your line is open.

Jennifer Gasperini: Hi, Jennifer Gasperini with MGMA. So I know that you can get credit for the CQM component of Meaningful Use if you're also participating in an ACO. But my question is, how exactly does the provider attest to that CQM component of Meaningful Use then, since the reporting deadlines don't align?

Terri Postma: Yes, the providers themselves are attesting and signing up the way that the EHR Incentive Program requires them to. I believe there is a button, an attestation button saying that the provider has reported their eCQMs via the ACO or that they have submitted them. There's something – I'm sorry, I'm not too familiar with that program's operational details, but it is done through that the EHR Incentive Program itself.

Jennifer Gasperini: OK, thanks.

Terri Postma: Yes, and then we coordinate on our end to tell the EHR Incentive Program what practitioners are participating in the ACO so that they can cross-check.

Operator: Your next question comes from the line of Val Sylejmani.

Val Sylejmani: Hi, Val Sylejmani with Cadence Health. My question was just to provide a little more clarification when we were talking about the Medicare beneficiary on the board. Was it that they should be a patient of an ACO participant—is that a requirement or is that just kind of nice to have?

Terri Postma: No, it's a requirement that the beneficiary be a Medicare beneficiary cared for by one of the ACO participants.

Val Sylejmani: OK, thank you.

Operator: Your next question comes from the line of Zedrick Buhay.

Zedrick Buhay: Hi good afternoon, my name is Zedrick Buhay with IPR Healthcare System. I have a question for home health and hospice organizations. Do we need to be already joined with an ACO currently to provide services to the beneficiaries of the ACO, or can we still provide services for an existing ACO?

Laura Dash: Zedrick, this is Laura. Can you repeat your question? I'm sorry, we were trying to follow but didn't get everything.

Zedrick Buhay: Yes, no – no problem. For home health and hospice organizations, in regard to providing services to beneficiaries of the ACOs, do we have to already be part of that ACO? Or can we provide services even though we're not part of that ACO?

Terri Postma: OK. This is Terri. So just remember that this isn't a managed care setting or anything like that, this is just normal fee-for-service. So you should continue − if you're a home health or any Medicare-enrolled provider, you should just continue to be providing services as you would normally provide them to a Medicare fee-for-service patient regardless of whether or not that patient is seeing providers that are participating in an ACO.

Zedrick Buhay: OK, that answers the question. OK, thank you.

Operator: Your next question comes from the line of Patrick O'Hara.

Patrick O'Hara: Yes, hi. Patrick O'Hara with Inovalon. I was wondering a little bit more about the EHR incentives and what exactly they are, and there wasn't too much detail, just a location where there's more information about it.

Terri Postma: Sure. I believe there's a link in the slide deck to the EHR Incentive Program, so if you want more detailed information on that. But just at a high level, this is an incentive program that runs through CMS that provides a financial incentive – oh yes, it's on slide 28. This provides a financial incentive to providers to implement and begin meaningfully using EHR technology. And it's in a graded fashion; I think it's the first year and so there's a Meaningful Use stages 1, 2, 3. I think they're working on 2 right now, or working on 3. I'm sorry, I don't really know exactly how far along they are in that program but this is − and then the financial incentives decrease over time. And I'm not sure if, like PQRS, it becomes actually a financial disincentive at some point. But I know that, I think this is one of the last years for the financial incentive. And then − but details of that program can be found.

And the way that we've aligned with them is in two ways. Number one, we have a quality measure, as I mentioned, in the ACO's quality performance standard that is worth twice what any other measure in the quality performance standard is worth and that assesses the number of primary care providers in the ACO that successfully qualified for the EHR Incentive Program incentive payment. And so the higher that number is the better for the ACO on the performance of that measure.

And then secondly, we've aligned with them because when the ACO reports quality measures to CMS at the end of each performance year, that actually satisfies the eCQM component of the EHR Incentive Program requirement. There are several other

requirements that eligible professionals have to satisfy. But the ACO satisfies at least that one portion on behalf of those eligible professionals.

