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National Provider Call

Medicare Shared Savings Program Accountable Care Organization: Preparing to Apply for 2016

April 7, 2015

Presented by:

Centers for Medicare & Medicaid Services
U.S. Department of Justice
Federal Trade Commission

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Introduction

Tricia Rodgers

Deputy Director,

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Agenda

This presentation will cover:

- Introduction
- What is an Accountable Care Organization?
- Organizational Structure and Governance
- Antitrust and ACOs
- Application Process for January 2016

Purpose of Today's Call

- 2016 Medicare Shared Savings Program application will be posted on the Shared Savings Program Application Web page.

- Prior to submitting an application, you should:
  - Establish your organizational structure
  - Establish your governance and leadership structure
  - Ensure all agreements meet requirements, are finalized and signed
  - Prepare:
    - Sample of participant agreement
    - Template listing all participants
    - Signed Executed Agreements for all ACO participants
  - Establish repayment mechanism, **only for 2-sided risk**

What is an Accountable Care Organization (ACO)?

Terri Postma, MD, CHCQM
Medical Officer
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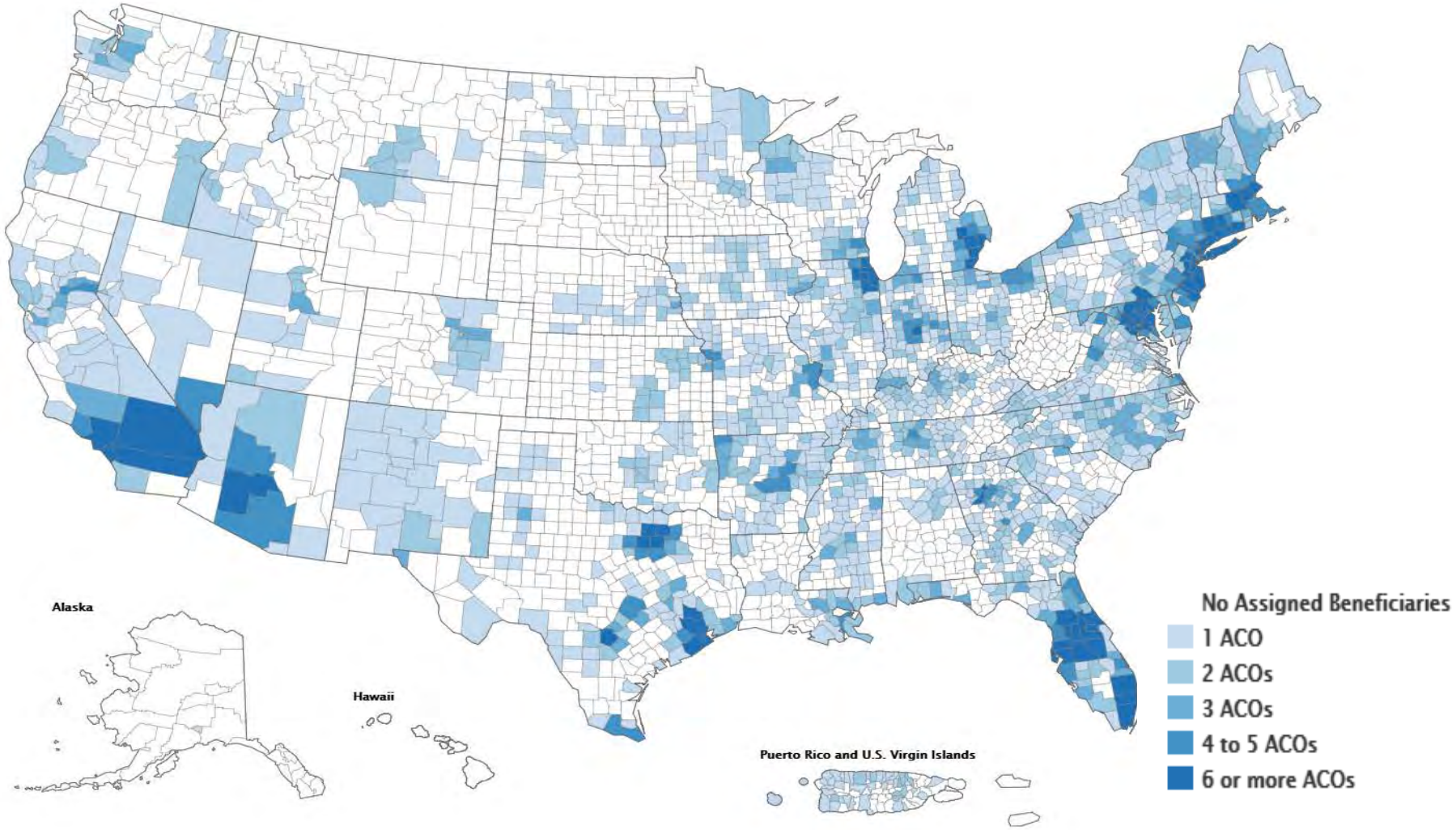
Shared Savings Program: Background

