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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO: Preparing to Apply for 2016
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Charlie Eleftheriou. Thank you, you may begin.

Announcements and Introduction

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on Preparing for the Medicare Shared Savings Program Application Process for the January 1st, 2016, start date. MLN Connects Calls are part of the Medicare Learning Network.

During this call, CMS subject matter experts will cover information on Accountable Care Organizations, or ACOs, ACO organizational structure and governance, application key dates, the Notice of Intent to Apply or NOI, submission and the first steps in submitting an application. A question-and-answer session will follow the presentation.

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

Secondly, please note that this call is being recorded and transcribed and the audio recording and written transcripts will be posted to the Call Details page and an announcement will be placed in the MLN Connects Provider eNews when they are available.

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

Presentation

Tricia Rodgers: Thanks Charlie. So we'll begin on slide 4 of the slide deck, and welcome to our first call for the 2016 application cycle for the Medicare Shared Savings Program. As Charlie noted, my name is Tricia Rodgers, and I'm the Deputy Director of the Performance-Based Payment Policy Group in the Centers for Medicare & Medicaid Services.

Let me start by saying that this call is geared to provide information to prepare our new applicants for the application cycle for the upcoming 2016 program performance year.

We'll have a separate call for those ACOs wishing to renew an agreement with CMS at a later date.

On slide 5, you'll find our agenda for today's call. In this session, we will introduce you to the Medicare Shared Savings Program, talk about what it takes to be an ACO, how your ACO should be structured, including the governance of the ACO, antitrust issues associated with the ACOs, new ACO Investment Model option, and how to successfully apply for the 2016 cycle for the Shared Savings Program. We have a robust agenda, so let's begin.

As you can see on slide 6, the 2016 application will be posted to the CMS website on June 1st. This will be a sample application, and we suggest that you take the steps now to prepare yourself for the application phase. This application requires you to establish your governing body and obtain signed agreements with your providers. Both of these requirements can take a substantial amount of time. In addition, you are required to submit several detailed narrative – explaining —narratives explaining the nuances of your ACO. So please do not wait until July 1st to begin preparing your application.

Prior to submitting an application, you should establish your organizational structure, establish your leadership and governance structure, ensure all agreements with your ACO participants meet our requirements and are finalized and signed. As part of the application, you must provide us with a sample of your ACO Participant Agreement, a list of all your ACO participants, and signed Participant Agreements that include the first page and the signature page for all ACO participants. And finally, establish a repayment mechanism, if needed.

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

Before we discuss the application, we believe it's imperative that we define and describe what Medicare means by an Accountable Care Organization.

So with that, we'll move on to slide 7, and I'll turn the call over to Dr. Terri Postma, who will speak to you about the definition of an ACO and the important elements you should focus on in order to become an ACO in a Medicare Shared Savings Program. Terri?

The ACO Medicare Shared Savings Program

Dr. Terri Postma: Thanks Tricia. Hi everyone, and thanks for joining us today. My name is Terri Postma, I'm a medical officer in the Center for Medicare. I trained as a neurologist, but I've been privileged to spend the past several years here at CMS working on the development and implementation of the Shared Savings Program. And I've been asked

to take some time today to give an overview of the program but also emphasize and take a deeper dive on some important elements that you should focus on as you develop your ACO and apply for participation.

We have a lot to cover, so I'm going to go through this really quickly. But don't worry, as you heard, we'll be posting the session on our web — we'll be posting the session along with the audio transcript and slides that will be available to you afterwards for your review. A lot of this information will also appear in the Toolkit before your having to submit your application.

I'm on slide 8 now. By way of background, a large body of research, for example, the work done by the Dartmouth Atlas Project and others, indicates that there are sometimes significant geographic variation in health care cost and quality, and demonstrated that more care does not necessarily equal better care. In fact, often the opposite is true.

Additionally, CMS had prior experience with ACO-like efforts through the Physician Group Practice Demonstration Project, which showed promise as a model for improving the quality of care delivered to a Medicare fee-for-service population while controlling growth and expenditures. Congress drew from the work of these researchers and the CMS experience to establish the Medicare Shared Savings Program through the Affordable Care Act.

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

Because the Shared Savings Program is a national program, it undergoes CMS rulemaking process, which involved issuing a Proposed Rule, accepting public comments during a mandatory public comment period, and then issuing a Final Rule. Our first Final Rule was issued in the fall of 2011. Since then, we've learned a great deal from our experience to date and have proposed and finalized some small changes along the way, for example, with quality measures through the annual Physician Fee Schedule Rule.

In December 2014, we published revisions to a broader set of program rules to improve the program for both beneficiaries and providers. We received a lot of comments by the February 6th deadline. And currently, we're in the process of addressing the public

comments and developing the Final Rule that will explain —incorporate the changes, many of which are anticipated to take affect for the 2016 performance year.

We recognize that many of you are anxious to know what the rule — new rules will be, some of which may impact your decision to participate in the program. I want to assure you that we're working as quickly as possible to publish the Final Rule. In the meantime, if you have any interest in participating beginning 2016, keep your options open and fill out the Notice of Intent to Apply. The NOI does not obligate you to complete an application.

Slide 9. On slide 9 you'll find a current map showing the geographic distribution of ACO-assigned patients. This represents over 400 organizations that are currently participating in the Shared Savings Program.

Now we'll move to slide 10. Anyone who's been involved in our health care system, particularly you, as providers, know that our health care system is fragmented. It's developed in pieces — so a hospital over there, a clinic over here, a post-acute care setting, etc. And those pieces have really developed without any conscious or well-designed connections among them.

Fragmentation of payment, particularly fee-for-service payment, often reinforces beneficiary's fragmented care. We believe that the Medicare Shared Savings Program represents a new approach to the delivery of health care in the fee-for-service setting. Its goal is to meet what our former administrator, Dr. Berwick, referred to as a three-part aim:

- Better care for individuals,
- Better health for populations, and
- Lowering growth in overall health care expenditures.

As I mentioned before, the program is built on the existing fee-for-service payment platform. It is not a managed care program or plan. Providers continue to bill Medicare and receive fee-for-service payments as they normally would. There is no lock-in of beneficiaries or providers. Rather, this is an incentive program for fee-for-service providers to demonstrate they can improve the quality and efficiency of care delivered to their fee-for-service populations.

Dr. Berwick also articulated his vision of a well-functioning ACO. He often described how he envisioned ACOs reducing fragmented care by creating what he called "journeys of care" for patients. He believed that to do this, ACOs should embrace the goals on this slide that reflect team-based, patient-centered care.

We're now on slide 11. Before I get into the details of the program, I'd like to review some very important definitions, which are critical to an understanding of the program

rules and the guidance that we have posted on our website. Please be sure you read and understand these terms and the differences in them. Lack of understanding can negatively impact your ACO's ability to complete required documentation and may ultimately lead to denial of your application.

