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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO: Application Process
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Contents

Operator: At this time, I'd like to welcome everyone to the 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'll now turn the call over Amanda Barnes. Thank you. You may begin.

Announcements and Introduction

Amanda Barnes: Thank you Holley. I'm Amanda Barnes 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 Medicare Shared Savings Program Application Process.

MLN Connects Calls are part of the Medicare Learning Network®. During this call, CMS subject matter experts will cover subject — pardon me, will cover helpful tips to complete a successful application for the Medicare Shared Savings Program, including information on how to submit an acceptable Accountable Care Organization, or ACO, Participant List, sample ACO Participant Agreement, executed ACO Participant Agreement, and governing body templates.

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

Please note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details web page. An announcement will be placed in the MLN Connects Provider eNews when they are available.

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

Presentation

Tricia Rodgers: Thanks Amanda, and welcome to our second call for the 2016 applicants for the Medicare Shared Savings Program. We will be going over with you today information concerning agreements, participant list issues, beneficiary assignment for the application cycle for the upcoming 2016 program performance year.

I'm moving on to slide 5 now. So we believe it's important to discuss three historically challenging issues related to your application. We hope this call gives you the information and tools necessary to develop a successful application, and we strongly

encourage you to work on these elements as soon as possible. We'll begin our presentation with information around submitting complete and accurate agreements between you and your participant providers. Next, we'll go over with you details about your participant list. And finally, we will go through the logic we use to determine beneficiary assignment for each ACO. And then as time permits, at the end, we'll open the lines for questions.

As you know, the Medicare Shared Savings Program is a voluntary program. It's an opportunity for providers to join together in Accountable Care Organizations. And participating providers and suppliers in the ACO will continue to bill and receive fee-for-service payments as they normally do. But at the end of each year, we will evaluate an approved ACO's quality and efficiency. If the ACO as a whole has met the quality performance standard and has reduced the growth in per capita costs for its fee-for-service population, the ACO will be eligible to receive a portion of savings it generated for Medicare. In turn, the ACO could allocate those savings to improve its infrastructure and reward participating providers.

Because the Shared Savings Program is a national program, we developed regulations and rules through our CMS rulemaking process, which involved issuing a proposed rule, accepting public comments during a mandatory public comment period, and then issuing a final rule. We are currently developing a final rule based on the proposals we issued in December and comments we received in February.

Similar to the first application call we had on the 7th, this call is intended to provide information to new applicants, but ACOs wishing to renew your agreement with us can listen in and learn, as we still plan to have a separate call for renewing ACOs at a later date.

And I am on slide 7 now. We have an ambitious agenda today, so let's begin with the ACO Participant Agreements. I'll turn the call over to Dr. Terri Postma, medical officer in the Performance-Based Payment Policy Group. Terri?

ACO Participant Agreements

Dr. Terri Postma: Thanks Tricia. Let's go to slide 8. The first thing I'd like to do is to begin by reviewing some important terms and definitions that I'll be using throughout my portion of the talk. These definitions are critical to an understanding of the program rules and the guidance that we have posted on our website.

An ACO, as you know, is formed by ACO participants. These ACO participants are defined and identified by a Medicare-enrolled billing Taxpayer ID, or TIN. Therefore, an ACO participant is an entity. For example, an ACO participant could be a hospital or a clinic or other — any other entity that is identified by a Medicare-enrolled billing TIN.

ACO providers and suppliers are individual practitioners or entities that have reassigned their billings to the TIN of an ACO participant. They're generally identified by a National Provider Identifier, or NPI. Our rules require that each ACO provider/supplier that has reassigned his or her billing to the TIN of an ACO participant must agree to participate in the Shared Savings Program.

Please make sure you read and understand the differences in these terms. Lack of understanding can negatively impact your ACO's ability to complete required documentation and may lead to denial of your application.

For example, the application asks you to list the ACO participant and to submit the agreement your ACO has with each ACO participant. That means the ACO must have an agreement between the ACO legal business entity and the ACO participant legal business entity, not with an individual practitioner or ACO provider/supplier that happens to bill through the TIN of that ACO participant. If the agreement you submit is not made between the correct parties, the agreement will be rejected and the TIN may not be included on your ACO Participant List.

Let's go to slide 9. I reviewed the next several slides in detail on the previous call we had in relation to Shared Savings Program requirements for governance and leadership. This time, I'm going to review them again, but I'll focus on the ACO Participant Agreement requirements.

The first slide here, on slide 9, illustrates the typical structure, but not the only structure, of an MSSP ACO, where a collection of ACO participants or Medicare-enrolled billing TINs have joined together to create an ACO. If your ACO meets eligibility for participation in the program, the authorized official of the ACO legal entity will sign a participation agreement with CMS. You can find an example of this on our website.

According to the definitions from the previous slide, the Medicare-enrolled billing TIN defines and identifies the ACO participants that have joined together to form the ACO. Again, individual practitioners that bill through the TIN of the ACO participant are called ACO providers/suppliers, and that's the bottom layer there on the slide.

Your ACO is required to have downstream agreements, called ACO Participant Agreements, with each ACO participant TIN that you submit on your application. These are the agreements that I'm going to be focusing on today. Your ACO may also choose to form individual ACO provider/supplier agreements. However, in most cases, it's not required because the ACO Participant Agreement includes all the ACO providers/suppliers that bill through the TIN of the ACO participant.

Slide 10. It's important that you be able to identify your ACO structural category because this is going to help you determine what agreements you need to submit as part of your application. Since I reviewed this in detail in the previous call, I'm only going

to go over this briefly today and, again, focus on how it relates to your ACO Participant Agreements.

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 in the ACO, with the governing body that's 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 ACO Participant Agreement that your ACO legal entity uses. And you'll also be required to submit an executed copy of each ACO Participant Agreement that has been signed between the ACO legal entity and each ACO participant TIN that you put on your list.

The second category is what we refer to as a single TIN ACO. In this case, the ACO is one large Medicare-enrolled TIN that is capable of satisfying the program requirements on its own. In this instance, the Medicare-enrolled TIN did not have to set up a separate legal entity to be its ACO. The ACO – the single ACO participant TIN and the ACO legal entity — is one and the same. In other words, the ACO participant TIN — the advantage – sorry, the advantage of this structure is that the sole ACO participant can use its existing legal entity and governing body as the ACO.

If your ACO is structured in this way, you'll be asked, as far as the application, to indicate that each ACO provider/supplier billing through your ACO's TIN has agreed to participate. In some cases as a condition of employment, the ACO providers/suppliers are required to agree to participate. For documents — for documentation purposes, you'll be asked to submit a sample of that employment agreement. But in other cases, your Medicare-enrolled TIN may have contractual agreements with ACO providers and suppliers who have reassigned their billings to your TINs, but who aren't automatically required to participate in the programs. For these practitioners, your ACO must get signed the ACO provider/supplier agreements and submit a sample of that agreement as part of the application.

