Medicare Learning Network®
Official Information Health Care Professionals Can Trust

MLN Connects™

National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO Application Process
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
April 22, 2014
1:30 p.m. ET

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. Sir, 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 Call on the Medicare Shared Savings Program, ACO application process. MLN Connects Calls are part of the Medicare Learning Network. During this call, CMS subject matter experts will be going over helpful tips for completing a successful application. The question-and-answer session will follow the presentation.

Before we get started, there are couple items I'd like to quickly cover. You should have received a link to the slide presentation for today's call in an email today. But if you have not seen that email, you can find today's presentation on the call details webpage, which can be found by visiting www.cms.gov/npc. Again, that URL is cms.gov/npc, as in National Provider Call. On the left side of that page, select National Provider Calls and Events, then select today's call by date from the list. The slide presentation is located there in the call material section.

One last note, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the call details webpage when it's available. And an announcement will be placed in the MLN Connects provider eNews.

At this time, I'd like to start the call by turning it 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. We're on slide 5, and welcome to our second call for 2015 applicants for the Medicare Shared Savings Program. As Charlie said, my name is Laura Dash.

The ACO Application

Moving to slide 6. During today's call we will go over with you ACO Participant Agreement, the ACO Participant List, and how CMS determines beneficiary assignment for each application. And the purpose of today's call is to discuss these three important and historically challenging issues related to your application. We believe that by providing this information now, you will have the tools necessary to develop a successful application. We strongly encourage you to work on these elements immediately.

I will begin our presentation with ways to ensure that you have complete and accurate ACO Participant Agreements between you and your ACO participants and provider/suppliers. Next, Kari Grant Vandegrift will go over with you details about your ACO Participant List. Finally, Dr. Walter Adamache, from RTI International, will go over in detail the logic we use to determine beneficiary assignment for each ACO. At the end we will leave time for you to ask us questions.

Let's start with slide 8. A quick background, I know we've discussed the program's background during our April 8th call, but just a quick overview for those joining us anew today. The Medicare Shared Savings Program is a voluntary program. It is an opportunity for providers to join together in Accountable Care Organizations or ACOs. Participating providers and suppliers in the ACO will continue to bill for and receive fee-for-service payments as they normally do. But at the end of each year, CMS will evaluate the ACO's quality and efficiency. If the ACO as a whole has met the quality performance standard and has reduced the growth and per capita cost 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. Because the Shared Savings Program is a national program, its rules were develop 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 our policies of the final rule are both improved and responsive to over 1,300 comments we had received.

Slide 9. We have an ambitious agenda today, so let's get started.

Definitions

Slide 10. 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 Identification Numbers, also called TIN. ACO providers/suppliers are NPIs, in other words, they are individual practitioners that have reassigned their billing to the TIN of an ACO participant.

So for example, if there is a group practice that's joining with other group practices to form an ACO, the group practice with its own Medicare-enrolled billing TIN would be the ACO participant. Any practitioners, in other words, any physicians, MPs, PAs, clinical nurse specialist, etc., that bill through the TIN of the group practice would be defined as ACO providers/suppliers.

Please make sure you read and understand the differences between these two 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 applicant –

excuse me, for example, the application asks you to list your 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. If the agreement is not made between the correct parties, the agreement will be rejected and the ACO participant may not be included in your ACO.

Let's move to slide 11. I mentioned earlier that this program is for groups of providers and suppliers to join together to form what are called ACOs. This slide illustrates the typical structure – not the only structure but the typical structure of a Shared Savings Program ACO, where a collection of ACO participants have joined together to create an ACO.

ACO participants can be hospitals, multispecialty group clinics, primary care clinics, solo practices, pharmacies that bill Medicare directly, rural health centers – virtually any legal entity that bills Medicare directly for services rendered to fee-for-service beneficiaries. The Medicare-enrolled billing TIN defines the ACO participant.

So walking through this chart, the first point is legal entity. So the ACO must have a formal legal structure to receive and distribute shared savings and a mechanism for shared governance. In particular, note that the legal structure of the ACO is evidenced by a TIN. If an ACO participant wants to form an ACO and in order to 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 an ACO, but it must meet the other eligibility requirements such as having at least 5,000 beneficiaries assigned to it.

Most ACO participants; however, will not be able to meet the eligibility requirements on their own. When that is the case, they may choose to join together to form an ACO. Note that if the ACO is formed by multiple ACO participants, the ACO's legal entity must be separate and distinct from any of the ACO participants.

Moving to the next point, ACO participants which are underneath the ACO legal entity. Keep in mind this is the most typical structure where the ACO participants have joined together, each with their own Medicare-enrolled billing TIN, and they have joined together to form this ACO.

And then finally, the last point on the chart, ACO providers/suppliers are the practitioners that bill through the TIN of the ACO participant. Now, there also has to be agreements with each ACO provider/supplier that bills through the TIN of an ACO participant, but we're not going to be discussing those today.

The ACO is responsible for ensuring that all of its providers and suppliers, in other words its NPIs, have also agreed to participate and to follow program regulations, but we do not ask to actually see those agreements as part of the application. However, they still must be in place. What we're asking for as part of the application are the agreements between the ACO legal entity and the ACO participant.

The ACO Agreement

So let's move to slide 12, ACO Participant Agreement. All ACO participants and provider/suppliers must agree to comply with the requirements and conditions of the program as well as all requirements set forth in our regulation at 42 CFR Part 425. Before you submit your ACO Participant List, you must execute an ACO Participation Agreement with the entity that will be an ACO participant. You cannot include an ACO participant on your ACO Participant List unless you first have a signed ACO Participant Agreement. In addition, you must notify any and all provider/suppliers so that you can ensure that they have agreed to participate in your ACO.

We are now on slide 13, which provides key points for common errors that we've seen. First, the ACO Participant Agreement must be between the ACO legal entity and the ACO participant legal entity. The agreement must be a direct agreement between those two entities. We will not accept agreements that use third party intermediaries such as IPAs or letters of intent. Each agreement should clearly identify the parties entering into the agreement, the date of the agreement, and the length of the agreement. You should also be sure to clearly state the correct legal business name of both the ACO and the ACO participant. We will verify your agreement using the ACO legal business name you provided to us on your notice of intent to apply and the ACO participant's legal business name you provided to us on the ACO Participant List, and they must match.

Now, moving to slide 14, Required Elements. There are a couple of required elements that must be in your ACO Participant Agreement, so please pay close attention to this slide. The agreements must include an explicit requirement that the ACO participant complies with our program regulations. It must include the ACO participant's rights and obligations. It must include how sharing and savings will encourage compliance with the quality assessment and performance improvement and evidenced-based medicine guidelines. It must include remedial measures that will apply. It must include an explicit requirement to agree to be a – that the ACO participant agrees to be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries. And it must include an explicit requirement to comply with certain federal laws.