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

Slide 12 shows some additional important definitions. In particular, these definitions are important for your understanding of assignment, which will be covered in the next provider call, so I won't go into detail here. But before the next provider call, you should have a good working understanding of these definitions, which are described in more detail on our website Q&As and also in the rule at 42 CFR 425.20.

Slide 13 lists several statutory criteria ACOs must meet in order to be eligible. First, the ACOs must agree to participate for at least a 3-year period. If we determine through the application process that your ACO meets requirements for participation, you'll be offered the opportunity to sign a 3-year agreement beginning 1/1/2016 and ending on 12/31/2018. Your ACO will be evaluated after each calendar year to determine whether it qualifies to share in savings for that year. Your ACO must also define certain processes and demonstrate that it meets patient-centeredness criteria. As part of your application, your ACO will be asked to submit narratives describing the processes your ACO is developing and will be implementing starting on 1/2016.

We're now on slide 14. Today and at the next provider call, we're going to focus on the four eligibility criteria and rules surrounding those criteria in order for your ACO to participate for your application. I'm going to cover the first two in detail today. The first two are — is that your ACO must have a formal legal structure and your ACO must have a mechanism for shared governance and leadership and management. The last two are going to be described in more detail at the next provider call. Your ACO must have at least 5,000 beneficiaries assigned to it. And your ACO must provide additional information about the ACO professionals that are participating, including the agreements that your ACO has with each ACO participant.

I'm on slide 15. Let's take a deeper dive on the legal entity and governing body requirements and what will be required of you as an applicant. The statute states that the ACO must have a formal legal structure to receive and distribute shared savings and a mechanism for shared governance. We further refine these requirements in the Shared Savings Program Rule, the references are 42 CFR 425.20, which defines an ACO

as a legal entity that is recognized under applicable State, Federal, or tribal law, is identified by a Taxpayer Identification Number, or TIN, and is formed by one or more ACO participants.

42 CFR 425.104 states that this legal entity has responsibility for receiving and distributing shared savings, repaying shared losses, establishing reporting and ensuring provider compliance with health care quality criteria, and fulfilling the other ACO functions described in the program rules. The legal entity must also be separate and distinct from any of the ACO participants when two or more Medicare-enrolled TINs or ACO participants have joined to form it. In other words, the TIN of the ACO legal entity must not be the same as any of the ACO participant TINs that you put on your ACO Participant List.

This slide illustrates the typical structure, but not the only structure, of a Shared Savings Program ACO, where a collection of ACO participants, defined by their Medicare-enrolled billing TIN, have joined together to create an ACO. Remember, the Medicare-enrolled billing TIN defines the ACO participant so that an ACO participant could be a hospital, a multispecialty group clinic, a primary care clinic or specialty clinic, a solo practice, a pharmacy that is Medicare-enrolled and bills Medicare directly, a rural health center, or virtually any other legal entity that bills Medicare directly for services it renders to fee-for-service beneficiaries.

Under each Medicare-enrolled TIN are the individual practitioners that have reassigned their billings to the TIN of the ACO participant. These practitioners are called ACO providers/suppliers and are identified by National Provider Identifiers, or NPIs. An ACO provider/supplier could be a physician, a nurse practitioner, physician's assistant, clinical nurse specialist, or any other practitioner that has reassigned his or her billings to the TIN of the ACO participant.

When the ACO is formed by two or more ACO participants, then the ACO must have a TIN, or tax ID, that is different than any of the ACO participant TINs. In other words, when an ACO is formed by multiple Medicare-enrolled TINs, none of them can act as the ACO legal entity. The reason for this is because the ACO must function as a mechanism for shared governance for the ACO participants that have joined to form it.

Note that it is possible for an existing legal entity to be an ACO and apply for participation. For example, it is possible for a large multispecialty group practice or other large Medicare-enrolled TIN to participate on its own. However, the entity must meet all eligibility requirements, including the requirement that the ACO be assigned over 5,000 beneficiaries. As we'll review in the next National Provider Call, there is no easy way to determine which Medicare beneficiaries your practices see will have had enough primary care services to be assigned to it, so it would be difficult for anyone to determine in advance if your practice would meet this requirement. Some of these, what we call single- entity TINs might choose to set up a separate legal entity to be

an ACO in case they need to invite other ACO participants to join them in order to meet program requirements like the assignment rule.

ACO Organizational Structures

Slide 16. It's important that you be able to identify your ACO's structural category as you go through the application. This will ultimately help you fill out your application appropriately and avoid Requests for Information, or RFIs, during the application review process.

The first category is the typical, or traditional ACO. It's the most common structure we see. This type of ACO is formed by many ACO participant TINs that have joined together to form the ACO. To meet program rules, they establish a separate legal entity to be the ACO with a governing body that is the mechanism by which the ACO participants share governance of the organization. For your application, you'll be required to submit a sample of the agreement the ACO has with each ACO participant. You'll also be required to submit an executed copy of each ACO Participant Agreement that has been signed by the ACO and each ACO participant.

The second category is what we refer to as a single TIN ACO. These ACOs are made up of one large Medicare-enrolled TIN that is capable of satisfying the program requirements on its own. The advantage of this structure is that the sole ACO participant can use its existing legal entity and its existing governing body as the ACO's legal entity and governing body. In other words, the ACO participant TIN is the same as the ACO legal entity TIN. The governing body of the ACO participant TIN is the governing body of the ACO legal entity. They are one and the same. The disadvantage of this structure is that it does not permit other ACO participants to join. So for example, we've seen situations where a single Medicare-enrolled TIN has applied to the program, but then realizes through the process that they are unable to meet the 5,000-assigned beneficiary requirement. And then it's too late in the process to recruit other ACO participants and set up a separate legal entity to meet program requirements.

If you're a single TIN ACO that is able to meet requirements, however, you will be asked as part of the application to submit some documentation to indicate that each practitioner billing through your ACO's TIN has agreed to participate. In some cases, as a condition of employment, those practitioners are required to agree to participate. For those practitioners, you'll be asked to submit a sample of the employment agreement. In other cases, your Medicare-enrolled TIN may have contractual agreements with practitioners that bill through it that don't automatically require their participation. For these practitioners, your ACO must have signed ACO provider/supplier agreements and submit a sample of that ACO provider/supplier agreement as part of the application.

The third category is what we refer to as single TIN ACO set up as traditional ACO. These are the single Medicare-enrolled TIN, or ACO participant, that has chosen to set up a separate legal entity as the ACO. Initially, it may be the only representative on the

ACO's governing body because it is the only ACO participant. The advantage of this arrangement is that the sole ACO participant has the flexibility to invite others to participate in case, for example, the entity is unable to have 5,000 signed beneficiaries.

Slide 17. As I mentioned previously, understanding your ACO's organizational structure will help you determine how best to answer the application questions. Question 4 asks if your ACO is formed among multiple, otherwise independent ACO participants. If you have more than one ACO participant TIN on your ACO Participant List, then we consider your organization to be formed among multiple independent ACO participants, regardless of any prior business relationships they may have. For a traditional ACO arrangement, you would answer "yes" to this question. When there is a single ACO participant TIN listed on your Participant List, however, you would answer "no" to this question.