The third category on the slide is what we refer to as a single TIN ACO set up as a traditional ACO. This is a single Medicare-enrolled TIN or ACO participant that has chosen to set up a separate legal entity as the ACO. Initially, it may be you're the only ACO participant on the list. In this case, your ACO is treated as a traditional ACO, and you will be required to submit both a sample participant — ACO Participant Agreement, as well as an executed ACO Participant Agreement.

I'm moving on to slide 11. Understanding your ACO's organizational structure will help you determine how best to answer the application questions. Questions four through six are all related to your ACO's legal entity and governing body. Since I reviewed these on the last call, I'm not going to repeat that today. Today, I'll focus on questions 26 through 29 that have to do with your agreement.

For a traditional ACO and a single ACO set up as traditional, you're going to follow the same pattern for submission. Under question 27, you'll be required to submit a sample of the ACO Participant Agreements you use. You'll answer "yes" to question 28, which requires you to attest that your ACO Participant Agreements do not contain prohibited referral language. Under question 29, you'll be required to submit an executed ACO Participant Agreement for each ACO participant TIN on your ACO Participant List.

Remember, each ACO provider/supplier that bills through the TIN of an ACO participant on your list must agree to participate and comply with program rules. We do not require you to submit documentation or prove that each of those ACO providers/suppliers has agreed, but it is your responsibility to ensure compliance with this important program rule.

For a true single TIN ACO, you'll answer questions 26 through 29 in a slightly modified way. In this case, if your ACO providers/suppliers are employed, and as a condition of employment, they must agree to participate and comply, then you'll answer "yes" to question 26 and submit a sample of your employment agreement. If your ACO providers/suppliers are contracted but not employed, then you must submit a sample of your ACO provider/supplier agreement under question 27 and attest that that agreement does not have prohibited referral language by answering "yes" to question 28.

If some of your ACO providers/suppliers are employed and some are contracted, you'd answer "yes" to question 26, submit your employment agreement, and submit a sample ACO provider/supplier agreement under question 27, and attest yes to question 28. If you are a single TIN ACO, you are not required to submit all executed agreements or employment contracts, so you can skip question 29.

Slide 12. All ACO participants and all ACO providers/suppliers billing through the TIN of an ACO participant must agree to comply with the requirements and conditions of the program, as well as all laws — all laws and regulations set forth in 42 CFR Part 425. Before you submit your ACO Participant List, you must execute an ACO Participation Agreement with the entity that will be an ACO participant. You cannot include an ACO participant on your ACO Participant List unless you have a signed ACO Participant Agreement. This means that someone with authority to bind the ACO participant TIN in its entirety must sign the ACO Participant Agreement. Again, it's your responsibility to ensure that all ACO providers/suppliers that bill through that TIN have agreed to participate and comply with program rules.

Slide 13. Please make sure your ACO Participant Agreements follow good contracting practices. One thing you'll note on this slide is that your ACO Participant Agreement must be made between the ACO legal entity and the ACO participant TIN legal entity, and it must be signed by a person authorized to bind these legal entities. Make sure that that's correct on your agreement.

The agreement also must be directly between the ACO legal entity and the ACO participant legal entity. Don't use a third-party intermediary. For example, we've seen situations where external third parties are either a part of the ACO Participant Agreement or where the agreements are made through a third party. If you submit such agreements as part of your application, you'll be required to re-execute direct agreements or to remove the ACO participant from your list.

Also, don't submit letters of intent. The ACO Participant Agreements must be formal agreements. Each agreement should clearly identify the parties entering into the agreement, the agreement date, and the length of the agreement. The correct legal business names for both the ACO legal entity and the ACO participant must be used in the agreement. If you're unsure about the name of the ACO participant's legal business name, ask them to give you a screenshot of their PECOS enrollment information. This is one of the ways that we validate whether the correct legal entity is on the ACO Participant Agreement.

Slide 14. There are several required elements that must be included in your ACO Participant Agreement. The agreements must have an explicit requirement that the ACO participant agrees to participate in and comply with Shared Savings Program Rules that are found at 42 CFR 425. It's good for you to make sure that those — that that reference is directly in your agreement. The agreement must describe the ACO participants and their ACO providers'/suppliers' rights and obligations in the ACO. For example, ACO participants are required to implement the required processes to promote evidence-based medicine, patient engagement, and care coordination. ACO participants must also comply with the ACO's process for reporting quality measures. These are some of the obligations in the ACO. There must also be an explicit requirement to comply with Federal criminal law, False Claims Act, Anti-Kickback statute, civil monetary penalties law, and physician self-referral laws.

Slide 15. As noted previously, the ACO has an obligation to ensure that all practitioners billing through the TIN of an ACO participant have agreed to participate and comply with program rules. To help your ACO enforce this requirement, include language in your ACO Participant Agreements that require all practitioners billing through the TIN to agree to participate and to comply.

Your ACO could verify compliance with this rule by either getting direct agreements with each practitioner billing through the TIN or by collecting agreements that the ACO participant has with each of its ACO providers and suppliers. If your ACO chooses to get each ACO provider/supplier to sign an agreement, include the same language that's in the ACO Participant Agreement.

Slide 16. Here we've made some suggestions for other things that you might consider including in your ACO Participant Agreement. For example, you might include an explicit requirement for the ACO participant and its ACO providers/suppliers to agree to help

complete quality reporting for a performance year, even if the ACO participant is terminated from the ACO. You might also consider including an explicit requirement for the ACO participant and its ACO providers/suppliers to comply with all relevant statutory and regulatory provisions related to appropriate use of data. Finally, you may also consider including an explicit requirement for the ACO participant and each of the ACO providers/suppliers to ensure their Medicare enrollment information in PECOS is kept accurate and up to date.

Examples of ACO Participant Agreements

Slide 17. Here are some examples that are found in our guidance documents. The correct scenario is that a large group practice decides to participate in an ACO. The owner of the large group practice signs an agreement on behalf of the practice to participate in the program and follow program rules. Also, all practitioners that have reassigned their billings to the TIN of the large group practice have also agreed to participate and to follow program rules. The ACO may include this group practice TIN on its list of ACO participants.

Slide 18. Here are two examples of problematic agreements. First, a large group practice decides to participate in an ACO. The owner of the ACO signs an agreement to participate in the program and follow program rules. However, not all practitioners that have reassigned their billings to the TIN of the large group practice have agreed to participate or to follow programs rules. The ACO may not include this group practice TIN on its list of ACO participants.