Slide 15. We also want to remind you that ACO Participant Agreements must also include an explicit requirement that all ACO provider/suppliers that bill through the TIN of the ACO participant have also agreed to participate and follow program regulations. Additionally, the ACO must also ensure that either they have a direct agreement with each ACO provider/supplier or the ACO has an indirect agreement with each ACO provider/supplier through the agreement the ACO participant has with each ACO provider/supplier. So, please be sure that your ACO participant agreements contain each of these required elements on slides 14 and 15, as we will be looking to be sure they are included when we review your application.

Slide 16. We also wanted to strongly recommend that you consider adding two elements, based on our experience these past couple of years, to be included in your ACO Participant Agreement. Specifically, we would recommend your agreement also include a statement that the ACO participant agrees to work with the ACO to meet quality

reporting standards and a statement that the ACO participant agrees to comply with all provisions of HIPAA and the ACO Data Use Agreement. I want to specifically emphasize that we receive a lot of questions from your ACO participants specifically related to quality reporting and how participation in an ACO impacts them.

As you know, the ACO – the ACO's complete and accurate reporting of quality data each reporting period will qualify ACO participants with Physician Quality Reporting System eligible professionals to earn a PQRS incentive payment and avoid the PQRS payment adjustment and will satisfy the requirements of some other Medicare quality reporting initiatives. If this information is not included in your ACO Participant Agreement, then it must be clearly discussed with each ACO participant before they sign the agreement as part of your ACO's education and onboarding process.

Slide 17 provides an example of a correct contracting agreement between the ACO and the ACO participant. Let's use that large group practice again that I referenced earlier. Let's say a large group practice decides to participate in an ACO. Its owner signs an agreement on behalf of the practice to participate in the program and to follow program regulations. Also all of the practitioners that have reassigned their billing to the TIN of the large group practice have also agreed to participate and to follow program regulations. In this case, the ACO may include this group practice TIN on its list of ACO participants. So this is a great example of what we're looking for and what's described in our program regulation.

Slide 18 provides two examples where we've seen problems for applicants in the past. The first example is an incorrect example; that is, let's say the large group practice decides to participate in an ACO, its owner signs an agreement to participate in the program and follow program regulation. That's so far OK. However, all of the practitioners that have reassigned their billing to the TIN of the large group practice have agreed to participate and follow the program regulations – have not agreed to participate and follow program regulations. In this case, the ACO may not include this group practice TIN on its list of ACO participants because not all of the practitioners billing through the TIN of the ACO agreed to participate and comply.

The second example of something incorrect that we've seen in the past is where several practitioners in this large group practice decide to participate in an ACO. However, the group practice as a whole has not agreed to participate and not all the practitioners that bill through the TIN have agreed to participate. In this case, the ACO, again, cannot include this group practice TIN on its list of ACO participants.

Now, we are on slide 19. And I want to leave you with a couple of final tips and hints. Generally speaking, it's in your best interest to use good contracting practices. We've seen a number of contracts that don't meet even the bare minimum for good contracting practices.

Some of the things that we've seen that make it very difficult for our reviewers to determine whether or not the ACO is meeting the requirements and can cause a lot of

back and forth and delay in processing your application and can even sometimes result in not being able to approve your application include some of the following.

First, be sure to clearly identify parties to the contract by their legal business name. So this is pretty typical of contracts – there's an opening paragraph or an opening sentence that says something like, "This participant agreement is by and between the ACO and X, Y, Z group practice." And it lists the ACO participant TIN legal business name, and the ACO legal business name. And it includes effective as April 22, 2014, for example. That type of a statement makes it really clear to the reviewer who the agreement is between. So please be sure that opening is very clear.

Next, be certain to include all the required agreement elements we discuss today on slides 14 and 15. Finally, each agreement must include a signature page that identifies the parties to these agreements. Please make sure the signature page includes two signatures – one signature of the person with authority to bind the ACO participant, and one signature from the ACO executive or authorized to sign contact role.

Lastly on slide 20 we have listed a couple of very common errors to avoid when drafting and executing your ACO Participant Agreement. Please be sure to include your ACO's correct legal business name and your ACO participant's correct legal business name. If there are any extensions such LLC, be sure to include them. I can't emphasize this enough. This is a common error or pitfall that we see and we need to make sure that we have – our reviewers have a very clear agreement that states who is agreeing to participate in the ACO and correctly states your ACO's name. It seems so simple, but we see so many people incur this problem, so please pay close attention.

Also, even if you are certain that you know what your ACO participant's legal business name is, we strongly recommend that you ask them to provide you a printout of their information from PECOS, the Provider Enrollment Chain Ownership System that is our Medicare enrollment record. Again, even if they're certain that they're giving you the proper name, again, this is a pitfall we see time and time again where the name is different in our records and the ACO participant ultimately may not be permitted to participate in your ACO because of something so simple.

So this is a screening process that we do. When you submit your ACO Participant List to us, we screen that list for data and program integrity and as part of that process we verify that the ACO participant legal business name provided matches what's in PECOS. So it's better for you to know ahead of time by asking for a copy of that PECOS printout to ensure your agreements are executed in the proper ACO participant legal business name and you don't run into any pitfalls in the fall once we're reviewing your application.

Also make sure that the ACO and ACO participant actually sign the agreement signature page, and be sure that the right person is signing. If you make any changes to the agreement, that's fine, but just please be sure that the change is initialed by both the ACO and the ACO participant to signify to us that both the parties agreed to the change.

And finally, if you choose to include any TINs in your participant agreement, please be ensure – please be sure the numbers aren't transposed and that the numbers are listed correctly. Oftentimes we get an agreement with a completely different TIN than the one you're trying to add to the participant list, and that's extremely problematic for us and not something that we can permit because it looks like you have an agreement with somebody else and not the proper entity you're trying to add to your list.

So now, it's my pleasure to turn over the presentation to Kari Vandegrift, Health Insurance Specialist in the Division of Shared Savings Program at CMS. She will speak to you today about the nuances associated with the ACO Participant List as it relates to the 2015 program year application cycle, Kari.

Kari Vandegrift: Thank you, Laura. Excuse me. My presentation begins on slide 22. The ACO Participant List is required as part of your application. It includes information about the ACO participants and in some cases ACO providers/suppliers. I will discuss what information is required in a few slides.

Before you submit your application, you will determine what entities will be part of your ACO as ACO participants. All ACO participants and providers/ suppliers must agree to comply with the requirements and conditions of the program as well as all laws, regulations set forth in 42 CFR Part 425.

Before you submit your ACO Participant List, you must execute an ACO participant-issued agreement with the entity that will be an ACO participant. Start talking with potential ACO participants early and make sure they are aware of all program requirements before they sign an ACO Participation Agreement with you. 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.