Question 5 asks you to attest if you answered yes to question 4. In other words — you were a traditional ACO and that you met the legal entity requirements — and that you meet the legal entity requirements that the ACO legal entity is different than the ACO participant TINs. For a traditional ACO, you must answer "yes" to this question. For other single TIN ACOs, you would answer "N/A" and move to the final question in the series.

Question 6 helps distinguish a single TIN ACO from a single TIN ACO set up as a traditional ACO. Question 6 states that you are not required to have a separate legal entity if formed by only one Medicare-enrolled TIN, but you might have chosen to do so. Traditional ACOs should answer "N/A" and single TIN ACOs should determine the correct response depending on whether the ACO TIN is the same or different than the single participating Medicare-enrolled ACO participant TIN.

The next set of questions on the chart have to do with what sample agreements must be submitted by your ACO.

Question 26 is for single TIN ACOs, where the single Medicare-enrolled TIN is the same as the ACO legal entity, so that you can submit a sample of your employment agreement if your practitioners must agree to participate as a condition of employment. Most applicants will answer "N/A" to question 26.

Under question 27, single TIN ACOs should submit a sample ACO provider/supplier agreement if practitioners billing through the TIN are not automatically required to participate as a condition of employment. All other ACOs will submit samples of the ACO participant agreements, that is that the agreements that the ACO has with — between the ACO and the Medicare-enrolled TINs.

Question 28 asks your ACO to attest that the ACO participant agreements and the ACO provider/supplier agreements do not include any prohibited referral language.

And finally, question 29 asks traditional ACOs and single TIN ACOs set up as traditional to submit their signed ACO participant agreements for each ACO participant that you've submitted on your ACO Participant List.

Slide 18. The statute requires that ACOs have enough primary care professionals for the assignment of at least 5,000 fee-for-service beneficiaries. We'll be using the ACO participant TINs to determine whether the ACO participants bill for at least 5,000 beneficiaries. This means that whatever ACO participants have joined together to form the ACO, they must also be billing for primary care services, as those are defined in the rule. The methodology for assignment will be reviewed in detail on a subsequent National Provider Call.

Required ACO Governance

Slide 19, your ACO's governing body. Your ACO's legal entity must have a governing body that is representative of the ACO participants and has meaningful beneficiary input. The program rules require the ACO participants retain 75 percent control over the governing body. We believe this is very important to demonstrate, among other things, clinical integration. In limited circumstances, it may not be possible for an organization to meet these requirements, so we built in flexibility for the ACO to describe how it will ensure meaningful representation by the ACO participants and meaningful input from beneficiaries. According to statute, the ACO must also have a leadership and management structure that includes clinical and administrative systems.

In the Final Rule, we've stated that the ACO's leadership and management must demonstrate an organization — an organizational commitment to the goals of the ACO, must have an experienced leadership team, which includes a medical director and a qualified health professional leading its quality assurance and improvement process. Consideration will be given to ACOs that have innovative leadership and management structures that meet the goal of the ACO.

Common Application Errors and Program Issues

Common errors in the application that I want to flag for you are the following — and believe me, we see a lot of these. So if, you know, you run the risk of doing this, think through it and try to avoid these traps.

The first one is not having enough ACO participant representation on the governing body, that is not meeting the 75 percent. This is really important. And although there is flexibility, there are very, very few times that we have granted the exception. So look now at how you can ensure that you have adequate ACO participant representation on your governing body.

The second thing is not demonstrating shared governance among the ACO representatives. So for example, we've seen some ACO participants are — have

overweighted representation by one at the expense of others. When we look at your governing body in the way it's structured, we're looking to see that it does demonstrate shared governance among the ACO participants.

Another thing is not having a beneficiary designated or appointed to the governing body, or not having a suitable alternative. ACOs may designate any fee-for-service beneficiary served by the practitioners in the ACO. You do not have to designate a beneficiary that ultimately becomes assigned. So don't let — don't let the fact that you don't have any — an assignment list deter you from recruiting and identifying the fee-for-service beneficiary that is capable of being on your governing body.

Next is control for executing the functions of the ACO, as described in the program rules. That control has to reside with the ACO, not with a parent or subsidiary organization. It has to reside with the ACO legal entity. So for example, the power to designate board members or the power to hire or fire key administrative personnel, the power to ensure compliance of ACO participants, or to determine how shared savings is distributed among ACO participants. These are the activities that the ACO governing body is responsible for, and those powers cannot reside with the subsidiary or with a parent company.

And finally, another common error we see is that the applicant's governing body does not have a fiduciary duty to the ACO alone. So for example, particularly vulnerable are existing organizations, such as IPAs, that attempt to apply with a subset of practices, rather than with all their practices. So be cautious about that.

And we have some good guidance up on our website that I encourage you to review and as well as our Final Rule for more information on those requirements for the ACO's governance, leadership, and management, and to have those things prepared and in place in advance of your application.

Slide 20 — I'm sorry, slide 20. As previously mentioned, in order to participate, the ACO must be willing to be accountable for the Medicare fee-for-service population CMS assigns to it. I want to again emphasize that unlike a managed-care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see, regardless of whether that practitioner's participating in the ACO or not.

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

We'll be implementing what we call a preliminary prospective assignment with retrospective reconciliation. What that means is that we'll perform a look back at the

performance year to determine what beneficiaries chose to receive a plurality of their care from ACO practitioners, but we'll also be providing the ACO with information along the way to help you better understand the fee-for-service population your providers care for by providing a list to preliminary prospective beneficiaries.

At the end of the year though, the ACO will only be held accountable for beneficiaries that chose to receive a plurality of primary care services from ACO practitioners. These are the beneficiaries for whom the ACO had the greatest responsibility during the course of the performance year to impact their care. This method is intended to create incentives for ACOs to standardize care processes and treat all Medicare fee-for-service patients the same, while aiding ACOs in understanding their patient populations and proactively redesigning care processes for them.

Slide 21 touches on how CMS assigns beneficiaries at a high level. And again, I'm not going to really go over this because we're going to go over this in great detail in a future provider call. But I did want to flag for you, once again, not to assume that your Medicare-enrolled TIN will meet the 5,000 requirement just because that TIN provides services to over 5,000 beneficiaries. The beneficiary must have received a plurality of the primary care services by the ACO as a whole compared to any other external TIN during the previous 12 months in order to be assigned.

Slide 22 lists the additional important programmatic issues that I'll quickly review in the next couple of slides.

Slide 23. The statute states that if a provider/supplier is participating in another initiative involving shared savings, they may not also participate in the Shared Savings Program. We've identified several existing initiatives involving shared savings, and they're listed on the slide and in the application. There may be others as well, for example, Next Generation, which I don't — I'm not sure is currently on the application, certainly not on the slide, but that is an overlapping initiative.