- Shared Savings Program Web site
- Mandated by Section 3022 of the Affordable Care Act
- Established a Shared Savings Program using Accountable Care Organizations (ACOs)
- Issued Final Rule November 2011
- Issued Proposed Rule December 2014
- Comment Deadline February 6, 2015

Shared Savings Program ACO Assigned Beneficiary Population ACO by County (Counties with more than 1% of an ACO's Assigned Beneficiaries)



Shared Savings Program: Vision

ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health, and lower growth in expenditures by:

- Putting the beneficiary and family at the center
- Remembering patients over time and place
- Attending carefully to care transitions
- Managing resources carefully and respectfully
- Managing the beneficiary's care proactively
- Evaluating data to improve care and patient outcomes
- Using innovations focused on the three-part aim
- Investing in care teams and their workforce

Shared Savings Program: Definitions

Accountable Care Organization (ACO):
ACO means a legal entity that is recognized and authorized under applicable State or tribal law, as identified by a Taxpayer Identification Number (TIN), and comprised of eligible groups of eligible providers and suppliers (as defined at § 425.102) that work together to manage and coordinate care for Medicare FFS beneficiaries.

ACO Participants:
Individuals or groups of Medicare-enrolled providers (as defined in § 425.202) or suppliers (as defined at § 425.202), as identified by a TIN.

ACO Provider/Supplier:
A provider or supplier that bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations.

Shared Savings Program: ACO Professionals

- **ACO Professional**:
  - Doctor of Medicine (MD)
  - Doctor of Osteopathic Medicine (DO)
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialists (CNS)

- **Primary Care Physician**:
  - General practice
  - Internal medicine
  - Family practice
  - Geriatric medicine

- **Primary Care Services**:
  - Certain Evaluation and Management (E&M) Healthcare Common Procedure Coding System (HCPCS) codes
  - Revenue center codes
  - G codes

Shared Savings Program: Statutory Requirements

By statute, ACOs must meet the following eligibility criteria:

- Agree to participate in the program for at least a 3-year period
- Define processes to:
  - promote evidenced-based medicine
  - promote patient engagement
  - report quality and cost measures
  - coordinate care
- Demonstrate it meets patient-centeredness criteria

Shared Savings Program: Statutory Requirements

By statute, ACOs must meet the following eligibility criteria:

- Have a formal legal structure to receive and distribute payments
- Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
- Shall provide information regarding the ACO professionals as the Secretary determines necessary

Shared Savings Program: ACO Structure

Most Common ACO Structure (Scenarios 1 & 3: Traditional ACO & Single TIN ACO set up at Traditional)

ACO (TIN)	• ACO Legal Entity (TIN is not the same as any ACO participant TIN)
Medicare Enrolled TINs	• ACO Participants Ex: Acute Care Hospital, Group Practice, Individual Practice, FQHC, RHC, CAH, Pharmacy, LTCH, SNF, ER, etc.
Provider & Suppliers (NPIs)	• ACO providers/suppliers that bill through ACO participants (e.g. physicians, NP, PA, CNS, pharmacists, chiropractors, PT/OT, etc)

ACO Organization Structures

ACO Structure	Notes
Traditional ACO (most common ACO structure)	• Multiple ACO participants joined to form the ACO. • The ACO is a separate legal entity from the ACO Participants. • Submit sample ACO participant agreement and all executed ACO participant agreements.
Single TIN ACO	• The ACO is comprised of one ACO Participant. • The ACO and ACO Participant are the same legal entity. • This structure does not permit participation of other ACO participants. • Submit sample employment agreement and/or sample ACO provider/supplier agreement.
Single TIN ACO set up as Traditional	• The ACO is comprised of one ACO participant. • The ACO and ACO participant are different legal entities. • This structure allows the ACO to add ACO participants in the future. • Submit sample ACO participant agreement and executed ACO participant agreement.