Move on to slide 23. The ACO Participant List is very important. Besides helping us determine if you are eligible to form an ACO, the ACO Participant List is the basis for allowing us to determine whether your ACO achieved shared savings. We use the ACO Participant List to assign beneficiaries to your ACO, stated another way, to determine which fee-for-service beneficiaries your ACO will be held accountable for. Beneficiary assignment is performed in order to establish a historical benchmark, perform financial reconciliation, and determine a sample of beneficiaries for quality reporting. The ACO Participant List also allows us to coordinate participation in the Physician Quality Reporting System under the Shared Savings Program and allows us to monitor the ACO.

Although each ACO participant TIN is required to agree to commit to a 3-year agreement with CMS to participate in the Shared Savings Program, we recognize there maybe reasons why an ACO participant may leave or be added to an ACO during the course of the agreement period. When such changes occur, the ACO must notify CMS within 30 days of the change. Please review the guidance at the link contained in the slide to learn more about how and when changes to ACO participants and ACO provider/suppliers will affect program operation.

Moving on to slide 24. A merged or acquired Taxpayer Identification Number or TIN is a TIN that was acquired by an ACO participant through purchase or merger. A merged or acquired TIN maybe added to the ACO Participant List so that we can use the information for beneficiary assignment during the historical benchmark years.

The merged or acquired TIN can be added to the ACO Participant List if the ACO participants subsumed the acquired TIN in its entirety, including all of the ACO providers/suppliers that billed under that TIN. All the ACO providers/ suppliers that billed through this – through the acquired TIN must have reassigned their billings to the ACO participant TIN and acquired the TIN – and the acquired TIN must no longer be used. Providers and suppliers can use the Medicare Provider Enrollment Chain and Ownership System, otherwise known as PECOS, to reassign their billings to a TIN. It is not required that applicants include merged or acquired TINs on their ACO Participant List.

Slide 25. It is important to note that merged and acquired TINs are not ACO participants. By virtue of the TIN being subsumed by another practice in its entirety, a merged or acquired TIN cannot execute a participant agreement with the ACO. Instead, the ACO applicant must submit other supporting documentation. Please see our merger and acquisition's frequently asked questions document for more information about this other supporting documentation. You can find those documents located under the statutes, regulations, and guidance section of the Shared Savings Program website. Please note, the link contain in this slide is currently incorrect. We will update it, pointing you to the statute, regulations, and guidance section of the Shared Savings Program website very soon and get the updated slides posted.

Onto slide 26. On this screen you will see the fields that are part of the ACO Participant List template you will fill out and submit with your application. In the first column, you will need to provide the Taxpayer Identification Number that the ACO participant uses to bill Medicare for primary care services. You will also have to provide the TIN legal business name. We will search for the TIN in PECOS to ensure the legal name you provided matches the legal name in its enrollment file. We do this to allow you to verify that the TIN you gave us is the correct TIN. You will have to indicate whether the TIN is Medicare enrolled and whether the TIN is not an ACO participant but is in fact they're merged or acquired TIN.

Finally, you will need to provide the name of the individual who is authorized to sign the ACO Participant Agreement on behalf of the TIN. We will ensure the name you provide matches the signatory on the executed participant agreement for the TIN.

I mentioned earlier that you'll have to provide information about ACO providers and suppliers on the ACO Participant List. These fields are required in some cases. If the ACO participant is a federally qualified health center or a rural health center, you will need to provide us the CMS Certification Number or CCN that the facility uses to bill Medicare and the National Provider Indicator or NPI of physicians who directly provide primary care services to patients at that facility. By including an NPI on the ACO

Participant List, you are attesting that the physician directly provides primary care. You should not include other types of providers, such as nurse practitioner, certified nurse specialist or physician assistant on the list.

If the ACO participant is a critical access hospital billing under method II 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.

Onto slide 27. We will use the ACO Participant List submitted with the application to preliminary assign beneficiaries to your ACO for the benchmark years, the 3 years prior to the start of the agreement period, and screen the ACO participants and ACO provider/suppliers that have assigned their Medicare billings to ACO participants. Walter Adamache will discuss beneficiary assignment in more detail later.

But in summary, CMS will use the ACO participant identifier you submitted on the ACO Participant List to look up beneficiary claims. We will use those claims to assign beneficiaries to your ACO. It is important to note that we will exclude claims from any ACO participants that are participating in another Medicare initiative involving shared savings as well as any ACO participants that bill Medicare for primary care services that were submitted with multiple Shared Savings Program applications.

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. Review our frequently asked questions webpage for more information about ACO participant exclusivity in the Shared Savings Program. And make sure that your ACO participants fully understand this exclusivity requirement when they agree to participate with your ACO. If the ACO participant signs up with another applicant as well and the TIN bills for primary care services, CMS will automatically exclude that TIN when performing preliminary beneficiary assignment for both applicants, which may affect your beneficiary assignment.

CMS will also use the ACO participant identifier you submitted on the ACO Participant List to make sure that each of your ACO participants meet the definition of an ACO participant and match information for the ACO participant in PECOS. We will use the ACO participant identifiers you submitted on the ACO Participant List to review the ACO participant or any ACO provider/suppliers with regard to their program integrity history, including any history of Medicare program exclusions or other sanctions or affiliations with individuals or entities that have a history of program integrity issues.

Onto slide 28. For the application cycle for the 2015 program year, applicants have one opportunity to resubmit their participant list. Applicants will receive a report that includes the number of preliminarily assigned beneficiaries and results of screening. We will send this to your application context in an email with an encrypted zip file attachment. In the

past a few applicants have experienced issues with receiving this email because their firewall has blocked the incoming email with an encrypted attachment. You will know if this happened to you because you will receive a followup email 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 work 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 one opportunity to make any changes necessary and resubmit. If you review the report and decide you do not have changes to make, you do not need to resubmit the ACO Participant List.

Slide 29. To wrap up, I will 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 the final submit on your entire application. By successfully uploaded, I mean that you have uploaded an ACO Participant List that meets the file formatting requirements. For example, a Taxpayer Identification Number must be nine digits and does not include any spaces, dashes, or other special characters. Another example is that if you have indicated to us that you have – your ACO participant is a federally qualified health center, you must provide CCN and NPI information. If the application system detects that you did not provide data in the correct format or required data, then it will give you an error report that describes the errors and you will have to correct them and re-upload.

We strongly encourage you to upload your ACO Participant List before the application due date. Do not wait until the final day before the deadline to upload your file. This is the most common reason applicants miss the application deadline. So please be sure to give yourself enough time to correct formatting errors.

Onto slide 30. Now I will turn the presentation over to Dr. Walter Adamache. Walter is one of our contractors working for RTI International. Walter will discuss with you the logic we use in order to determine beneficiary assignment for each ACO, Walter.

Beneficiary Assignment

Walter Adamache: OK. I'm Walter Adamache, with RTI. And – Mitch and I will discuss beneficiary assignment and, in particular, the logic and some of the rules we follow, and then give you some examples.

First off, we have two types of beneficiary assignment – one of them is what we call a preliminary perspective assignment and that's done during the application phase, and another – and for interim reports as well. Then we have a final retrospective beneficiary assignment. That retrospective is done at the end of each performance year and helped – it's used to help use a financial settlement.