The next one. Several practitioners in a large group practice have decided that they want to participate in an ACO. However, the group practice as a whole has not agreed to participate in the program. In this instance, the ACO may not include this group practice TIN on its list of ACO participants.

Tips, Reminders, and Common Errors

Slide 19. I mentioned previously using good contracting practice. So here are some other tips and reminders. First, in the contract opening statement, clearly identify the parties to the contract by their legal business names. Include the required ACO Participant Agreement elements in your contract. In the signature page, it's required that the signature of a person with authority to bind the ACO participant signs, as well as the signature of an ACO executive or authorized-to-sign as listed — as you have listed in HPMS. On the signature page, we have some additional suggested elements, which are to include the date, the ACO participant legal business name as verified in PECOS, the ACO participant TIN. And if the participant is a sole proprietor, list both the enrollment TIN and the billing TIN if they're different.

Slide 20. We've seen a lot of errors in the ACO Participant Agreements that lead to problems for applicants. To avoid errors, check to make sure your ACO Participant

Agreements use the correct ACO legal business name. Make sure they use the correct ACO participant legal business name. For example, make sure that you include any name extensions, such as L.L.C., Incorporated, M.D., or P.A. Also be sure to confirm that the ACO participant's legal business name matches PECOS. And, again, you can do this by asking the ACO participant to give you a screenshot of its enrollment information in PECOS.

The legal business names on the signature page must match the legal business names identified in the opening of the agreement. Also, make sure that the ACO and the ACO participant have each signed the ACO Participant Agreement signature page, and make sure that the proper parties have signed. These names must match what's in HPMS and what's on the ACO Participant List.

Make sure that if changes are made to the agreement, that the changes are initialed by both parties. Also, if the ACO participant TIN is listed in the agreement, once again, be sure it is listed correctly.

Following these basic rules and requirements will help your ACO avoid problems during review of your application. I'm now going to turn things over to Amanda.

Keypad Polling

Amanda Barnes: Thank you Terri. At this time, we will pause for a few minutes to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. Please note there will be a silence on the line while we tabulate results. Holley, we're ready to start polling.

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

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold while we complete the polling.

And thank you for your participation. I'd now like to turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you so much Holley. Now it is my pleasure to turn the presentation over to Kari Vandegrift, health insurance specialist in the Division of Shared Savings Program here at CMS. She will speak to you today about the nuances associated with the ACO Participant List as it relates to the 2015 program year cycle of the Medicare Shared Savings Program. Kari?

The ACO Participant List

Kari Vandegrift: Thank you Amanda. My presentation begins on slide 22. The ACO Participant List is required as part of your application. It includes information about the ACO participants and, in some cases, ACO providers/suppliers. We will use the ACO Participant List you submit with your application to determine your eligibility to become an ACO in the Shared Savings Program.

As Terri stated earlier, an ACO participant is an individual or group of ACO providers/suppliers that is identified by a Medicare-enrolled Taxpayer Identification Number that alone — or together with one or more other ACO participants — comprises an ACO. The ACO Participant List is the collection of ACO participant TINs that we will use to determine an applicant's eligibility to become an ACO. In the case of Federally Qualified Health Centers and Rural Health Clinics participants, the ACO Participant List will also include some provider/supplier data points.

We will use the ACO Participant List you supply with your application to determine whether or not your ACO meets the eligibility requirement of 5,000 assigned beneficiaries. The ACO Participant List is very important. Not only is the list used to determine an applicant's eligibility, but after an ACO is accepted to participate in the Shared Savings Program, we also use the list to assign beneficiaries to the ACO, establish the historical benchmark, perform financial reconciliation, determine a sample of beneficiaries for quality reporting, coordinate participation in the Physician Quality Reporting System, and monitor the ACO for program integrity issues.

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

Before you submit your ACO Participant List, you must execute an ACO Participation Agreement with the entity that will be an ACO participant. We encourage you to start talking with potential ACO participants early and make sure they're aware of all the program requirements before they sign an ACO Participation Agreement with you.

Slide 23. Once an ACO is accepted into the program, you must notify us of participant additions or removals within 30 days of the change. While you report the change to us within 30 days, these changes will not take effect for full program participation until the following performance year. For example, if an ACO participant TIN is added in 2016, it will not be included in assignment until 2017. ACO participants who leave the ACO during a performance year will continue to be used in that performance year's assignment, sampling for quality reporting, financial reconciliation, and quarterly and annual reports. To learn more about the impact of changes to your ACO Participant List, visit the Shared Savings Program website to review the changes in ACO participants and ACO providers/suppliers during the agreement period guidance document.

Slide 24. A merged or acquired Tax Identification Number, or TIN, is a TIN that was acquired by an ACO participant through purchase or merger. A merged or acquired TIN may be added to the ACO Participant List so that we can use the information for beneficiary assignment during the historical benchmark years. The merged or acquired TIN can be added to the ACO Participant List if the ACO participant subsumed the acquired TIN in its entirety, including all of the ACO providers/suppliers that billed under that TIN.

All the ACO providers and suppliers that billed through the acquired TIN must have reassigned their billing to the ACO participant TIN, and the acquired TIN must no longer be used. Providers and suppliers can use the Medicare Provider Enrollment Chain and Ownership System, otherwise known as PECOS, to reassign their billings. It is not required that applicants include merged or acquired TINs on their ACO Participant List.

Slide 25. It is important to note that merged and acquired TINs are not ACO participants. By virtue of the TIN being subsumed by another practice in its entirety, a merged or acquired TIN cannot execute a participant agreement with the ACO. Instead, the ACO applicant must submit other supporting documentation. See our Merger and Acquisitions' Frequently Asked Questions document for more information about this — other supporting documentation. This document is located under the Statutes/Regulation/Guidance section of the Shared Savings Program website.

On slide 26, I will introduce you to the data points you will need to provide to build your ACO Participant List. We will provide you step-by-step instructions for providing us your ACO Participant List during a future webinar. We recommend you begin collecting your ACO Participant List data points because it's important that you provide us with accurate and timely data. We will screen every participant you provide on your ACO Participant List to make sure they are eligible to participate in the program.

For most individuals or entities appearing on your ACO Participant List, you will provide the Medicare-enrolled TIN and the TIN legal business name as it appears in PECOS. Additionally, you will be asked to identify care-enrolled and whether or not the TIN is

merged or acquired. You will also provide the first and last name of the individual with authority to bind the ACO participant who signed the ACO Participant Agreement.