And when the — when you as an ACO submit your ACO participants, that will be screened during the application review — and we'll let you know if there are any overlapping ACO participants and give you a chance to resolve the issue. But if any of those ACO participants is overlapping and remains on your ACO Participant List, your application will be denied.

Slide 24. CMS will share data with ACOs under certain circumstances, and some of the application questions have to do with data sharing. Aggregate data reports provided at the start of the agreement period, quarterly data reports thereafter, and in conjunction with the end year performance reports. These are the types of reports you can expect to receive once you're admitted to the program. Aggregate data reports will contain a list of the beneficiaries used to generate the report. Beneficiary identifiable claims data is

provided for patients seen by ACO primary care providers, who — once they've been notified and not declined to have their data shared.

We're now on slide 25. Patient engagement and shared decisionmaking are important aspects of this program. We believe this initiative works best when patients are true partners with their practitioners.

To facilitate the transparency of the program, the ACO participants must notify beneficiaries at the point of care that they are participating in the program. You'll do this by posting signs in each setting in which fee-for-service beneficiaries receive primary care services. Beneficiaries will also receive general information about the program through the Medicare & You handbook. You should be aware there are also marketing guidelines that your ACO must follow, and we'll give you more details on that if your ACO is admitted to the program. And, of course, ACOs are required, as I mentioned earlier, to offer beneficiaries the opportunity to decline data sharing before requesting their claims data.

Quality Measures and Reporting Quality Data

Slide 26 talks about how quality is another important part of this initiative. The ACO cannot share in savings, even if the savings have been generated, without first meeting the quality performance standard. We've finalized the set of measures that support the three-part aim focusing on better care and better health. The four domains are:

- Preventive health,
- At-risk and frail elderly populations,
- Patient or caregiver experience of care, and
- Care coordination and patient safety.

Measures were chosen based on their ability to address high prevalent conditions, the patient safety and prevention, chronic ambulatory conditions, care coordination, and patient experience of care. The measures align with other incentive programs, such as The Million Hearts Initiative, PQRS, and EHR — or the EHR Incentive Program.

We're on slide 27. Consistent with statute, measures include process, outcome, and patient experience of care measures, and are derived and collected from claims data, survey data, and medical records. The quality performance standard is phased in over the course of the agreement period. In your first performance year, the quality performance standard is defined only as full and complete reporting. So if your ACO reports on all measures, it qualifies for the maximum sharing percentage. However, in the second performance year, more than half the measures will be pay-for-performance. And in the third year, nearly all measures are pay-for-performance, and the ACO's sharing rate will be based on a sliding scale according to how your ACO performs.

Slide 28. It's also important that your ACO participants understand how the ACO reporting impacts their ability to — how the overlap occurs with PQRS and the EHR Incentive Program, and how ACO reporting impacts their ability to avoid payment adjustments. Details of quality measures submission are provided to ACOs through webinars and other educational materials developed by CMS. These can be found on our website, and I encourage you to review the quality reporting or requirements before applying to — and before getting your ACO participant agreements in place to ensure that your ACO can meet its obligations to the program and to your ACO's providers and suppliers.

We're on slide 29. Meaningfully using EHR technology is an important skill for practitioners in an ACO to learn. To signal the importance of developing this capability, one of the measures in the quality performance standard counts twice that of any other measure. Specifically, ACO measure number 11 calculates the number of primary care providers participating in the ACO that earned an EHR Incentive Payment. Additional information about the EHR Incentive Program can be found on the link on the slide.

Slide 30. Before applying to participate, your organization should review and understand the quality reporting requirements and clearly articulate the quality reporting requirements to ACO participants, including the alignment of other CMS quality reporting incentive programs like PQRS and develop a plan for quality reporting. I can't overemphasize the importance of quality reporting. And it's really vital that your ACO participants that join together understand the program, understand the reporting requirements, and commit to the ACO, including the quality reporting.

Some ACOs have met the requirements to enter the program, but because their ACO participants weren't well educated or committed, the ACO had trouble at the end of the year implementing care processes and doing quality reporting. Don't let this happen to you. It may be better to wait a year and ensure the commitment of each ACO participant rather than risk failure because you rushed through the development process.

Financial Performance

Slide 31. Benchmarks — the benchmarks for the ACO are established by taking the claims submitted by ACO participants, assigning beneficiaries to the ACO in each of the three benchmark years, and then calculating the average per capita cost of the population for each benchmarking year. We then roll it up to establish a 3-year average per capita cost for the ACO's average fee-for-service population.

The benchmark is risk-adjusted and updated by the projected absolute amount of growth in their national per capita expenditures for Parts A and B services. Performance year risk-adjusted expenditures are compared then to the benchmark. ACOs may share in savings if they qualify based on their quality performance and if the performance year per capita expenditures meet or exceed what's called the minimum savings rate, or

MSR, below the benchmark. The MSR is designed to take into account normal variations. The ACO then shares from first dollar back to the benchmark. So the ACO demonstrates that the costs have been — that per capita expenditures have met or exceeded the MSR, which is a confidence interval, but once the ACO has demonstrated that, then the ACO shares from first dollar back to the benchmark.

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

Under Track 2, the ACO will have an opportunity to share in savings but also be at risk for losses in return for a higher sharing rate, which is a maximum of 60 percent, and a higher sharing cap of 15 percent of the benchmark. Losses will be calculated to take into account quality performance, such that higher quality performance will protect the ACO from sharing losses maximally. The MSR is fixed at 2 percent on both the up- and down-side. Once met or exceeded, the ACO will share in savings or losses from first dollar.

Slide 32. As part of a coordinated interagency effort, CMS worked with FTC and DOJ antitrust agencies, as well as the IRS and OIG. The antitrust agencies have currently released an antitrust policy statement that complements the Final Rule. It addresses stakeholder antitrust concerns and offers a voluntary expedited antitrust review and guidance on avoiding running afoul of antitrust laws for newly formed ACOs that wish to participate in the program. You're going to hear a little bit more about that shortly.

The IRS released a response to comments for those tax-exempt entities that wish to participate. And the OIG, jointly with CMS, issued an Interim Final Rule with comment regarding CMP, kickback, and referrals for ACOs.

I encourage you to follow these links and read more about these concurrently published documents. And with that, I'll conclude and turn it over to Patrick Kuhlmann from the United States Department of Justice, who will give a brief overview of the antitrust policy statement. Patrick?

Antitrust and ACOs

Patrick Kuhlmann: Thanks Terri. I have to start with a brief disclaimer. The views I express today do not necessarily reflect those of the U.S. Department of Justice.

I want to note that my colleague, Rob Canterman, from the Federal Trade Commission, is on the line as well, I think. And the Department of Justice and the Federal Trade Commission, which I'll refer to collectively as the antitrust agencies, work in tandem to enforce the antitrust laws.

As Terri mentioned, I'm hoping to provide a very quick overview of the antitrust laws and how they apply to Accountable Care Organizations and also to direct you to some further guidance if you — should that be necessary.