Now, what we have to have in terms of whether we're talking about, you know, qualifying for the program during the application phase, you have to have at least 5,000

preliminarily assigned beneficiaries in order to be in the program before each of the 3 years preceding the agreement period. And when we get to your current group of perspective applicants, the years will be 2012, ‘13, and part of ‘14 – just the first 6 months of 2014.

An important thing to notice is that – is that when we assign the person to – respectively, that person who’s assigned to one year may not be assigned to your ACO in a subsequent time period, and they may not make it to your final retrospective. The beneficiary is not assigned forever to a program or – and could come and go as their claims history dictates.

We use claims submitted to Medicare for primary care services in the assignment process. And we look at those claims and then we compare it to the TINs and CCNs in your participant list to see which claims we should attribute to your ACO.

OK. So, with regards to the TINs, we used the TINs to identify the qualifying practice claims. There are two types of TINs that we see; one’s the Employer Identification Number, also known as the EIN, and the Social Security Numbers or SSN. Physician group practices use EINs on their claims. For solo physician practices, CMS needs the ACO participant TIN submitted on the claim. Now, some of these solo practices, they used their Social Security Number while others, especially those who have incorporated themselves as professional corporations, used EINs. Whatever they’re using for claim submission, that’s what they should be on the participant list.

Other participating entities include rural health clinics, federally qualified health centers, method II critical access hospitals, Electing Teaching Amendment or ETA hospitals. And we use Medicare’s CMS Certification Numbers to identify those four types of entities. And as you heard earlier, rural health clinics and federally qualified health centers also must submit attestation lists of the physicians providing primary care.

Laura Dash: Right. And Walter we’re on slide, I think, 33 moving to 34.

Walter Adamache: Thirty four, sorry.

Laura Dash: … for everyone’s benefit.

Walter Adamache: OK. OK. So what are the individual provider types? We divide the individual provider types into three major subgroups. One are the primary care physicians or PCP and they constitute internal medicine, family practice, general practice, and geriatric medicine. All other physicians, medical doctors, and doctors of osteopathy are considered to be other physicians. The primary care physicians and other physicians together with nurse practitioners, clinical nurse specialists, and physician assistants are called ACO professionals.

Slide 35. Here we have our definition of primary care services. And they are of three types, one are evaluation and management services, sometimes called E/M, provided at office and other outpatients settings, and this constitutes CPT codes 99201 through 99215; nursing facility care settings, CPT codes 99304 through 99318; rest home and custodial care settings, CPT codes 99324 through 99340; and home services, CPT 99341 through 99350; wellness visits, and we have HCPCS codes G0402, G0438, and G0439. For RHCs and FQHCs we also look at their revenue center codes on their outpatient claims. And this is particularly the case for RHCs; for FQHCs it's only for – before 2011.

As we go through the claims we're going to identify Medicare beneficiaries on the claim. To be eligible – for a beneficiary to be eligible for assignment to an ACO, they must have assessed by a certain criteria, and they must sign – must satisfied during the assignment period. So they first off must have a record of Medicare enrollment. They have to be in our system somewhere or CMS's system. They must have at least one month of Part A and Part B together. They cannot have any months of only Part A or only Part B. As I say that, if they start off let's say at beginning of the calendar year with combined both Part A and B and for some reason drop down to just Part A, then they don't qualify later on in that enrollment period.

They cannot have any months of Medicare group health plan enrollment – that's your typical HMO. They can't have any there at all. Beneficiary must reside in the United States, that includes Puerto Rico and the territories. And finally, to be eligible to be assigned to an ACO, they must have received a primary care service from a physician at the ACO.

Slide 37. If the beneficiary meets the assignment criteria, then we use a two-step process to sign the beneficiary to an ACO. And we use the second step only if they can't qualify as the result of step one. So for step one, they must receive at least one primary care service from a primary care physician at the participating ACO. And they must receive more of their primary care services from primary care physicians at the ACO than from other ACOs or non-ACOs. This is a competition, in other words, for the beneficiary. So the organization that provides the most of primary care services as measured by Medicare-allowed charges is the one that is awarded the beneficiary.

Now, this step here concentrates on the primary care physician. It is possible that a beneficiary hasn't seen a primary care physician during an assignment period. And so, if they haven't, then we go to step two, and that's slide 38.

So these are the beneficiaries who, you know, didn't have the primary care services from a primary care physician. So we then go look at all the allowed charges for all the ACO professionals and, regardless of the specialty, and then we say, which organization, whether it's the ACO or another ACO or some nonparticipating practice, who provide the most or more than anyone else. That's our plurality rule.

Next slide. To help you understand this process we have a couple examples. And what I'm going to do is, we've got some notes here on 39 that help set you up for the examples. The first is that we create an organizational ID that we put on each claim that we work with. When we look at a claim, we look at the TIN or CCN on the claim and say, "Is that TIN or CCN on the participant list for a particular ACO?" If it is, we put that ACO's claim number on the claim. And if it's not on the participant list for any ACO, then we use the actual TIN or CCN for the so called Organizational ID.

Next is, we get ready to look at the next slide – several slides. What we're going to show there is that the top row of each slide shows the ACO or non-ACO provider to which the beneficiary was assigned. So the top row is the one that –who won the beneficiary.

So we're going to slide 40. And here we have Beneficiary A1 who has been seen by three different organizations – one is an ACO A9999, then we have two non- ACO organizations which the beneficiary went to for some primary care during the time period. In the column called PCP we showed the allowed charges at each organization for those primary care services provided by primary care physicians. The PCP is primary care physician. The final column, the ACO professional column, shows the allowed charges provided by all ACO professionals. And again, it's just to remind you that include the primary care physicians, other physicians, plus nurse practitioners and physician assistants, and clinical nurse specialists.

In this case, Beneficiary A1 is assigned to the ACO A9999 because it had the highest allowed charges for primary care services provided. It has 454 then the other two organizations, one had $300 and the other had 250. And we make this assignment on the primary care only, even though, as you look in the final column we can see that the other two non-ACOs actually had more primary care services but they involved providers other than primary care physicians.

So we go next to slide 41 for another example. And here Beneficiary B3 was assigned to a non-ACO provider. And it was competing against two ACOs – A5656 and A9999. In this case, the nonphysician provider had $1,200 in allowed charges from primary care physicians, and they clearly have more than the either two of the ACOs. In this case, it all happens to be the case that they also provide more primary care from all providers not just the primary care.

Next slide, A42. Here we have a Beneficiary A3. We again have our ACO A9999 competing against two non-ACO providers. In this case the beneficiary did not receive any primary care services from a primary care physician. That shows up in the PCP column, as all zeroes.

So this beneficiary was not assigned in step one, instead it is assigned in step two. And in this case, it was assigned to the ACO because the allowed charges for – from this ACO were higher than the allowed charges from the other two organizations.