Slide 27. This slide is important for anyone who's applying and plans to include a Critical Access Hospital billing Method II or an Electing Teaching Amendment Hospital, otherwise known as CAHs and ETA hospitals, on your ACO Participant List. In addition to all of the data points listed on slide 26, you will need to provide three additional identifiers. In order to identify Part A claims for these two facility types, you must include their CMS Certification Numbers, otherwise known as CCNs. You will also provide the CCN legal business name as it is listed in PECOS and an identification code of C for CAH or T for ETA.

Slide 28. This slide is important for anyone who is applying and plans to include a Federally Qualified Health Center or Rural Health Clinic. For these facilities, you will provide the data points listed on slide 26, as well as the CCN, CCN legal business name, and the CCN identification code of F for FQHC or R for RHC.

For FQHCs and RHCs, you will also provide the organizational National Provider Identifier, or NPI, and the organizational NPI legal business name as listed in PECOS. In addition, you must identify the individual physicians who provide primary care services at the FQHCs and RHCs. Identify these physicians by including their individual NPI, first name, and last name. This provider/supplier data included on your ACO Participant List is known as your attestation list. We will talk more about the attestation list later in this presentation.

Slide 29. During our screening process, we will verify if the TINs, CCNs, and NPIs you provided are Medicare-enrolled. If a TIN, CCN, or NPI is not approved in PECOS to bill Medicare at the time we begin our screening process, the participant will be denied. It can take 45 to 90 days for a MAC to complete processing an enrollment application. That process takes longer if the enrollment application is incomplete or a survey and certification review is required. If you plan to submit data for a TIN that is not currently enrolled in Medicare, you should let them know that the processing time is a minimum of 45 to 90 days, and they may want to begin the enrollment process soon.

We encourage you to communicate with your ACO participants. If an ACO participant changes their TIN used to bill Medicare, and the new TIN is not on your ACO Participant List, any claims billed under the new TIN will not be captured in assignment. Additionally, we cannot approve any ACO participant data that does not go through our screening process. So make sure to provide your information to us timely through the application process so that we can screen your participants in preparation for 2016.

In addition to verifying enrollment, we conduct the PECOS legal business name match. The purpose of this check is to verify that the TIN or CCN you provided is correct.

Accordingly, you will need to update your executed agreement to acknowledge the correct legal business name if you supplied us a different one.

We also look to identify if there's any overlap with other shared savings initiatives. ACO participants must remain exclusive to one Medicare shared savings initiative. They also must remain exclusive to one Shared Savings Program ACO if they bill for primary care services.

During the process, we also look to see if the participants are in good standing. An ACO participant cannot have any Medicare exclusions or sanctions. We will also identify if the participant is a sole proprietor. For sole proprietors, some of the sole proprietors have two TINs:

- An enrollment TIN, which is their Social Security Number, and
- A billing TIN, otherwise known as an Employer Identification Number.

If a sole proprietor bills Medicare claims using an EIN and not their SSN, you must submit both of their TINs on your ACO Participant List. We use the Social Security Number to validate enrollment and the EIN is used for assignment.

For FQHCs and RHCs, we also verify whether the NPIs you provided are enrolled as physicians in PECOS. We will deny any NPIs that are not identified as a physician. It is important that you work with your potential participants to gather accurate data. If a TIN, CCN, or NPI is not found in PECOS, it will not go through our screening process.

For the ACO participant data you supply by July 31st, you will only receive one opportunity to correct TINs, CCNs, or NPI errors. And that includes if you provide us a TIN or a CCN that is typo'ed or NPI that is typo'ed. You will only have one opportunity to correct it if you submit it fresh as part of your application in August and it's incorrect. There will not be an opportunity to correct the TIN or CCN. Correcting a numerical TIN, CCN, or NPI is the same as adding a new participant and would not be considered for a program participation until the next performance year. I encourage you to begin collecting your ACO Participant List data early so that you have time to verify its accuracy. We will provide instructions for — providing the ACO Participant List data with your application during a future webinar.

I will now turn the presentation over to Walter Adamache from RTI International.

ACO Beneficiary Assignment

Walter Adamache: Hi, this is Walter Adamache. Today I'm going to be discussing the assignment of Medicare beneficiaries to MSSP-ACOs. Before I get into the details of this, we want to remind you that when we assign a beneficiary to an ACO, that that

beneficiary is still able to receive services from other organizations that might not be part of your ACO.

Having said that, as we get going into my discussion, I will be talking about the logic of assignment, but also the information that we use that you provide to us from the participant list that help us do the assignment process.

I'm on Slide 31 now. And what we want to tell you about are two types of ways we assign beneficiaries to ACOs. One is a preliminary prospective assignment, and that's what we'll be doing for you applicants this upcoming fall. And then, during the time when we do financial settlement, we do what's called a retrospective assignment. And the beneficiaries that will be involved in each type of assignment may not be the same, identical beneficiary.

As stated earlier, in order for an ACO application to be approved, an ACO needs to have at least 5,000 preliminarily assigned beneficiaries in order to be in the SSP program in each of the three benchmark years prior to the agreement period. For those who are applying for 2016, that refers to 2013, '14, and '15.

A beneficiary assigned in one year of the program may or may not be assigned to the same ACO in the following or preceding years. CMS uses a claim submitted by — to Medicare for primary care services in the assignment process. And the question is, how do we know which of those claims to use, and that's where the participant list comes in. We use information that you provide to us on the participant list to determine which claims to attribute to your ACO.

Slide 32. The ACO participant TINs are used to identify qualifying physician practice claims. As mentioned earlier, there are two types of TINs — Employer Identification Numbers, or EINs, and Social Security Numbers, or SSNs.

Physician group practices typically use EINs on their claims. Solo physician practices, however, we need to have in your application the TIN that you use when submitting claims. And for some of these solo practices, they use their Social Security Numbers, while others, such as professional corporations, use EINs.

Next, slide 33. Other participating entities include, as discussed earlier, Rural Health Clinics, Federally Qualified Health Centers, Method II Critical Access Hospitals, Electing Teaching Amendment Hospitals. And for those last four mentioned, we need CMS Certification Numbers to identify them in the claim. And also, as mentioned earlier, RHCs and FQHCs must also submit attestation lists for the physician providing primary care services. We'll come back to this point in a minute.

So when we go into the assignment process, we rely partly on individual provider types. And one set of provider types are primary care physicians, also called PCPs in our jargon.

The four types of primary care physicians that are identified — or defined for this program are internal medicine — that's general internal medicine, family practice, general practice, and geriatric medicine. Then there are — all other physicians are grouped together. That would include cardiologists, gastroenterologists, etc. Then we have another category, which we call ACO professionals, which includes both types of physicians that we listed above plus three non-physician practitioners — nurse practitioners, clinical nurse specialists, and physician assistants.