ACO Organization Structure Scenarios

Scenario	Q4	Q5	Q6	Q26	Q27	Q28	Q29
1 - Traditional ACO	YES	YES	N/A	N/A	Must submit sample ACO participant agreement	YES	Must submit executed agreements for each ACO participant
2 - Single TIN ACO A*	NO	N/A	NO	YES – must submit a copy of the employment agreement	N/A - SKIP	N/A	N/A - SKIP
2 - Single TIN ACO B*	NO	N/A	NO	NO	Must submit sample ACO provider/supplier agreement	YES	N/A - SKIP
3 - Single TIN ACO set up as Traditional	NO	N/A	YES	N/A	Must submit sample ACO participant agreement	YES	Must submit executed agreement for the sole ACO participant TIN Legal Name & ACO participant TIN on the ACO Participant List must be different

Statutory Requirements: Assignment

- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries

- Assignment is based on primary care services rendered by primary care physicians.
  - This means some of the ACO participants must bill for primary care services (e.g. hospitals employing ACO professionals, group practices of ACO professionals, etc).

Statutory Requirements: Governance & Leadership

- Shared governance through a governing body with representation by ACO participants and beneficiaries
  - ACO participant representation
  - ACO participants hold at least 75% control of the governing body
  - Beneficiary on the governing body
  - Flexibility for organizations to meet requirements

- Demonstrate an organizational commitment, leadership, and resources necessary to achieve the three-part aim and demonstrate clinical integration
  - Experienced leadership team
  - Medical Director
  - Qualified health professional to lead the quality assurance/improvement process

Patient Population

- ACO accepts responsibility for an “assigned” patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Assignment will not affect beneficiaries’ guaranteed benefits or choice of doctor or any other provider
- Finalized a preliminary prospective assignment with a retrospective reconciliation

Patient Population (cont.)

- Identify all beneficiaries who have had at least one primary care service rendered by a physician in the ACO

- Followed by a two step assignment process:

  - First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
  - Second, for beneficiaries that remain unassigned, identify beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any ACO professional

Other Program Requirements

- ACO participants cannot concurrently participate in other Medicare shared savings initiatives
- Data sharing
- Beneficiary communication
- Quality
- Benchmarking

Participation in Other Shared Savings Initiatives

- ACO participants cannot participate in multiple Medicare initiatives involving shared savings, including:
  - Independence at Home Medical Practice Demonstration (ACA Sec. 3024)
  - Medicare Healthcare Quality Demonstration (MMA Sec. 646)*
  - Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)*
  - Physician Group Practice Transition Demonstration
  - Pioneer ACO Model demonstration
  - Other ongoing demonstrations involving shared savings
- Additional programs, demonstrations, or models with a shared savings component may be introduced in the Medicare program in the future

* Only contracts with shared savings arrangements

Data Sharing

- Aggregate data reports provided at the start of the agreement period, quarterly aggregate data reports thereafter and in conjunction with year end performance reports

- Aggregate data reports will contain a list of the beneficiaries used to generate the report

- Beneficiary identifiable claims data provided for patients seen by ACO primary care providers who have been notified and **not declined to have data shared**

Beneficiary Communication

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

Quality Measure & Performance

- ACO Quality Performance Standard is made up of 33 measures intended to do the following:
  - Improve individual health and the health of populations
  - Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination
  - Support the Shared Savings Program goals of better care, better health, and lower cost
  - Align with other incentive programs like the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs

Quality Data Reporting

- Quality data is collected in three ways:
  - Claims/Administrative data
  - ACO Group Practice Reporting Option (GPRO) tool
  - Clinician Assessment of Health Providers and Systems (CAHPS) Survey (patient/caregiver experience survey)

- Complete and accurate reporting in the first year qualifies the ACO to share in the maximum available quality sharing rate

- Pay for performance is phased in for the remaining performance years

- Shared savings payments linked to quality performance are based on a sliding scale that rewards attainment
  - High performing ACOs receive a higher sharing rate

ACO GPRO Reporting & PQRS

- ***ACO reporting matters!***

  - Eligible professionals billing through ACO participant TINs will avoid the PQRS payment adjustment only if the ACO satisfactorily reports GPRO quality measures under the Shared Savings Program.