Now, one of the questions you might have is, how many beneficiaries do I need to get into the ACO? You've heard there's a minimum of 5,000. So what we have are two sets of examples and these examples here are drawn from some – one of the earlier applicants, so these are real numbers.

And so, on slide 43 we have three examples of ACOs that made the 5,000 threshold. What we're going to do is walk you through what happened to – how they got to their final number.

First off we'll take ACO number 1 as an example. We found 11,839 beneficiaries had at least one primary care service with a physician at their – them. They ended up with 7,570. They lost 4,269 so to speak, and we break that down to why that beneficiary wasn't assigned to that ACO. Most of those 4,269 were because they did not provide a plurality of primary care services – 4,008 of the beneficiaries got most of their – more of their primary care from other providers. We also lost 93 people who only had Part A or only part B during the time period. Another 241 were lost because they had some managed care – at least one month of managed care during the assignment process. One person had non-U.S. residence and 17 were other Medicare Shared Savings initiatives.

As you see, by far the largest category is not winning on the plurality of primary care. And you notice that the losses can be sometimes quite high. ACO number 2 had the highest number of beneficiaries with at least one service from their physicians, but lost more than anyone else – they ended up with 10,245, but they lost over 17,000 to other providers. And ACO three actually had the most assigned beneficiaries, even though they didn't have the highest in the first row.

We go to next, slide 44, we see the composition of the practices that constituted each of these ACOs. ACO 1 had 65 primary care physicians and 81 other special physicians and 22 nurse practitioners, physician assistants, and clinical nurse specialists. The other two ACOs, which had more assigned beneficiaries, had more of all these types of providers, with the exception of ACO 3, didn't rely as much on physician assistant and nurse practitioner.

On slide 45 we give you an example of some three ACOs that did not achieve the 5,000 beneficiary threshold. And as you'll notice for all three of them –ACO A, B, and C – in terms of number of beneficiaries with whom they had contact, at least giving them one primary care service, they all have more than 5,000 initially. But when you look at the blue highlight line where the assigned beneficiaries are, they all fell under 5,000. In some cases they weren't that far off, but they were still under 5,000. And the primary reasons that they didn't have these beneficiaries assigned to them was because of again, competition with other providers, either other ACOs or other providers who are not part of the ACO program.

And then we go to slide 46. And then we can see that by comparison to the first set of three that these – and by the way the column headings are incorrect, they should be ACO

A, B, and C rather than 1, 2, and 3. But the number of physicians and other practitioners in these practices are much lower in these three that failed than in the first set of three.

OK. That is the end of mine and I'm going to turn you back to Laura Dash.

Important Dates

Laura Dash: Great. Thanks, Walter. We hope these presentations have helped you in preparing for your applications. On slide 48, we just wanted to go over a couple of reminders that we're required 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.

So in summary, your Notice of Intent to apply or NOI will be accepted from May 1st to May 31st at 8 p.m. Eastern Time. Next you'll need 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. And those forms must be submitted by June 9th, 2014. Since it takes three to four weeks for us to process User ID requests, we again, stress the importance of completing this step as quickly as possible. We will accept applications from July 1st through July 31st at 8 p.m. Eastern Time. We plan to issue application dispositions in November 2014.

Please note that 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 an NOI and receive a new ACO ID. After this has been completed, you must submit a 2015 application using the templates and responding to questions in the application. CMS will not evaluate any previous submissions.

On slide 49, please just mark your calendars for the upcoming application calls that we plan to provide throughout the 2015 Shared Savings Program application cycle.

And on slide 50, we asked that you continually monitor our Shared Savings Program website for updates. If you have any questions regarding the application throughout the process, you may contact us via email at sspaco_applications@cms.hhs.gov.

This concludes the prepared portion of the Shared Savings Program application call. I will now turn the call over to our moderator for question-and-answer portion of our call.

Keypad Polling

Charlie Eleftheriou: Before we move in to question and answers, I will 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'll be a moment of silence on the line while we tabulate the results. And we're ready to start polling.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together in your office 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. And 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. Once again, please hold while we complete the polling.

All right. And we have completed the polling portion of today's conference call.

Question-and-Answer Session

Charlie Eleftheriou: And 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. In an effort to hear from as many callers as possible, we asked that you limit yourself to one question at a time. If you have more than one question please press star 1 after your first question's been answered to get back in the queue. We will address additional questions as time permits. We're ready to take our first question now.

Laura Dash: And before we take our first question. I just want to point everybody back to slide 48, the NOI deadline is May 30th. I'm being told I maybe said May 31st, but the slide is correct, it is May 30th at 8 p.m. Eastern Time. So I just wanted to be crystal clear that that slide is correct.

Thanks, Charlie.

Operator: And to ask a question press star followed by the number 1 on your touchtone phone, to remove yourself from the queue, please press the pound key. Please remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you're asking your question so anything you say or any background noise will be heard in the conference. And your first question comes from the line of Bonnei Shok.

Bonnei Shok: Hi, just a quick question. In the assignment of beneficiaries for step one, is it based on a primary care service in 1 year or the 3 preceding years?

Walter Adamache: We do it at 1 year at a time. In terms of qualifying for the Shared Savings Program as a whole, you need to have at least 5,000 in each of the 3 prior years.

Bonnei Shok OK. But the beneficiary is assigned base just on that 1 year …

Walter Adamache: Correct.

Bonnei Shok: ...of having the primary care? – Thank you.

Operator: And your next question comes from the line of Michelle Ilitch.
Michelle Ilitch: This is a followup to the next question on slide 31 you verbally spoke that you will be including 6 months of 2014 in your look-back period. Can you confirm exactly what years are included in the look back?

Walter Adamache: OK—2012, entirety, 2013 in its entirety, then we blend the last 6 months of 2013 and the first 6 months of 2014 to be our third benchmark period.

Michelle Ilitch: Thank you.

Operator: And your next question comes from the line of Emily Davies.

Charlie Eleftheriou: Hello, Emily?

Operator: Emily, your line's open. And that question has been withdrawn. Your next question comes from the line of Nanci Wilson.

Nanci Wilson: Yes. Thank you very much. I would like to know how dual eligibles in California would be addressed if they have been attributed to a beneficiary assignment.

Charlie Eleftheriou: Can you give us one quick question, actually, could you repeat the question please?

Nanci Wilson: Yes. If we have – a somebody that is assigned as an ACO participant and they end up going with Cal MediConnect for dual eligibles medi-medi, then how is – how is that point to immediately affect the already assigned attribution of that beneficiary?

Terri Postma: This is Terri Postma. So the – there's a demonstration involving dually eligible patients in some states and, depending on how those states structure that demonstration will – the answer is different depending on how the – how the state structures the demonstration. We do have some QAs on our website that I would refer you to that walk you through the choices that the states have to make.