My first, and my really key point, is that participation in the Shared Savings Program does not confer antitrust immunity. The antitrust laws still apply. So you should be alert for any potential antitrust issues as you form and operate your Accountable Care Organizations.

So I'm going to move to slide 34. The antitrust agencies recognize that many ACOs do not raise any antitrust issues and benefit patients by engendering more effective and more efficient care. However, under some certain circumstances, antitrust issues may arise for an ACO, and there's really three potential problem areas.

First, there is price-fixing. Agreements on price among competing providers are automatically illegal if they're not part of a legitimate joint venture; however, if an ACO involving competing providers participates in the Shared Savings Program, and that ACO uses the same governance and leadership structures and the same clinical administrative processes to serve patients in commercial markets, then the antitrust agencies will evaluate the ACO with competing providers on a case-by-case basis. This is what we, in antitrust jargon, call the rule of reason.

Also in this price-fixing category, I want to note that the sharing of competitively sensitive information regarding services outside of the ACO could potentially facilitate collusion and is a no-no.

The second potential problem area is monopolization. This means an ACO with monopoly power undertakes anticompetitive acts to acquire or maintain that power.

Finally, the third potential problem area is mergers. If providers — if a provider acquires a competing provider to form an ACO, that transaction is subject to antitrust scrutiny. And I guess it's probably worth noting that while providers may form an ACO via merger, you know, the Affordable Care Act nor the regulations — applicable regulations require that.

Moving to slide 35. As Terri mentioned, the antitrust agencies have issued some guidance for participants in the Shared Savings Program in the form of a policy statement. This guidance applies to collaborations among independent providers. If you're doing a merger instead of a — if you're doing a merger instead, that would be analyzed under separate merger guidelines that the agencies have formulated that apply generally.

In addition to the rule-of-reason approach, which I described earlier, the policy statement creates a safety zone for ACOs that have low market shares. This means that

if you fall within the safety zone, the antitrust agencies are not going to challenge the ACO, absent extraordinary circumstances. Of course, being outside of the safety zone itself, that's not enough to raise a red flag, it just means that, you know, it would require a case-specific analysis to rule out the possibility of antitrust issues.

The statement offers guidance for ACOs outside the safety zone, including a list of some practices that you may want to avoid. And as Terri mentioned as well, it also establishes a voluntary review process whereby newly forming ACOs can come to us at the antitrust agencies and get our views on whether the formation and operation of the ACO likely would raise antitrust concerns.

So this has been a very quick survey, but I do want to direct you to other guidance that's available, the policy statement, other materials are available at the websites listed on slide 35. Those websites also have an email box where you can send us questions regarding the policy statement. And I'm happy to answer any questions at the end of the presentation.

And now, I'm going to turn things over to Tricia, who's going to discuss the 2016 application process.

The 2016 ACO Application Process

Tricia Rodgers: Thanks, Patrick.

So I'm moving on to slide 37, and together, let's walk through the actual application process for program year 2016, as well as the key deadlines that you need to meet.

Slide 38 shows a chart of the key dates for the 2016 application process. It's imperative that all applicants meet these deadlines.

I'll go through each of the steps more thoroughly later in the slide presentation, but for now know that before you can submit an application, you must first submit a Notice of Intent to Apply, or NOI. Note that we posted the NOI memo on our How to Apply Application web page on April 1st. The memo provides detailed instructions about the NOI process and sample NOI questions. You may access the NOI web form and start your submission beginning May 1st, and the deadline for the NOI submissions is 8 p.m. eastern time on Friday, May 29th. We will not accept late NOI submissions. If you fail to meet the deadline, your next opportunity to apply for the Medicare Shared Savings Program will be next year for the 2017 cycle.

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

These forms must be submitted by June 9th, 2015. We would like to emphasize that you should take this step immediately upon receiving an ACO ID Number, which will be included in your NOI receipt notice email. You must have an ACO ID to request a User ID. Directions on completing the CM User ID access are also included in this email. It takes 3 to 4 weeks for CMS to process User ID requests. So again, we stress the importance of completing this step as soon as possible.

Additionally, if you previously submitted an application for the Medicare Shared Savings Program and your application was either denied or withdrawn, you must complete the process again from the beginning. This means that you must submit a 2016 NOI and receive a new ACO ID. After completing this, you must submit a 2016 application using the appropriate 2016 templates and naming conventions, as well as responding to attestation questions in the application. We will not evaluate any previous submissions.

We will accept applications from July 1st through July 31st, 2015. Again, the deadline for application submissions will be at 8 p.m. eastern time on July 31st. We plan to issue application dispositions in November of this year. If an applicant is denied and would like to seek a reconsideration, the applicant will have up to 2 weeks after the final determinations are issued to request a review of that denial.

I'm on slide 39 now. We developed an Application Toolkit to streamline your application submission. This toolkit gives you precise directions and examples of supporting documents that are integral parts of the application. It's important that you use templates we provide to complete the application. Do not alter the templates. Only fill in the cells where — which are applicable to your ACO. We would also like to reiterate that it's important to use the naming conventions that we provide. We developed the naming conventions to make the application and review process more efficient.

The toolkit includes regulation reference page, links to published program guidance, and FAQs for each question in the application. It also includes the CMS 588, or Electronic Funds Transfer Authorization Agreements. It includes the ACO participant list submission instructions, the Governing Body Template, the ACO Participation Agreement Template, and the Executed Agreement Template.

Slide 40 is where we are now. And your — it is — your first step in the application process is to prepare and submit your Notice of Intent to Apply, or NOI, as we briefly discussed.

Beginning May 1st, you may access the NOI on the How to Apply website. Step 1 on this web page will direct you to the link for the NOI memo. The NOI memo provides detailed instructions about the NOI process and provides a sample NOI question. We will publish the link to the NOI online web form on Friday, May 1st, 2015. We will accept NOIs from May 1st through May 29th, 2015, at 8 p.m. eastern time.

After you submit your NOI, you will receive an NOI receipt notice by email. We will send this notice to the primary and secondary application contacts listed in the NOI. The NOI receipt notice email will include your ACO Identification Number or ACO ID and then instructions on obtaining CMS User IDs. Again, it's important to know that submitting an NOI does not obligate you to submit an application; however, you must submit an NOI in order to submit an application.

Slide 41 references the NOI receipt notice will provide you with detailed instructions about how to access and fill out CMS Form 20037, which is the Application to Access CMS Computer Systems. This is the form you need to get a CMS User ID. Follow these directions exactly as they appear on the NOI receipt notice. This step is critical in order to process your request successfully.

If you're applying for new CMS User IDs, you must fill out the specified form found in your notice. Return the completed form to us via tracked mail, for example, FedEx, within 3 business days of receiving the NOI receipt. And the forms should be sent to the address on the slide, but that is Attention: HPMS Access, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C4-18-13, Baltimore, Maryland 21244.