The Attestation List

Slide 35. As we discussed earlier, for FQHCS and RHCs, we require what's called an attestation list. And this is because the Act requires assignment to be based on services furnished by physicians. The problem is that the FQHC and RHC claims contain limited data on the type of practitioner providing the service. We know who's responsible, but not necessarily who provided the care — and that's where the attestation list comes in. And again, it's required for those FQHCs/RHCs that belong to ACOs. There is no corresponding attestation list for those FQHCs and RHCs which happen to belong to — or outside an ACO.

Slide 36. The attestation list is comprised of physicians who deliver primary care services at FQHCs and RHCs. During assignment, these physicians will be considered as primary care physician for these organizations. If they are non-PCP specialists in other settings, they will be able retain that status for the services they provide in those other settings.

The attestation list should include not only those physicians who currently provide primary care services, but also those who delivered primary care services during the assignment period. And that means for the new applicants, the assignment period is the three benchmark years prior to the July application. And for all other assignments, the assignment period is the preceding 12 months. So if you had a physician who was with you 2 years ago and they're not now, we still need their NPI, and it has to be on the attestation list if they provided care in an FQHC or RHC and you want those beneficiaries assigned to you.

Slide 37. So what is our definition of primary care services? We've been using the term. They consist of three broad categories: Evaluation and management services. And we have four large categories here — office or other outpatient settings, CPT codes 99201 through 99215; nursing facility care settings, CPT codes 99304 through 99318; rest home and custodial care settings, CPT codes 99324 through 99340; home services, CPT codes 99341 through 99350. Another launch category are the wellness visits. And these are HCPCS Level 2 codes, G0402, G0438, G0439.

For clinic visits, for Rural Health Clinics and their providers, we need their UB revenue center codes, that's Uniformed Billing revenue center codes, 0521, 0522, 0524, and 0525. For FQHCs, we only use that on older-claims, not the most recent set of claims. For FQHCs, I want to mention another wrinkle. As you know, there is a new billing code

called G-codes. They do not supersede the CPT codes 99201 through 99215. The codes that — those codes still must be on the claim in addition to the G claim — the G-codes. Otherwise, we can't use those G-codes in assignment.

Beneficiary Eligibility Criteria and Assignment

Slide 38. In addition to the information we take off the claims, we have some basic beneficiary eligibility criteria. And they are — a beneficiary is eligible to be assigned if the criteria are satisfied during the assignment period. First, they must have a record of Medicare enrollment. Medicare needs to have some sort of record on them in our system.

The beneficiary must have at least 1 month of Part A and 1 month of Part B enrollment together. You cannot have, during the assignment period, any months of only Part A or Part B.

Beneficiary cannot have any months of Medicare group health plan enrollment, such as an HMO, during that assignment period. And that is partly because we need the claims, and those organizations don't submit claims. Beneficiaries must reside in the United States, and in this case, we have a broad definition that includes also Puerto Rico and territories, such as Guam and the Marianas Islands and the Virgin Islands, and so forth.

And finally, the primary — the beneficiary must have a primary care service with a physician at the ACO to be considered eligible.

Slide 39. If the — this is part of our basic logic on how we assign an eligible beneficiary. If a beneficiary meets the eligibility criteria, the beneficiary is assigned to an ACO using a two-step process. Now we only use step 2 of the process if they don't get assigned in step 1, so step 1 is fairly critical. CMS will assign a beneficiary to a participating ACO when the beneficiary had at least one primary care service furnished by a primary care physician at the participating ACO and more primary care services, as measured by Medicare-allowed charges, furnished by the primary care physicians at the participating ACO than from primary care physicians at any other Shared Saving Program ACO or non-ACO individual or group TIN.

OK. So the key here is that we need some services assigned by a primary care physician at the ACO. If a beneficiary — contact with the ACO will say, through a cardiologist, and say the non-ACO provided primary care service through, say, general internal medicine, then the beneficiary would be assigned or at least — be assigned so to speak to a non-ACO. They're not truly assigned, but they're not assigned to the ACO.

Slide 40. Again, this step applies only if the beneficiary isn't assigned in step 1. Well, how does that happen? Well, this benefic — the beneficiary may not have received a primary care service from a primary care physician anywhere. They may have just seen a cardiologist or a gastroenterologist during the year. So we use the same type of logic.

That is to say, the beneficiary will be assigned to the ACO if the beneficiary had at least one primary care or service from a physician at the participating ACO, and more primary care services, again, measured by allowed charges from the ACO professionals, and that includes the nurse practitioners, etc., at the participating ACO than from any other ACO or non-ACO individual or group TIN.

Beneficiary Assignment Examples

I'm going to go through three examples now. And on slide 41, we have some notes as we get ready for these examples. In the examples, we'll use what we call the Organizational ID, and for an ACO, that is their A number. That's the ID number that you were assigned when you became — applied to become an ACO. And all TINs and CCNs on the ACO's Participant List are associated with the ACO's A number. Also included, the TIN or CCN for non-ACO are the IDs — the Organizational ID for those types of organizations. In the example, for each beneficiary assignment, the top row indicates the ACO or non-ACO to which the beneficiary was assigned.

Slide 42. This is our first example, and we have a little table here. The left-hand column — it says Beneficiary, so we're talking about Beneficiary A1. Second column is the Organizational ID. And this beneficiary saw three different organizations. The first line, the A number is participating ACO A9999, then the next two lines down are the IDs of physician group practices or solo physician practices.

Next two set of columns are the Allowed Charges for Primary Care Services that a beneficiary received from these three organizations. The column label PCP are the allowed charges for primary care services from primary care physicians. And the last column are the allowed charges from ACO professionals altogether.

So in this particular case, the beneficiary A1 is assigned to ACO 999 because it had the highest allowed charges for primary care services provided by primary care physicians at $454, even though two other non-ACO practices had higher allowed charges provided by an ACO professional. That is to say, if we were to look at the final column, you'd say, "Oh well, the beneficiary had more services from those two other organizations." But in step 1, this is where the beneficiary was assigned. It's the PCP column that matters. The professional column is disregarded in this case.

Next slide. In this case, Beneficiary B3 — excuse me — the beneficiary was not assigned to an ACO because a non-ACO provider, in this case all three, had the highest level of charges for primary care services provided by primary care physician, at $1,200. And there are two other ACOs, we treat them individually. And so, we don't add the $800 and $600. They're two separate entities, and so the beneficiary was not assigned.