At a high level the choices are to either passively enroll dually eligible beneficiaries into a managed care setting or to retain them as fee-for-service. If they are retained as fee-for-service, then – if the – if they are attributed to that – to that demonstration, they will not be available for the ACO for assignment. If they are passively enrolled in a managed care plan, they wouldn't be available for assignment because they're not fee-for-service anymore.

So take a look at the QAs on our website and that's www.cms.gov/sharedsavingsprogram/ and you'll see a tab on the left that has frequently asked questions. Click on that and then you'll see a table of contents. Click on the one

that refers to dual eligible beneficiaries and you should have a walk through there of the demonstration and how it impacts assignments.

Nanci Wilson: OK. Am I still open with this – my mike still open?

Charlie Eleftheriou: Yes.

Terri Postma: Yes.

Nanci Wilson: Well, the only thing that I'm saying, in the State of California, as we might do this application effective January 1st, there is passive enrollment that can occur all the way up to first quarter of 2015. As a result we might submit the information and then what might happen is the Cal duals will indicate that those individuals have been passively assigned. And it will be interesting to know how CMS is going to handle that – if it's just going to be followed out for that year and then the next performance year those individuals would be excluded? Because there is so much overlap here, that that is of concern.

Terri Postma: Yes, yes, and if you're worried about like applying with a certain number and making it with just over 5,000 beneficiaries, you should really take that into consideration because what you'd want to do then is make sure that you have enough ACO participants that bill for primary care services so that you can continue to meet eligibility, meaning that your ACO can continue to have 5,000 beneficiaries assigned during the performance years, if that's a big concern.

Nanci Wilson: OK, thank you.

Terri Postma: You're welcome.

Operator: Your next question comes from the line of Tiffany Francis.

Tiffany Francis: Hi, thank you. I have a question related to slides 37 and 38, The Assignment Policy Step 1 and 2. I understand that if they have a primary care service at a primary care physician – one of the assigned primary care types, that then it follows policy step 1. Is that anytime within the 3 years of basing the PCP, anytime in the 3 years, or only in the most current year that we're looking back at?

Walter Adamache: This is Walter Adamache. We look at it at one 12-month period at a time.

Tiffany Francis: So if they didn't see it like so for our – look back, if it's the first 6 months and the last 6 months of 2013, the first 6 months of 2014, if they didn't see a PCP during that time but then you go back further to 2012 and they did, are they considered attributed to the primary care physician?

Walter Adamache: In 2012, they are.

Tiffany Francis: But not for – OK, so you could be attributed differently for each of the 3 years?

Walter Adamache: That's correct.

Tiffany Francis: OK, and then for – I'm sorry, and then for step 2 to be attributed to like a specialist – basically for primary care services, if it's just on cost, whoever has the most allowable amount? It doesn't have anything to do with how many visits, it's just to whoever CMS paid the most to?

Walter Adamache: Correct, but they are highly correlated, the number of visits and total log charges are highly correlated.

Tiffany Francis: Right.

Walter Adamache: So, they tend to go up together, although some E/Ms are reimbursed at higher rates than others.

Tiffany Francis: Sure, sure. OK, thank you.

Charlie Eleftheriou: Yes, we'll take our next question now please.

Operator: Your next question comes from the line of Jamie Stevens.

Jamie Stevens: Hello. If a multisite physician group with approximately 50 providers under one TIN has one clinic with two providers participating in the Comprehensive Primary Care Initiative or CPCI, can the group with – like this with the minority sub-set participating in another Innovation Center project still participate in the ACO, and is done by including those two physicians or can it be done by excluding those and having all other physicians participate?

Laura Dash: Thanks so much for the question, if you could just pause one minute, we're just going to confer with the team will respond momentarily. We just want to be sure, thanks for taking a minute, we want to be sure that we are answering your question completely and accurately. So if you wouldn't mind submitting that question to us through our mail applications mailbox, we'll respond accordingly. Thanks so much and apologies for not having an immediate answer.

Terri Postma: Yes, and this is Terri again, so the general policy is that if there is another initiative – Medicare initiative – involving shared savings, ACO participant TINs may not participate in both the Shared Savings Program and that overlapping initiative.

There are other initiatives like the Dual Demonstration that we mentioned previously that we don't consider overlapping, but we do make some adjustments to the calculations – we do make sure that beneficiaries aren't double counted in both initiative, that there's not beneficiary overlap.

So, but it's really a case-by-case basis, you know, program-by- program basis, so we should be updating that list in the application and in our guidance, but we'll get that answer back to you.

Laura Dash: Thanks, next question.

Operator: And your next question will come from the line of Jennifer Teeter.

Jennifer Teeter: Yes, Jennifer Teeter from Frederick, Maryland. While we all like to think, I'm sure, that our physician practices know how to look up their listing in PECOS, I also know what a challenge that has been for some of the organizations that have applied previously. Is there a look-up ability somewhere in Medicare systems where you can put in a tax ID and see how an organization is listed without being that organization?

Laura Dash: Hi, this is Laura Dash. I understand your frustration. I know that it's one we've worked very diligently with our ACO applicants on previously as well. I know that our partners in the Center for Program Integrity are currently working on various ways that an ACO might be able to look up that type of information. Certainly if we had those capabilities we would be sharing them and making sure applicants knew about that immediately. So that's something to certainly look for in the future. For now, there's not any way to access the Medicare system that we know of to obtain that information, which is why we recommend that you ask the ACO participant to provide that screenshot or printout to you.

We do have some additional information that we're working on to help aid the application process, and you can look for that when our application is posted on the CMS website, May 30th. So I would encourage you to go back to our website on May 30th, once we have the 2015 application toolkit live. And we'll have some additional helpful hints there, specifically with respect to this issue, Jennifer.

Jennifer Teeter: Thank you.

Operator: And your next question will come from the line of David Carrison.

David Carrison: Yes, good afternoon. I have a – I guess restatement or clarification on slide 24 and slide 25. In the merged and acquired TINs, as far as I do – I believe I understand correctly, if I understand correctly, the merged and acquired TINs will now be – they cannot be used, they can no longer be used once they are acquired. At that point, the question is, on slide 25, which says, "merged acquired TINs but not ACO participants and merger acquired TIN cannot execute participant agreement," so is this just restating more of the same? In other words, once it's acquired, the acquired TINs will now be part of the – the ACO – if the ACO acquired it or part of the potential participant? They'll be using that TIN, that TIN number moving forward, is that what it's saying? The acquired or merged TINs are deleted and no – are void, null and void?

Laura Dash: So the merged acquired TIN, as you stated early on, you are correct in that they would not continue billing going forward. So once they merge into another TIN or are acquired by another TIN we would no longer see any billings in the Medicare system for that TIN. That is the reason that we wanted to clarify, that there wouldn't be a participant agreement, as there wouldn't be anyone to sign that. Those folks would be under a new TIN. They would an agreement under the new TIN.

The old TIN, we just need documentation to let us know that there was a merger or an acquisition done. And you can look at the mergers and acquisitions frequently asked questions on our Shared Savings Program website to learn more about that, but yes, the TIN would not continue billing going forward.