Please note that your ACO must have at least four CMS users. Each individual form must include the requestor's Social Security Number, ACO ID Number, dated and original signature. We recommend that you initially obtain CMS User IDs for the following contacts:

- The primary and secondary application contact,
- The primary authorized to sign contact, and
- The information technology, or IT, primary contact.

Again, we stress that it can take 3 to 4 weeks to process CMS user access requests, so it's critical to do this step as soon as possible. CMS User IDs are necessary to submit your application.

We're on slide 42 now. If your contact already has a CMS User ID, include an authorization letter from the ACO, which authorizes that person to request, receive, and submit — to gain access to the ACO's data maintained in the CMS system. The letter must include the following: First, submitted on the ACO's official letterhead. Next, clearly indicate that the name and state that the person will be serving as a consultant on behalf of the ACO. It also must include the authorized ACO Identification Number, or ACO ID that the consultant will have access to, and it must be signed by the ACO's authorized official.

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

Next is slide 43. If you're a consultant and you already have a CMS User ID, please follow the directions found on this slide. Your CMS User ID is unique to you, not to the ACO or the ACOs that you represent. Therefore, if you currently have a CMS User ID, you do not need to apply for a new or different one. Instead, you will need to make us aware of which ACO or ACOs you are representing by sending us the information found on slide 42 on that ACO's letterhead.

It's important that the ACO authorizing official sign this letter, and it needs to be made into a PDF and emailed to hpms_access@cms.hhs.gov. Please complete these necessary steps as soon as you receive your NOI receipt confirmation email.

Slide 44 explains that it is fraudulent to use another user's CMS access or allow someone else to use your CMS access. This activity is strictly prohibited and will result in the termination of the individual's CMS user access if found in violation of this policy.

We are now on slide 45. We will post the sample 2016 Application and Toolkit on our website on June 1st, 2015. We suggest that you review this application thoroughly and as soon as possible. The more familiar you are with the application and its requirements, the more likely you will have fewer problems when completing the application. If you have any questions while reviewing the application, please forward them to us at sspaco_applications@cms.hhs.gov. We encourage you to be proactive in the application process to avoid issues meeting our deadlines. Do not wait to begin the application process.

We will accept applications through the Health Plan Management System, or HPMS, from July 1st through July 31st, 2015, at 8 p.m. eastern time. Again, I want to reiterate the importance of timely submissions. We will not accept late application submissions. If you fail to meet the deadline, your next opportunity to apply to the Medicare Shared Savings Program will be for the 2017 cycle.

If you would like to get an idea of the requirements expected of you, you may review the 2015 application material that currently appears on our Application website. This will be available for you to view until the Sample 2016 Application is posted on June 1st.

Slide 46 is very important. In order to get paid, you must submit a completed CMS Form 588, Electronic Funds Transfer, or EFT, Authorization Agreement with your application. This form may also be referred to as EFT Form 588, the 588, or the banking form.

CMS validates the banking information before any EFT deposits are made. We recommend that as soon as your ACO is formed, you establish a validated account and set up an active checking account using your ACO's legal business name and TIN. We would like to emphasize that your ACO legal business name and TIN must match the information we have on file with your application, the CMS 588 Form, and that of your financial institution. You will not receive EFT if this information does not match.

If there are any errors, our Office of Financial Management, or OFM, will notify the contact person on the CMS Form 588 to ask for corrected information. If your ACO's TIN or legal business name changes, you must notify CMS as soon as possible via email at the sspaco_applications@cms.hhs.gov. A revised hard copy of the Form 588 and cover sheet must also be sent to us via tracked mail.

During the application process, the CMS Form 588 must be submitted to OFM via tracked mail, for example, FedEx, at the same time the application is submitted in HPMS. The form must be sent to CMS, 7500 Security Boulevard, Mail Stop: C5-15-12, Attention: Jonnice McQuay, Location: C4-02-02, Baltimore, Maryland 21244.

We consider applications incomplete without the CMS Form 588. Additional guidance is found in the Application Toolkit.

Slide 47 is a summary of the important application steps. First being, act early. Time is of the essence, so submit and complete all steps as early as possible according to the timeframes provided. Second, educate your providers about quality reporting. It will take input from all your participant TINs to report the quality measures. Third, provide at least four contacts for your ACO. These contacts must be available through the Notice of Intent to Apply in the application's phase, which runs from May 1 through November.

All correspondence between the ACO and CMS must include your ACO ID Number and a legal business name. Never share any CMS User IDs, and contact CMS with applications questions at sspaco_applications@cms.hhs.gov.

At this time, we're going to forward to slide 50. We'll go back and cover slides 48 and 49 in a moment. And I'm going to turn the presentation over to Stephen Jenkins from the Centers for Medicare & Medicaid Innovation at CMS, who will speak to you about the new model called the ACO Investment Model, or AIM. Steve?

The ACO Investment Model

Stephen Jenkins: Thank you Tricia, and thank you everybody in the Medicare Shared Saving Program team for allowing me to present to you today on the ACO Investment Model.

Now, skipping to slide 51. You know, creating an ACO, you know, requires a long-term investment horizon. You know, starting and sustaining an ACO requires investment and

it takes time to recoup some of those investments. So that can create a barrier to entry into the model. Some ACOs may lack the capital to enter into the Medicare ACO programs or there's a — they can create concerns with cash flow and the ability to endure through the ACO transformation.

So moving to slide 52. The ACO Investment Model provides pre-paid shared savings to ACOs for staffing and infrastructure that supports population care management, financial management, and other essential ACO functions. And this is our response to, hopefully — creating a way to rise over the kind of challenges of the investment and cash-flow issues.

Moving to 50 — slide 53. The amount of pre-paid shared saving that we offer to individuals that are starting in 2016 is we provide an upfront, fixed payment of $250,000, plus an upfront, variable payment of $36 per beneficiary, and that we create the list using the Medicare Shared Saving Program's preliminary, prospectively assigned beneficiary list in their most recent quarter. And then we also provide an additional $8 for beneficiary per month to each indiv — to each ACO. So that provides them an upfront funding and then an ongoing funding to help transform the — transform ACO care management and also ACO investments in IT infrastructure.

Now moving on to slide 54, AIM eligibility. There are some requirements to be eligible for the ACO Investment Model. Applicants must participate and be in good standing with the Shared Savings Program. They must have 10,000 or fewer aligned beneficiaries. They must be provider-based, with the exception of ACOs with Critical Access Hospitals, or CAHs, or small IPPS hospitals of 100 beds or fewer. Participants must also not be owned by a health plan. And they must not have participated in the Advanced Payment Model previously.

Now once we've — you've qualified for the eligibility criteria, there's a selection criteria based on your application. So after you've completed the application, each ACO will be judged on four — or five categories. The first category will be location in terms of the ACO penetration for your primary care service area, which will be 4 points of your 20 points. Then there'll be another 4 points for — if your organization is determined rural — is a rural organization, which is based on RUCA codes. And if you have a RUCA code of 4 to 10, or 65 percent of your provider sites are above — have a RUCA code of 4 to 10, then you're considered a rural location.