Third example, slide 44. In this case, Beneficiary A3 did not receive any primary care services from a primary care physician. Therefore, the PCP column has $0 in all three cases. So this beneficiary was not assigned in step 1. Instead, they're going to be

assigned in step 2. And here, Beneficiary A3 is assigned to ACO A9999, again because it had the highest allowed charges for primary care services or those services provided by ACO professionals, and they have $300, whereas the two competitors had 250 and 200, respectively.

Slide 45 and next couple, we're going to talk about some of the assigned beneficiaries for three typical ACOs that were accepted into the program. And so these are actual numbers from previous successful applicants. And this gives you an idea of what it will take to help you prepare your participant list.

Slides 45 and 46 work together, and we'll go over number 45 first. So in slide 45, the top row here tells us the number of beneficiaries who received at least one primary care service from a physician at the ACO. So ACO 1 had 11,839 beneficiaries that got at least one primary care service from a physician there, and ACO 2 had 28,127, and so forth.

The next line shows the final number of assigned beneficiaries after all the exclusions have been made. So ACO 1 started with 11,839, but the final number of assigned beneficiaries was 7,570. For ACO 2, they started off with 28,127 that had one contact with them — at least one contact. And their total number of assigned beneficiaries after exclusions was 10,245. For ACO 3, they had 24,297 who had one — at least one contact with physicians. Their final number assigned was 16,588.

The next line shows total number of beneficiaries who were excluded, that is to say, they weren't assigned to the ACOs. And in case of the ACO 1, the total number excluded was 4,269. The subsequent rows tell us the reason they weren't assigned. So under excluded beneficiary row, we see the ACO did not provide a plurality of primary care services. So that was the major reason for ACO 1 — 4,008 of the 4,269 excluded beneficiaries were lost to the ACO because of the plurality or — rule. And you can see that ACOs 2 and 3 also lost the majority of their beneficiaries due to the plurality.

Then we have the other reasons. And by the way, these reasons are not mutually exclusive, but number of beneficiaries only had Part A or only Part B during the assignment period. ACO 1 had 93. ACO 1 also had 241 beneficiaries at least 1 month in a group health plan, and so they were not eligible for assignment. ACO 1 also had a beneficiary with at least 1 month of non-U.S. residence. And then finally, we have – we exclude those beneficiaries who are included in other shared savings initiatives, such as Pioneer. ACO 1 had 17 of those beneficiaries. So this is how the number of assigned beneficiaries.

Now for these three ACOs, we're going to look at their provider complement. So let's go to slide 46. And here, we see for each of them how many physicians or providers they had at each type. So ACO 1 had 65 primary care physicians, ACO 2 had 188 primary care physicians, and ACO 3 had 244. And if you correlate that with what's going on in

slide 45, you can see that having the primary care physicians, a lot of them, is very important.

ACO 1 also had other physician types — 81 other specialist physicians, and they also had a number of non-physician practitioners — that are the PAs, NPs, and clinical nurse specialists — 22 of them. Then you see the comparable numbers for ACO 2 and 3.

So that's some profiles of what — three ACOs that were able to get into the program that had at least 5,000 beneficiaries in each of the benchmark years. Slides 47 and 48, and we're going to 47 now, are assigned beneficiaries with three ACOs that did not achieve the 5,000 threshold. So we'll see what they look like.

ACO A had 7,664 beneficiaries who had at least one primary care service from a physician at the ACO. And we see the comparable number for ACOs B and C. The final number of beneficiaries assigned in each case was under 5,000. For ACO A, it was 4,817. We then show the number of excluded physicians — beneficiaries altogether. Again, the majority were lost because of the plurality rule. In ACO A's case, 2,004 of the beneficiaries that were excluded were — excluded because the ACO did not provide the plurality of care. We also see that ACO A has a number of people who had group health roll during that period as well as only Part A or only Part B.

Now to help understand these numbers and address 45 and 46, we'll go to slide 48 now and see what the size of these ACOs in terms of number of physicians looks like. And we can see here, in slide 48, that the number of primary care physicians for each of these ACOs — and, by the way, this slide should be ACO A, B, and C, not 1, 2, and 3. Sorry. And you see the number of primary care physicians is a lot lower than it is for — on slide 46, and also for the other type of ACO professionals. So the story here is that if you want to increase number of assigned beneficiaries, well, you need to have a good number of primary care physicians and other providers as well.

And that concludes my part of the talk.

Important Application Dates

Tricia Rodgers: Thanks Walter. This is Tricia again. We hope these presentations will help you prepare your applications. So I'm on slide 50 now. As a reminder, we ask that you — or we need to start each new application cycle on January 1st, so it's really important that you meet the deadlines outlined both in this presentation and with the dates on our website. Remember, we will accept your Notice of Intent to apply, or NOI, from May 1st through May 29th of this year, and that is an 8 o'clock p.m. eastern time deadline.

Then you'll need to submit your CMS User ID forms for individuals who will be submitting applications and for those who may use CMS data once your ACO is approved. And then you must submit these forms by June 9th, that's the CMS User ID

forms by June 9th. And it can take up to 3 to 4 weeks for us to process these User ID requests. So again, we stress the importance of completing this step as soon as possible.

And finally, we will accept applications from July 1st through July 31st, and that, too, is an 8 o'clock p.m. eastern time deadline. And then we plan to issue application dispositions in November of this year.

Please note if you've previously submitted an application for the Shared Savings Program and your application was either denied or withdrawn, you must complete the process again from the beginning. This means that you must begin with submitting an NOI and receive a new ACO ID. Then you will need to complete the 2016 application, and we will not evaluate previous submissions.

Slide 51 gives you some dates to mark your calendars for upcoming application calls that we plan to provide for the 2016 application cycle. Again, June 9th, the 2016 application submission review; July 7th, we'll have training on HPMS application module submission; and July 14th will be the ACO application question-and-answer session.

I'm on Slide 52 now. We ask that you continually check our Medicare Shared Savings Program website for updates. And if you have questions regarding the application throughout the process, you may contact us via email at sspaco_applications@cms.hhs.gov.

So this concludes the prepared portion of the application call. So I'm going to turn the call over to Amanda now.

Question-and-Answer Session

Amanda Barnes: Thank you so much Tricia. Our subject matter experts will now take your questions about the Medicare Shared Savings Program application process. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your questions to just one.

All right Holley, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Again, star 1 to ask a question, pound to remove. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question will come from Bonnie Shok.

Bonnie Shok: Hi, we're an ACO that will be renewing. And I'm wondering, do we submit the same Notice of Intent as a new application?

Tricia Rodgers: Thanks for that question. There is information on the website for new applicants and renewing ACOs and the NOI submission process. There is a memo online that you should read. When the NOI becomes available, the renewing ACOs will go through HPMS to renew and the new applicants will fill out the online form to request — just to submit the NOI. Thank you

Bonnie Shok: Thank you.