So in those ways the Shared Savings Program aligns with that incentive program. And I would encourage you to take a look at that and be transparent with the providers that are forming or joining your ACO so that they understand it, too.

Patrick O'Hara: Great. One more quick question. How is it rated? Is it based on the percentage of providers that use it as an ACO as a whole, or provider level? How is it regulated or judged?

Terri Postma: The quality measure, ACO number 11?

Patrick O'Hara: Yes.

Terri Postma: Yes, the specifications for that can be found on our website, as can the specifications that describe the numerator and denominator of each of the measures.

Patrick O'Hara: OK, great, thank you.

Charlie Eleftheriou: Thank you. We'll take one more question.

Operator: Your final question is a followup from the line of Jennifer Teeter.

Jennifer Teeter: Yes, I'm from Frederick, Maryland. I had a question about an ACO participant that is interested in terminating a relationship with an existing ACO and joining a newly formed ACO, and the timing aspect of that, related to being able to receive attribution under the new ACO that they plan to join. How long does it usually take CMS to process a provider out of an ACO, and how does the attribution work? Is it calendar year? Could you talk about that briefly?

Terri Postma: Yes, so there's a normal drop/add process that we have, so the existing ACO would have to submit a request to drop that TIN from its ACO participant list. And that process occurs concurrently with our evaluation of the new applicant list.

So what would have to happen is that the existing ACO would have to submit that drop to CMS through HPMS and − using that normal drop/add process, and then the applicant could put that TIN on its list when it applies for the program. And so, assuming there aren't any issues on either side of that, it should all work out.

So there's a date, a drop date that needs to be submitted. And so the one that when − the ACO that they're participating in would submit the drop date as of the end of this year, the end of 2014, so that that TIN would be free for the ACO that's applying to pick them up beginning January 1st. That assumes, of course, that the ACO that's applying has been able to meet all the requirements and is accepted into the program. Because if they're not,

then the ACO participant TIN is kind of left hanging in the wind, you know, without a home. So that TIN is going to want to be sure that the applicant will be successful.

Jennifer Teeter: So actually the dropping off of the existing ACO needs to happen prior to the application going in at the end of July in order to make that process work.

Terri Postma: It can happen generally concurrently because we're going to be evaluating those lists at the same time. But the sooner, the better.

Jennifer Teeter: And does their being a primary care physician complicate this any further or is that the same process?

Terri Postma: No, it's generally the same process.

Jennifer Teeter: Thank you.

Terri Postma: Yes.

Charlie Eleftheriou: And Victoria, if we have another question we'll take one more.

Operator: OK. Your final question comes from the line of Val Sylejmani.

Charlie Eleftheriou: Hello.

Val Sylejmani: Hi, this is Val Sylejmani again with Cadence Health. I was just wondering if we were going to expect any changes to the 2015 application from last year's.

Laura Dash: Hi, it's Laura. Yes, you should only be using the 2014 application that's posted to our website as a guide. We will be, as we said previously, posting the 2015 application to our website on May 30th. So yes, we do anticipate a couple of things will change. So only use the '14 information as a guide currently, please.

Val Sylejmani: OK. So the templates that are in the Toolkit, those won't − they may change a little bit but not significantly as far as the − what is being asked.

Laura Dash: Yes. Again, the 2014 information is only as a reference so the 2015 …

Val Sylejmani: Right, OK.

Laura Dash: … information will be posted by May 30th.

Val Sylejmani: Thank you.

Additional Information

Charlie Eleftheriou: Thank you, and unfortunately that's all the time we have for questions today. If you have additional questions or if we didn't get to your question, please reference slide 49 for some resources and contacts for assistance.

On slide 51 you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your MLN Connects Call experience.

And lastly, I'd just like to thank our subject-matter experts and all participants who joined us for today's MLN Connects Call. Have a great day, and our next call will be on the 22nd of this month. Hope to see you there. Thank you.

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

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