Terri Postma: And this is Terri…

David Carrison: OK. I'm sorry, just one other, one other question that's relevant to this, to follow behind this. At that point, when you're doing the look back, and let's say you acquired a TIN during the look-back period, how do you account for or how do you list your beneficiaries under that acquired – that acquitted TIN when you're trying to complete the look- back portion?

Terri Postma: Yes, so this is Terri, let me give you a little bit of background about why we included this. This came from a question that we had early on in the development of the program, where we had some ACOs come to us and say, "You know, for example, I'm a very large group practice and during the benchmark period, we acquired or merged with several other formerly –TINs that formerly billed Medicare, is there any way we can take into – get you to take into account the claims billed by those practices, because now they're essentially – you know, they're billing through our TIN? All their beneficiaries followed them with us, so it really makes sense to incorporate their history into ours."

And we said, "OK, we can – we can work with this." And so we set up these rules for ACOs to indicate on the ACO Participant List if there was a TIN that was previously used to bill Medicare that has now been merged or acquired with an ACO Participant TIN. So just follow the instructions in the application. There's certain documentation we need and attestations that need to be submitted. But once that's done, then what we can do is, we can pull the claims that were associated with those – now defunct TINs and incorporate them into the calculation of the benchmark for the three benchmarking years. Does that help?

David Carrison: It does, thank you very much.

Terri Postma: OK.

Operator: And your next question will come from the line of William Costello.

William Costello: Hi. This is William Costello from Loyola University Medical Center. And my question kind of dovetails off that last one, not exactly the merge, but back on

slide 23, just when you have 30 days to add or subtract ACO providers. Question is, let's say the year starts and the doctor or one of the providers leaves or get added on, do they and I thought that – looking online and I think I got some of the answers. So that if some people did come and you're able to use them for – you're able to actually those individuals. But if – I guess my question is – let's say, you add something new and you hadn't – had already – had used their participants, do you get to use them as beneficiaries or not?

Laura Dash: OK, so for – participant additions or subtractions that occur after an ACO is accepted into the program and begins participating, we'll use the example – say you joined January 1, 2015, and 6 months in, you have additional TINS that want to participate with your ACO. You would tell us within 30 days of those agreements are signed and you would indicate who the TINs are and we would go through the same prescreening process that we've described to you today. And so, meaning, we would check PECOS and everything for their name, then if they are approved for participation, you would begin seeing them in beneficiary assignment beginning in January 1, 2016. So if you add them during one performance year, you would not see them in assignment until the next performance year. And then they would be picked up for benchmarking and stuff like that.

We have guidance on our website for this as well. With data sharing, you could begin requesting data on beneficiaries seen in that participant's office after they're approved, but for your specific questions about assignment, it would begin the next performance year.

William Costello OK, great. Thank you very much.

Operator: Once again if you would like to ask a question, please press star then 1 on your telephone keypad. Again, star 1 to come into the question queue. OK, your next question will come from the line of Emily Davies.

Emily Davies: Hi, my question is, if a specialist also provides another specialist also do the primary care, so how would that be included in this?

Walter Adamache: This is Walter Adamache at RTI. It depends, if you're talking about the situation where only the specialist has given primary care, since it's going to show up on step two – if the beneficiary has not received primary care –primary care from any other primary care physician the United States. So if this cardiologist for instance is the only physician that sees that beneficiary, then that would be a beneficiary caught up in step two of the assignment process.

Emily Davies: OK.

Operator: Your next question will come from the line of LeAnn Rivers

LeAnn Rivers: Yes, our question is, in your opinion, what do you see the role being right now for a small rural home health and hospice providers, and I guess I'm asking, what kind of strategic plan do you see providers like us needing to implement at this time?

Terri Postma: This is Terri. So we really believe that all Medicare-enrolled providers and suppliers play a part in that journey of care for the fee-for- service beneficiaries. So that's why when we created the roles, we allowed any Medicare enrolled fee-for-service provider to participate in an ACO.

So to the extent that there's – there are home health agencies or other facilities that bill for – or that bill Medicare for services – for fee-for- services patients, any of them may join with other Medicare-enrolled providers and suppliers to form an ACO and work with those providers and suppliers that form the ACO to develop a plan for improving care quality and efficiency of care for their fee-for-service population. I know that's a pretty general answer, but do you have maybe a more specific question?

LeAnn Rivers: No, that's a good answer; I guess more specifically, we are looking to identify a good strategy as to how to go about joining up with a provider. And – you know in our area, to be able to deliver the services that are going to be most beneficial to that particular ACO.

Laura Dash: Yes, it's fair enough. There may be a – I would suggest if you want to be involved in an ACO that's applying this year, you need to talk to other providers and suppliers in your geographic areas, see if any of them are thinking of applying. That way you can join with them and work through that process with them right from the beginning.

Another way to go about it is if you're a Medicare-enrolled TIN that perhaps can't participate on its own, you might want to look at the list of ACOs that's on our website and if any of them are in the area, talk with them directly about joining for the next performance year. There's still time to do that.

LeAnn Rivers: OK, that's a great answer, thank you.

Operator: And your next question will come from the line of Cory Schulman

Cory Schulman: Oh yes, thank you. My question is, does the ACO participant have to be an existing Medicare provider in order to participate as a provider in the ACO?

Terri Postma: This is Terri. So this is – this is a program that's open to Medicare-enrolled providers and suppliers. So when you submit the application, you will have to put the Medicare-enrolled tax ID onto your ACO Participant Lists. And then that indicates to us – we'll be checking to make sure that they're Medicare enrolled and we'll also be checking to see whether or not they billed for primary care services and that sort of thing. So yes, the program is available for Medicare-enrolled TINs.

Cory Schulman: So just as a followup question, our – the specialist is Medicare enrolled, but we act under them, under technical component versus professional component and we are not, but he does the billing for us so it's under his tax ID, and I just want to be sure that should be acceptable into an ACO as a participant.

Laura Dash: Cory, can you clear – we're having a little bit of a hard time hearing you – you're coming in very faintly, so can you just repeat that one more time? There's a specialist that you're working with and they are a Medicare enrolled TIN?

Cory Schulman: Yes, that is correct. They have – they have their own TIN and PTAN and we did something – we as the facilitator of that service. We do not have the relationship with Medicare, but he does. So we're acting under his TIN, then I just want to get clarification that we should be able to participate in the ACO as long as the billing is under his TIN.

Terri Postma: So the ACO – sorry, the ACO participant TIN, and let me just clarify that that's a legal entity. So let's assume that this specialist is a solo practice, so it would be his solo practice that would be the ACO participant. And that TIN is what would go on the ACO Participant List. And along with others, I would assume, since as a solo practitioner, it would be very unlikely that he could qualify on his own to form an ACO.