Then there is 2 points for organizations that are interested in moving towards a higher risk track, that's a Track 2. And then there's also — in terms of your application, there's your spend plan and your demonstration of need. So we will create a review panel that determines the — that reviews each of your quality — your spend plan and your statement of need to determine the points for each of those.

And lastly, the AIM Application, you'll notice that we are trying to match with the Medicare Shared Savings Program, so we will — while we do not require a Notice of Intent, we do — we will be providing our application early, on June 1st, 2015. And our application deadline is the same as the Medicare Shared Savings Program, so our deadline is 8 p.m. on July 31st.

And with that, if there's other information that you have about the ACO Investment Model, you can go to our website, which is at the CMMI website, or you can email us at the ACO Investment Model inbox, which is AIM@cms.hhs.gov. Thank you very much.

Upcoming ACO Application Calls

Tricia Rodgers. Thanks Steve. So this is Tricia. Let's go back to slide 48 to talk about the upcoming application calls.

So, we'd like to make you aware of our upcoming application calls. And our next call takes place on Tuesday, April 21st, 2015, from 1:30 to 3 p.m. eastern time. Complete details and registration information are available on our web page.

On this call, we will address specifically the more intricate issues associated with your application. And this call will focus on beneficiary assignment, the participant list, and agreements between ACOs and providers. Our subject matter experts will explain these topics so that you can better prepare for the application process. Since these have been the most complicated issues in past cycles, we believe that the information we will provide, coupled with the lead time, will give you the opportunity to have a successful and efficient application process.

Please mark your calendars for the upcoming application calls that we plan to provide through the 2016 Application cycle:

- April 21st is the agreement, the participant list, and assignment.
- June 9th is our 2016 Application Submission Review.
- July 7th is training on the Health Plan Management System, or HPMS, Application Module Submission.
- July 14th is the ACO Application question-and-answer session.

Please note that these calls in June and July are only available to the potential applicants that successfully submitted a Notice to Intent to apply by the May 29th, 2015 deadline. We will send out information about these calls via email directly to the contacts that you listed in your NOI. As a result, we ask that you review your NOI submission carefully and confirm that all information is complete and accurate.

Slide 49 speaks to the — that we continually — we ask 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 slide also provides you with an email address and phone numbers to contact in the event that you're having problems with your CMS User ID form, password reset, or technical issues with HPMS.

So this concludes the prepared portion of the Shared Savings Program Application Call, and I'm going to turn it back over to Charlie.

Keypad Polling

Charlie Eleftheriou: Thank you. Before we move into to our question-and-answer portion of the call, we're going to pause for a moment to complete keypad polling so that CMS has an accurate account of the number of participants on the line with us today. Please note there will be a short amount of silence on the line while we tabulate the results. And we're now ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9

Again, if you're the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling. Please hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Charlie.

Question-and-Answer Session

Charlie Eleftheriou: All right, thank you. Our subject matter experts will now take your questions. Because this call is being recorded and transcribed, please state your name and the name of your organization before asking your question. And in an effort to hear from as many callers as possible, we just ask that you limit yourself to one question at a time, please. If you do have more than one question, please press star 1 after your first question is answered to get back in queue, and we'll address followup questions as time permits. And now we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchstone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Please note your line will remain open during the time you are asking your question so anything you say or

any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

And there are currently no questions in queue.

Charlie Eleftheriou: If you have a question …

Operator: Please hold for your first question. Your first question comes from the line of Georgia Green.

Georgia Green: Hi, can you hear me?

Tricia Rodgers. Yes, go ahead.

Georgia Green: Excellent. So I realize that the bank account is required in order for the application to be considered complete. And I just wanted to verify that that needs to occur prior to the submission on July 31st, or would it be possible to complete that, you know, between July 31st and the first RFI submission?

Tricia Rodgers: Thanks for that question. You need to submit your CMS Form 588 by the July 31st deadline. If there are issues, there are ways to make a change — minor changes to that. But you do need to complete the Form 588 by the July 31st deadline. Thanks.

Georgia Green: Thank you.

Operator: Your next question comes from the line for Mazhar Jaffry.

Mazhar Jaffry: Hello, this is Mazhar Jaffry, and I am representing A.D. Maxim Consulting from Michigan. I just have one question and that is in regards to — from the management perspective. The person who could lead the entire ACO program, does that person have to be a physician or that person, like M.D. physician or some D.O. physician, or that can be a managing person with MBA background who can lead the organization as a COO or the president of the organization?

Dr. Terri Postma: Hi, this is Terri Postma. There are several leadership in management requirements. The ACO is required to have had administrative leadership, so things like a general manager or CEO, things of that nature, and you can look up the specifics in the program rules. But in any case, those folks aren't expected to be clinical. But in terms of the clinical leadership of the ACO, there are two people in particular that we mention in the program rules. One is the medical director, which must be a board certified and licensed physician, and then the other is any qualified health professional that's responsible for leading the ACO's quality improvement and assurance program. Now that person could also be the medical director. But if that person — if those roles are separated into two roles, then the medical director must be a physician and the other,

leading the quality assurance and the improvement program, can be any qualified health professional.

Mazhar Jaffry: Oh, thank you so much for the explanation. That clarifies my question because I think it would be very integral that who's going to do — be running the organization. But I think you've explained it very well that clinical should be coming from physician side, but administrative could be somebody who has like some strong health care experience working different organizations, has leadership roles in the past experiences. Thank you.

Dr. Terri Postma: You're welcome. And I just wanted to mention also that we have those definitions and explanations in the back of the toolkit, so those will be available.

Mazhar Jaffry: Thank you so much. Really appreciate it.

Dr. Terri Postma: OK.

Operator: Your next question comes from the line of Bonnie Shok.

Bonnie Shok: Hi, I was wondering if an existing ACO has a separate renewal process or if we start all over again as if we're brand new?

Tricia Rodgers: Hi, this is Tricia Rodgers. So we'll have more information online about how existing ACOs who would like to renew their agreement with CMS — there will be a Notice of Intent to Apply for you as well. The information is up online right now under the memo, the NOI Memo. And we will have a subsequent call to go over that process to renew an existing application. But at this time — that's what's available right now is the Notice of Intent to Apply Memo online and the dates for both new applicants and existing ACOs to renew.

Bonnie Shok: Thank you.

Operator: Your next question comes from the line of Kristine Gates.

Kristine Gates: My question is regarding attribution of patients to see a physician assistant in a Federally Qualified Health Clinic. Is the attribution done using NPIs, CCNs, or some other methodology?

Tricia Rodgers: Hi Kris, this is Tricia. So we are going to be addressing all of that in our next call on the 21st. If you could please hold those questions, we'll be going into much greater detail on assignment during that call. Thanks.

Kristine Gates: All right, thanks.

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

Male caller: Hi, this isn't Barbara, but it's Barbara's colleague. If you're a member of an ACO now, and that ACO is going to terminate at the end of this year, 2015, is there any specific thing different that you have to do to sign up for a new ACO?