Operator: And your next question will come from Mazhar Jeffry.

Mazhar Jeffry: Yes, this is Mazhar Jeffry, and I'm calling from A.D. Maxim Consulting. And thank you so much for such a nice call. I think it's a lot of information. I think it will take me some time to understand because we'll be applying for ACO for the first time. But there is — the question I have is that we have to submit sample ACO Participant Agreement and execute all — and like all ACO Participants Agreements. Is — are there examples already available on the website so we can take the information from there, or we have to create these agreements on our own?

Tricia Rodgers: Thank you for that question. This is Tricia. So along with — when the application becomes available, you will also have an Application Toolkit that has a reference guide in it that will give you examples and a lot of other information that Terri described in the call this afternoon in her section of the presentation. So right now, the 2015 information is there that you can look at until the 2016 information becomes available. It will give you some idea of what — of what you'll be looking at when the 2016 information becomes available. Thank you.

Mazhar Jeffry: Thank you so much. And one more question, in the 2016 application will be available — the date is already mentioned here. Is that correct?

Tricia Rodgers: We expect to put the sample application up on June 1st. So check the website.

Mazhar Jeffry: Got it. OK. Sounds good.

Amanda Barnes: Thank you.

Mazhar Jeffry: Thank you so much.

Operator: Your next question will come from Trudy Prailer.

Trudy Prailer: Hi, this is Trudy Prailer. Thank you for the presentation. I'm from Behavioral Care Management, L.L.C., and we're a new organization and we're investigating becoming a new ACO that will represent the behavioral care provider types, such as psychologists, psychiatrists, neurologists, social workers, counselors, and so on. I noticed that that is not a provider type on your listing here, and I was just wondering how we might be able to integrate those services.

Dr. Terri Postma: Hi, this is Terri. So the Shared Savings Program is built around providers — Medicare-enrolled providers and suppliers that bill for primary care services, as we've defined those in the rules. So you might look to see what the definition of primary care services is. I think your first challenge is going to be meeting the assignment criteria …

Trudy Prailer: Um-hum.

Dr. Terri Postma: … as Walter went through. And although some of the folks that you mentioned may be Medicare-enrolled and may be billing Medicare for those primary care services. So you'll want to look through those definitions very carefully. And — but you'll also note that the Shared Savings Program welcomes any Medicare-enrolled entities to join with primary care providers and — who are eligible to participate.

So, you know, there is definitely a role for all Medicare-enrolled providers to play. Whether or not that structure would really be able to meet the requirements of the rule is something you're going to have to look through the rule very carefully. The concept is that primary care providers are — agree to become responsible for the whole care of the patients, not just — not just specialty-specific care. Does that make sense?

Trudy Prailer: Yes, it does. Thank you very much.

Dr. Terri Postma: Um-hum.

Operator: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Your next question will come from Bob Carpenter.

Bob Carpenter: Hi. Last time — on the last call, you mentioned that there were two types. One was a risk ACO and the other was just a shared benefit. So today someone told me that there's a third type, and that the percentage of savings, which was 50 percent on the upside only and 60 percent on the risk one, have changed. I don't know if it's fair to ask that question at this point in time because we didn't talk about those things, but is there a third one and are those percentages changed?

Dr. Terri Postma: Hi, this is Terri. Like we discussed in the last call, there are two tracks available for ACOs. One is Track 1, which is Shared Savings only, and the sharing rate is 50 percent for the — up to 50 percent for those ACOs. The other track is Track 2, which involves — which is when an ACO agrees to share in savings but also share in losses that might be generated. So the sharing rate there for shared savings is up to 60 percent. The shared losses though could be between 40 and 60 percent, depending on the quality attained by the organization.

You might also know that in the rule that we published, the proposed rule that we published in December, we proposed adding a Track 3, which would also be a two-sided, performance-based risk track. However, those rules are not finalized as of yet. And so, just stay tuned for that. We're working on those — finalize those rules as quickly as possible. And if additional tracks should become available by the time that you apply, then we'll make sure to include that. But those rules aren't finalized yet.

Bob Carpenter: Thank you.

Operator: And your next question will come from Paula Englander.

Paula Englander: Hi, I'm calling from Innovative Prosthetics, and I have a similar question to someone who was calling about her behavioral group. We're looking to put together rehabilitation specialist and would include, you know, nonphysicians, we're certified prosthetists here. And I'm wondering how that fits into this model.

Dr. Terri Postma: So this is Terri. Like I said, all Medicare-enrolled entities are welcome to join with the entities that are able to form an ACO. The basis for forming an ACO is really practitioners, Medicare-enrolled practitioners that bill Medicare for primary care services and agree to become accountable for the whole care of the beneficiary.

So if there are other Medicare-enrolled providers or suppliers that bill Medicare but might not necessarily bill for primary care services, or for B, what one could consider true primary care providers, they are welcome to join with those other — with the primary care providers that are Medicare-enrolled to form the ACO. So take a look at the program rules and the entities that are able to form an ACO vs. those who are welcome to join in with those Medicare-enrolled providers. Did that answer your question?

Paula Englander: Can you tell me specifically where I could find those rules?

Dr. Terri Postma: Sure. It's 42 CFR 425. I like to go to ECFR online. If you Google ECFR, you'll come to a website that has all the rules and regulations listed. And you can read the regulations text, the rules, for the program there. Another way to get to it is by going on to our website at www.sharedsavingsprogram — sorry,

www.cms.hhs.gov/sharedsavingsprogram, and you'll find a link to the program rules there.

Amanda Barnes: And also in slide 12, you'll find a hyperlink to the Final Rule as well.

Terri Postma: Oh, thanks. Oh, the other thing is that our website we have a lot of QAs, and some of those may address some of your more basic questions about the structure and formation of an ACO.

Paula Englander: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question will come from Robert Melchor.

Robert Melchor: Hi, I'm Bob Melchor from NexCentra Health Network in Wichita, Kansas. Two questions. One is, who can or cannot be an actual owner of the ACO? And then secondly, it's my understanding, assuming you continue to qualify, the program is for three years, and what happens in year 4? Thank you.

Dr. Terri Postma: This is Terri. One of the things that we don't address in the program rules is ownership. So the ACO has a lot of flexibility there. What we do address, however, are legal entity and governing body requirements that specifically control over governing body decisions and the responsibility of the governing body.

So the governing body must be 75 percent under the control of the ACO participants. But again, we don't talk about whether they're owners or not or who is owning the ACO. Just as long as the legal entity and the governing body are meeting our program rule requirements, then the organization can participate in the program.