Cory Schulman: No he's not forming the ACO. He's being asked to be a participant, not a provider. I mean in other words, – we've been asked by an ACO to submit a bid to participate and to offer a specialty outsourced diagnostic service. And so my question is, because we don't have that relationship with Medicare but the specialist does – for Medicare beneficiaries, are we – can we basically be under his tax ID to provide the services for the ACO members?

Terri Postma: Well, once the ACO is formed, and take a look at the statutory definitions of these things because the ACO has to be formed by Medicare-enrolled providers and suppliers. But once it's formed, the ACO may choose to contract out with various entities to provide services and what not. But that's all at the discretion of the ACO.

Cory Schulman: OK, so that was what I was getting at. Thank you.

Terri Postma: OK.

Cory Schulman: I believe what you're saying is that they have the choice as to whether they can work with us, but – because that's they're – they're entitled to make that, that's their prerogative. They can make that decision.

Laura Dash: Yes, absolutely.

Cory Schulman: OK. Where can I find that information about what that – as an ACO provider, they would – they can make that – they can make that decision? Is that in – where would I find that on the CMS site? Can you share that with me, please?

Terri Postma: Well, I mean, you can go to the statute where it outlines what the program is and who can participate and apply or you can look at our website and the regulations that established the program.

Cory Schulman: Alright, that sounds good. Thank you very much.

Terri Postma: You're welcome.

Operator: Our next question will come from the line of Denise Vladovich.
Denise Vladovich: Thank you. Just kind of a basic question on slide 11. When you're talking about just the common structures, we have a legal entity with its own tax ID number to receive and distribute shared saving, correct? Separate from the other participants' TIN.

Laura Dash: Yes, it's the – the statute makes it clear that it's the ACO participants that – and the regs. – talk about it's the ACO participants joining to form the ACO, and when there are several different ACO participant TINs, they have to have a legal entity that's separate from any one of them. So that that legal entity then becomes a function for shared governance among the ACO participants and also becomes the mechanism of receiving the shared savings and distributing it out to all the participants.

Denise Vladovich: Excellent. So in that case, the question has come out about tax issues because that ACO would be receiving revenue from the shared savings, so then are they taxed on that revenue and that something built into the budget as tax issue?

Laura Dash: Yes, it's something that our regulation don't address, but we did work with the IRS when we were developing the regulations and concurrently with the rule they issued some guidance, particularly, for tax exempt hospitals that want to be an ACO.

But I think they also have some general guidance about the tax implications for ACOs that you might want to look at. And that link can be found on our shared Savings Program website under the – there's that tabs – those tabs on the left; I think it's the left tab on the bottom is the regulations. And when you click out on that tab, then it will bring you to a page, and it will have all the links to the concurrent notices that were published simultaneously with the rule from the IRS, the joint CMS-OIG waiver document ,and then also the FTC and – or the antitrust agencies, antitrust policy statement.

Denise Vladovich: Perfect, thank you so much.

Laura Dash: You're welcome.

Charlie Eleftheriou: Thank you and we have time for one last question.

Operator: OK, your final question will come from the line of Jason James.

Jason James: Yes, hello. With just a pretty simple question is, this may be something where you can direct me to the website, but for the notice of intent to apply, is there a place on the website where it goes into kind of the detail of kind what is required, the specific information that's required in that notice? I mean, if it's just – the TINs for the participants or do we have to go on a more detail than that in the notice?

Laura Dash: No, yes, Jason, we do have that published to our website currently. So if you go to the Shared Savings Program website on the cms.gov, and it's in the left-hand flyout bars, there's – not the one for this is at the bottom and the one right above is that Shared Savings Program Application. If you click on that link, you'll see that it lays out the three steps to apply to become an ACO.

Step 1 is to submit the Notice of Intent to apply, and we have a link on the website currently that gives you a sample of what the NOI will look like. And it's I think eight or 10 quick questions just about your ACO name, entity. It does not require you to list the ACO participant information. You'll do that in the actual application itself.

The NOI will not be released, as I said earlier until May 1st, so that's coming, but this – the documents – the NOI memo that's currently posted in our website now will show you exactly what that NOI will look like come May 1st.

Jason James: OK, thank you.

Charlie Eleftheriou: And I think that's all the time we have today unless we have another quick question, we have 2 more minutes, we might be able squeeze one in if someone else is on the line.

Operator: OK, then your next question will come from the line of David Carrison with a followup.

David Carrison: Yes, very last question, this is actually – it's been addressed before, but once again, confusion on the benchmark years. So I understand that it will be 2012, 2013, the last 6 months of the – there'll be a blending of the last 6 months of 2013 and the first 6 months of 2014. The question itself is once again, is it – is every participant, is each specific participant – not participant, beneficiary that would be counted, would they have to have been seen or would they have been billed – will Medicare have been billed on their behalf for each of these years, each of these – for this whole time period or just 1 year – 1 year would be sufficient? I believe there was – Mr. Walter said something about 1 year at a time, so that's what's confusing me, the1 year at a time statement.

Walter Adamache: OK, this is Walter Adamache. Essentially, when we go through the assignment process, we look at each 12-month period independently of the others. So probably, we assure is continuing on seeing the providers as the participants, say in each of the benchmark periods, then they're going to be assigned in each of those benchmark periods.

David Carrison: OK.

Walter Adamache: Did that answer your question?

Terri Postma: This is Terri. This is sort of my – I don't know, probably less detailed…

Laura Dash: Summary.

Terri Postma: Yes, summary of the assignment algorithm, which is that in each benchmarking year, we – like Walter said, we take each year as sort of its own. And so we assign a population for each of those years, we determine what the per capita cost of that population for that year was, and then we weight those years, those costs for each of those years by a certain percentage, roll it all up, and then that becomes the average per capita cost for the fee-for-service population for those benchmarking years.

So – and then – so when we go forward into the performance years, we're taking each year by itself, creating an assignment for each year, comparing it back to that benchmark. And the reason we do that – in part is because– it's because when you do three averages and combine them together, it's creating a much more stable benchmark than it would be if you use just 1 year prior, for example.

So, and then when going forward into the performance years, you're comparing apples to apples because you're always taking a 1-year assignment approach. And I just want to clarify one thing is that, when we do the initial assignment and benchmarking for – during the application cycle, we're doing that sort of half year thing because we're using the most current information that we have at the time. But when we calculate the final benchmark for your ACO, it will be the complete 3 years. So the complete 2012, 2013, 2014, just to make sure everybody's on the same page of that.

Laura Dash: And more specifics on our assignment on financial methodology, also can be accessed through our Shared Savings Program website.

David Carrison: OK.

Additional Information

Charlie Eleftheriou: Thank you. And that is unfortunately, all our time for today. On slide 52, you'll find some information on how 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. I'd like to thank our subject matter experts today and all participants who joined us for today's MLN Connects call. Have a great day and we'll see you at the next call. Thank you.

Operator: This concludes today's call.

This document has been edited for spelling and punctuation errors.

-END-