Tricia Rodgers: Hi, this is Tricia. By member, do you mean ACO Participant TIN?

Male caller: Yes.

Tricia Rodgers: So the ACO that is terminating or has terminated would need to let us know that the ACO wants to terminate and, therefore, we would put an end date for each of the participants at the end of this year so there would be no overlapping issues when we screen the participant TINs that are applying under the new 2016 Application cycle. But that is — that is the extent that needs to happen. If there — if it shows an overlap with another existing ACO, we'll let you know during the Request for Information process.

Male caller: OK, thank you.

Tricia Rodgers: Thank you.

Operator: Your next question comes from the line of Mario Espino.

Mario Espino: Yes, good afternoon and thank you. Is the AIM program developed also for the Federally Qualified Clinics?

Steve Jenkins: Hello Mario, this is Steve Jenkins responding. Your questions is, is that are Federally Qualified Clinics also exempt from the — are you allowed to have a Federally Qualified Health Clinic, is that your question?

****Post-Call Clarification: ACOs with FQHCs are eligible to apply and will be considered along with all other eligibility and selection criteria.****

Mario Espino: Yes, in the AIM program.

Steve Jenkins: At this time, no, that is not the case. But keep on — keep watching our website for any changes on that.

Mario Espino: OK, thank you.

Steve Jenkins: Yes.

Operator: Your next question comes from Ray Lake.

Charlie Eleftheriou: Hello?

Ray Lake: Hello. Is there — is there any truth to what we're hearing that providers and/or CMS patients will be passively assigned to an ACO at some point if they do not voluntarily join one?

Tricia Rodgers: Hi, this is Tricia. So, ACOs are assigned based on the providers that they see and the services they get from ACO participants. That means the providers and suppliers that the beneficiaries see. They are not enrolled, it is not — they are not locked in, but they are assigned. And they do have the ability to opt out or decline to have their data shared, but the assignment to an ACO does not have any impact whatsoever on the services they receive as a fee-for-service beneficiary.

Dr. Terri Postma: This is Terri Postma, and were you also asking about providers?

Ray Lake: Yes, correct.

Dr. Terri Postma: OK. So AC — Medicare-enrolled TINs — this is a voluntary program. And so – and ACOs are formed by the Medicare-enrolled TINs that have joined together to form the ACO, so it is a purely voluntary program.

Tricia Rodgers: With signed agreements and so on and so forth between the participant TIN and the ACO.

Dr. Terri Postma: Um-hum. Does that answer your question?

Ray Lake: Yes, it does. Thank you.

Tricia Rodgers: Thank you.

Operator: Your final question comes from the line of Heidi Harting.

Heidi Harting: Yes, just quickly, I want to confirm if participating in CPCI that we would not — our organization will not be able to participate in an ACO, is that correct?

Dr. Terri Postma: Yes, this is Terri Postma. So, if a Medicare-enrolled TIN is already participating in CPCI, that is an overlapping program, and as such, that ACO participant TIN would be flagged as an overlap if it came through on one of the ACO Participant Lists. So you're correct. An ACO — a Medicare-enrolled TIN may not participate in both the Shared Savings Program and CPCI.

Heidi Harting: Thank you.

Tricia Rodgers: Thanks.

Operator: My apologies, we have another question from Peggy Oliver.
Peggy Oliver: Yes, Peggy Oliver, the Gastroenterology Group. We have offices in two States. The one State, which is about 45 minutes to an hour from the other office, they have formed an ACO connected to one of the hospitals over there, and we've joined that ACO. When they pulled Medicare for our claims data because it's one Tax ID Number, it came up with both the one State's participants and also the second State's because of the same Tax ID Number. So my question is, do I try to join another ACO in the second state? Because obviously those participants that are now in that ACO, from — it's the State of New Jersey, so those New Jersey residents are not seeking services in the State of Pennsylvania. So how do I — what happens with this?

Dr. Terri Postma: Hi, this is Terri Postma. So the way that the program is structured is that we pull all the claims affiliated with each ACO participant on the ACO's list. There is no way for us to distinguish where one clinic site is versus another when those clinics are jointly billing through the same ACO Participant TIN. So, the providers that are billing through the TIN of those ACO participants will continue to participate, and whichever ACO that TIN is listed — whichever ACO's Participant List that TIN is listed on. Does that make sense?

Peggy Oliver: It does make sense. So basically, anyone in the State of New Jersey, we will not be associated with an ACO in this state, correct?

Dr. Terri Postma: Well, I don't know who the "we" is that you're referring to.

Peggy Oliver: The practice.

Dr. Terri Postma: Oh, the practice is affiliated with the ACO on which the ACO Participant TIN is listed. So if your practice is billing through a Medicare-enrolled TIN that is an ACO participant, then all of the practitioners that are billing through that TIN have to agree to participate and comply with that ACO and the program rules.

Peggy Oliver: OK. So even though the New Jersey patients of ours will not ever be seeking services in the State of Pennsylvania?

Dr. Terri Postma: No, they're not, but they obviously sought enough services to get assigned to the ACO through the practitioners in that clinic that's billing through the TIN. So those practitioners should continue to be responsible for those patients.

Peggy Oliver: OK. And we will be, but only in the State of New Jersey and the ACO is in the State of Pennsylvania. So like I said, it's almost an hour from here. So, obviously, patients are not going to travel an hour to the other State to seek services.

Dr. Terri Postma: Right. That's fine and it's not required. Beneficiaries aren't locked in. This isn't a network arrangement like a managed care plan or anything like that. So ...
Tricia Rodgers: And this is Tricia. It doesn't matter if the ACO is headquartered in Pennsylvania, it can have — as long as all of the participants under the ACO have agreements and are billing through the TINs under which the ACO participants have, then the patients that go see the participants billing through those TINs will be assigned, regardless of where they get those services. Even if it's through the participant TINs in New Jersey, they would be assigned to the ACO because the practice that you work for in New Jersey is part of the ACO that is from Pennsylvania.

Peggy Oliver: OK, all right. So, I don't have to worry about the State of New Jersey, we have our ACO and it's just getting off the ground now so we're good to go.

Tricia Rodgers: It sounds that way, but you might want to touch base with the ACO just to make sure that you understand all of the requirements that they will have of everyone billing through the TIN.

Peggy Oliver: OK. All right, thank you very much.

Tricia Rodgers: Thank you.

Peggy Oliver: OK, bye-bye.

Operator: And we have no more questions at this time.

Additional Information

Charlie Eleftheriou: OK. Well, in lieu of that, we will end our call for today. On slide 58, you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and totally voluntary, but we do hope you'll take a few moments to evaluate your experience.

I'd like to thank all of our subject matter experts in the room here and those on the line, and all the participants who called in to join us for today's MLN Connects Call. Thank you very much and have a great day.

Operator: This concludes today's presentation. You may now disconnect your line. Presenters please hold.

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