  - ACO participant TINs, and their eligible professionals, may not report PQRS information independently (outside of the ACO).

- For more information, see "Medicare Shared Savings Program Interaction with the Physician Quality Reporting Program" http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PQRS-FAQs.pdf

Alignment with EHR Incentive Program

- To signal the importance of EHR use, the percent of PCPs that earn an EHR Incentive Payment measure (ACO #11) is double weighted for scoring purposes.

- EPs participating in the Shared Savings Program meet submission requirements and satisfy their Clinical Quality Measures (CQM) reporting for the EHR Incentive Program if the ACO satisfactorily reports via the ACO GPRO web interface ***and*** the EPs meet the other program requirements for Meaningful Use stage 2.

- For additional information about the EHR Incentive Program see http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html

Prepare for Quality Reporting

- Understand your reporting responsibilities:
  - Complete and accurate GPRO reporting is crucial.
    - ACOs are responsible for searching elsewhere, including providers outside the ACO, if necessary to locate the information needed to completely report on each patient in the GPRO web interface.
  - Select a vendor to administer the CG CAHPS survey.
- Prepare for quality reporting ***now*** by:
  - Securing providers' commitment to ACO quality reporting;
  - Educating your ACO participant TINs and ACO providers/ suppliers on the role they have in helping the ACO succeed in quality reporting.

Financial Performance

- ACOs demonstrate savings if the actual assigned patient population expenditures are below the established benchmark **and** the performance year expenditures meet or exceed the minimum savings rate (MSR)
- The MSR takes into account normal variations in expenditures
- Under the one-sided model, the MSR varies based on the size of the ACO's population
- Under the two-sided model, the MSR is 2% of the benchmark

Interagency Coordination

Three notices were issued with the Shared Savings Program Final Rule:

- Federal Trade Commission (FTC) and Department of Justice (DOJ): Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program

- Internal Revenue Service (IRS): Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations

- Office of the Inspector General (OIG) and CMS: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center Interim Final with Comment

Antitrust and ACOs

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Rob Canterman, Attorney
Federal Trade Commission

*The views expressed do not necessarily reflect those of the U.S. Department of Justice, the Federal Trade Commission, or any Commissioner.

Key Antitrust Issues for ACOs

- Antitrust agencies recognize many ACOs are procompetitive and may benefit patients by improving quality of care and lowering costs.
- But, under certain conditions, ACOs may raise antitrust concerns, and participation in the MSSP does not confer antitrust immunity.
  - Price-fixing
    - Agreements among competing providers on price or other competitive terms not part of a legitimate provider joint venture.
    - Improper sharing of competitively sensitive information among competing ACO participants could facilitate collusion in providing services outside ACO.
  - Monopolization
    - Power profitably to raise prices above competitive level or reduce output, and exclusionary or other anticompetitive conduct to achieve or maintain power.
  - Mergers
    - Consolidations that may lessen competition in a relevant market.

FTC/DOJ Antitrust Enforcement Policy Statement

- Provides guidance to form procompetitive ACOs.
  - Applies to collaborations among independent providers.
  - Establishes rule-of-reason analysis for ACOs that use same governance, leadership, clinical and administrative processes for both MSSP and for commercial business.
  - Creates ACO Safety Zone.
  - Includes guidance for ACOs outside Safety Zone.
- Provides for 90-day, expedited voluntary review.
- Policy Statement and other guidance available at:
- http://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care/accountable-care-organizations
- http://www.justice.gov/atr/public/health_care/aco.html

Application Process for New Applicant January 2016 Starters

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Centers for Medicare & Medicaid Services

Application Process

- Deadlines
- Application Toolkit
- Step 1 – Submit Your Notice of Intent (NOI) to Apply
- Step 2 – Obtain a CMS User ID
- Step 3 – Submit Your Application

Application Cycle: Deadlines to Apply for Program Year 2016

Notice of Intent to Apply Process	Deadlines
NOI Memo Posted on CMS Web site	April 1, 2015
NOI Sample Posted on CMS Web site	May 1, 2015
NOI Accepted	May 1, 2015 – May 29, 2015
NOI Due	**May 29, 2015 at 8:00 pm Eastern Time**
CMS User ID Forms Accepted	May 6, 2015 – June 9, 2015

Application Process	Deadlines
Sample Application Posted on CMS Web site	June 1, 2015
Applications Accepted	July 1, 2015 – July 31, 2015
Applications Due	**July 31, 2015 at 8:00 pm Eastern Time**
Application Approval or Denial Decision Sent to Applicants	Fall 2015
Reconsideration Review Deadline	15 Days from Notice of Denial

Application Toolkit

- The Toolkit provides directions and examples for each application question including:
  - Regulation reference page, guidance, and FAQs
  - Link to Form CMS 20037 Application for Access to CMS Computer Systems
  - Link to Form CMS-588 Electronic Funds Transfer
  - Templates:
    - ACO Participant List Template
    - Governing Body Template
    - ACO Participant Agreement Template
    - Executed Agreements Template

Step 1 – Notice of Intent to Apply

- The first step in the application process is to submit a Notice of Intent to Apply (NOI) to the Medicare Shared Savings Program

- We posted on the Shared Savings Program Application Web site on April 1, 2015

- NOI Process:
  - Complete NOI and submit by **May 29, 2015 at 8:00pm Eastern Time**
  - You will get a confirmation notice e-mail containing your ACO ID and instructions on how to complete CMS Form 20037 Application for Access to CMS Computer Systems in order to obtain a CMS User ID.
  - Submitting an NOI **does not** require you to submit an application for 2016 program start date. However, without an ACO ID and CMS User ID you will not be able to access the appropriate modules in the Health Plan Management System (HPMS) to complete any of the required 2016 application.

Step 2 – Obtaining a New CMS User ID

- The second step in the application process is to obtain a CMS User ID.
  - You must have at least four (4) CMS Users.
  - Use the CMS guidance available in the Toolkit
  - Send the completed CMS User ID form by traceable mail (i.e. FedEx or UPS) to CMS:

    CMS
    Attention: HPMS Access
    7500 Security Boulevard
    Mail Stop: C4-18-13
    Baltimore, MD 21244-1850
  - It takes 3-4 weeks to process the requests. **Submit the form(s) immediately upon receiving your NOI confirmation notice E-mail.**
  - CMS Form 20037 is due **June 9, 2015**.

Existing CMS User IDs

- CMS User IDs are unique to the individual, not the ACO.

- If a User already has a CMS ID, an ACO authorized contact must send an email to HPMS_Access@cms.hhs.gov that includes the following:

  - Clearly identify the User's name and existing CMS issued User ID.
  - Clearly identify the ACO Legal Business Name and CMS Issued ACO ID.
  - A statement that authorizes the user to gain access to the ACO's data maintained in CMS systems.
  - CMS issued ACO ID number for each ACO the user requests access.

Existing CMS User IDs for Consultants

If a Consultant already has a CMS ID, he or she must submit an email to HPMS_Access@cms.hhs.gov including:

- A .pdf letter on ACO letterhead that authorizes the consultant to gain access to the ACO's data maintained in CMS systems.
- Clearly indicate the consultant's name, CMS issued User ID, and state that he or she will be serving as a consultant on behalf of the ACO(s).
- ACO Legal Business Name and CMS Issued Identification Number(s) (ACO ID) the User is authorized to access.
- If multiple users from the same consulting firm are authorized to gain access, include all user names and User IDs.
- If the consultant is working with multiple ACOs, one letter is required from each ACO. These .pdf letters can be attached in one email.
- Letter must be signed by the ACO's authorizing official.

Fraudulent Use of CMS User IDs

- It is considered fraud if you use another person's CMS User ID and password or, conversely, allow someone else to use your CMS User ID and password.

- This activity is strictly prohibited and may result in the termination of the individual's CMS User ID and password.

Step 3 – Submit Your Application

- The 2016 Sample Application will be posted on the Application Web page on June 1, 2015.

- 2016 applications are accepted July 1 through July 31, 2015. The deadline is at 8:00pm Eastern Time.

- You may review the 2015 Application materials on the How to Apply Web page for reference until the 2016 Application is posted.

Banking Information

- Establish a valid **checking** account
- Use the ACO's legal business name and TIN
- You **will only** receive your electronic funds transfer (EFT) if this information is complete and accurate
- Submit CMS Form 588 to:

  CMS
  7500 Security Blvd., Mail Stop: C5-15-12
  ATTENTION: Jonnice McQuay, Location: C4-02-02
  Baltimore, MD 21244-1850

- Applications are incomplete without CMS Form 588

Recap Important Application Steps

- ACT EARLY
- Educate your participants about the importance of reporting
- List at least 4 contacts for your ACO (Primary and Secondary Application Contacts and Primary and Secondary IT Contacts)
- Include ACO ID number and legal business name on all correspondence
- Never share CMS User IDs and passwords
- Contact CMS: SSPACO_Applications@cms.hhs.gov if you have any questions about the application process

Upcoming Application Calls

- **April 21: Shared Savings Program ACO Application Process: ACO Agreements, Participant List, and Assignment**
  - Topics
    - Beneficiary assignment
    - Participant List
    - Agreements between ACOs and providers
  - Registration information and complete call details

- **Save the date:**
  - June 9: 2016 Application Submission Review
  - July 7: Training on HPMS Application Module Submission
  - July 14: ACO Application Question & Answer Session

Contacts for Assistance

- Shared Savings Program Application Web site

- For NOI submission and application questions:
  - SSPACO_Applications@cms.hhs.gov

- For help with Form CMS-20037 and CMS User ID (e.g. new access to HPMS, trouble finding the HPMS Web site):
- HPMS_Access@cms.hhs.gov or (800) 220-2028

- For password resets and if your account is locked:
  - CMS_IT_Service_Desk@cms.hhs.gov or 1-800-562-1963

- For help using HPMS and technical assistance: HPMS@cms.hhs.gov or (800) 220-2028

ACO Investment Model (AIM)

Stephen Jenkins
ACO Investment Model Lead,
Center for Medicare & Medicaid Innovation
Center for Medicare & Medicaid Services

Opportunity

The business case for an ACO requires a long investment horizon:

- Starting and sustaining an ACO requires investment
- Shared savings offset investment costs over a long period of time

Barriers to model entry:

- ACOs may lack capital needed to enter Medicare ACO programs/models and sustain participation
- ACO concerns regarding cash flow and ability to endure through the ACO transformation

ACO Investment Model (AIM)

The ACO Investment Model provides pre-paid shared savings to ACOs for staffing and infrastructure that supports population care management, financial management or other essential ACO functions.

Amount of Pre-Paid Shared Savings

- **An upfront, fixed payment:** Each ACO will receive $250,00.

- **An upfront, variable payment:** Each ACO will receive a payment in the first month equivalent to the number of its preliminary, prospectively assigned beneficiaries on its most recent quarterly report multiplied by $36.

- **A monthly, variable payment:** Each ACO will receive a monthly payment equal to the same number of preliminary, prospectively assigned beneficiaries used to calculate the first payment above, multiplied by $8.

AIM Eligibility

To be eligible for this round of AIM funding, applicants must:

- Be accepted into, participate and be in good standing in the Shared Savings Program.
- Have 10,000 or fewer aligned beneficiaries
- Be provider-based, with the exception of ACOs containing Critical Access Hospitals (CAHs) or small IPPS hospitals (100 beds or fewer)
- Not be owned by a health plan
- Not have participated in the Advance Payment Model

Selection Criteria

	Test 1 (New MSSP Starters in 2016)
ACO penetration (preference for lower penetration)	• Included (4 points)
Rural Location	• Included (4 points)
Movement to higher risk track/ Retention	• Included (2 points)
Demonstration of need (i.e. needs statement)	• Included (2 points)
Quality of Spend Plan	• Included (8 points)

AIM Application

The application is accessible via the AIM website: http://innovation.cms.gov/initiatives/ACO-Investment-Model/ on June 1, 2015.

2016 applications are accepted July 1 through July 31, 2015. The deadline is at 8:00pm Eastern Time.

Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.

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

Thank You

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