And I'm sorry, what was your other question?

Robert Melchor: Am I still on?

Dr. Terri Postma: Yes.

Robert Melchor: So a consulting entity could be an owner of an ACO?

Dr. Terri Postma: Again, we don't — we don't specifically address any — or we don't have rules or requirements around ownership.

Robert Melchor: OK. And my second question was, it was my understanding that assuming you continue to qualify each year, it's a 3-year program. And what happens year 4?

Dr. Terri Postma: Oh, that's a good question. So right now, the folks that started in 2012 and 2013 are finishing up with their 3-year agreement. And we'll have a process in place for organizations to choose to renew 3-year agreements with us. And, like Tricia said, we're going to be holding a separate call for those folks. So at the end of 3 years, your organization would have the opportunity to renew or to complete their participation.

Robert Melchor: Thank you very much. That's all.

Amanda Barnes: Thank you.

Operator: Your next question will come from Loretta Miller.

Loretta Miller: Thank you for taking my call, and thank you for the program. My question is about assigned beneficiaries. On slide 47, did any of these ACOs get approved? And also, I'm asking that because we're looking at being a single TIN ACO, and I wanted to know what — I know we don't have 500 beneficiaries, so I'm asking what other options are there? Thanks.

Tricia Rodgers: Thanks for your question. This is Tricia. So the law requires that each ACO be able to provide services to at least 5,000 beneficiaries. So if your application shows that you don't have enough participants to do that, then you will be given an opportunity to either add more ACO participants that can add to your assignment numbers or you can withdraw your application. Or if you don't withdraw, then we would deny your application if you do not meet the 5,000 beneficiary requirement. But you will be given an opportunity to add, which means you would have to complete the participation agreement — the participant agreement and get signatures and also add the TINs through the application process.

Dr. Terri Postma: And this is Terri. One of the things that we discussed in the last call was understanding how your ACO is set up. You might consider, if you're a single TIN ACO and you don't think that you'll be able to meet that requirement for 5,000 assigned beneficiaries, you might consider setting yourself up as a Scenario 3 ACO.

That's a scenario where your Medicare-enrolled TIN, your single ACO participant TIN, has set up a separate legal entity to be your ACO. And that will give you the flexibility during the application process if you're not able to meet the 8,000 — 5,000 requirement. That will give you the flexibility to join with other Medicare-enrolled ACO participant TINs underneath that separate ACO legal entity.

Loretta Miller: OK.

Amanda Barnes: Thank you.

Loretta Miller: That's good. Thanks.

Tricia Rodgers: You're welcome.

Operator: Your next question will come from Kim Harmon.

Kim Harmon: Hi, I'm Kim Harmon with the Texas Medical Association. I have a group of rural physicians that are going to apply for some advanced funding. And I wanted to see if that timeline for that application fell in line with the MSSP. I understand we would have to do — apply for MSSP and then apply for the advanced funding, is that correct?

Tricia Rodgers: So they — this is Tricia. They are separate applications. And on our last call on the 7th, there was a separate presentation that Stephen Jenkins gave. And the timelines for that application are online, but they are separate applications. You would need to apply both to the Shared Savings Program and be accepted under the Shared Savings Program in order to get the funding through the AIM model. Does that answer your question?

Kim Harmon: It does. Thank you. And the program on the 7th has been recorded so I could listen to that?

Tricia Rodgers: Yes, you may.

Kim Harmon: OK. Thank you.

Tricia Rodgers: Thank you.

Operator: The next question will come from Denise Vladovich.

Denise Vladovich: Hi, thanks for taking my call. We are representing a very rural area where much of the primary care is provided by mid-level providers, especially PAs, and so we've had a couple of situations. I was going to ask you about how these beneficiaries might be attributed.

We have an independently owned PA group. It has its own TIN, they do their own billing under their own NPI numbers, and they're overseen by a specialist who's not a primary care. And so how would those be assigned? And then we also have a Rural Health Clinic with PAs that provide the bulk of the visits under — and they bill under their own NPI. So if those NPI numbers of mid-levels are excluded, how do those visits get considered in the plurality of care issue? And is there anything we need to know when we're submitting those names to the participant list?

Kari Vandergrift: Sure, thank you. So for the nurse practitioner example that you gave first, you can still submit the TIN. They could be ACO participants if they're

Medicare-enrolled and pass our check. They would fall under the step 2 of the assignment process.

If there is a specialist who is seeing these patients that's also part of your ACO, we would determine the plurality of allowed charges, and the nurse practitioner visits would go under that step 2 methodology. For the RHC, we need you to supply to us all of the NPIs associated with physicians that provide primary care services. We will use those physicians to determine if a beneficiary is eligible. But the program assignment starts with the physicians in it. So step 1 is primary care, step 2, we have the specialist physicians. So provide us with the physician-level data and the nurse practitioners, physician assistants, those folks can help determine plurality under step 2 of assignment.

Denise Vladovich: Because it would be gauged by — under the CCN, everything under the CCN as opposed to the NPI numbers then?

Kari Vandergrift: Yes. So the CCN is what appears on the claim rather than the TIN. So we need the CCN in order to identify the facility, and then the NPI to determine that a physician provided the services.

Denise Vladovich: OK, so those PA NPI numbers would still be credited then, if you will, even though they're not showing up on the list?

Kari Vandergrift: Right. You don't include them on your ACO Participant List, just the physician level for the RHC, but we still find their claims and can use them in the second step of assignment.

Denise Vladovich: Perfect. Thank you so much.

Amanda Barnes: Thank you. Holley, we have time for one final question.

Operator: All right. Your final question will come from Jenny Reinhart.

Jenny Reinhart: Hello?

Amanda Barnes: Hi there.

Jenny Reinhart: Hi, I had a question on page 38, where you talk about beneficiary eligibility. It mentions that they cannot have any months of Medicare group private health plan enrollment. Can you define what you include as far as what type of enrollment that would be?

Tricia Rodgers: Hi, this is Tricia. Thanks for your question. So that's any Medicare Advantage Plan.

Jenny Reinhart: OK. So it is any type of — any nontraditional, any Medicare Advantage — they can't have been enrolled in that?

Tricia Rodgers: That's correct, anything that is not Medicare fee-for-service or traditional Medicare.

Jenny Reinhart: And is that for the entire 3-year historical benchmark period or …?

Tricia Rodgers: At — at any time. Any ...

Kari Vandergrift: The 12-month period at which we're looking at assignment ...

Jenny Reinhart: OK, I'm sorry. Just the 12 months ...

Kari Vandergrift: Each year of your benchmark, we'll look at the 12 months — so benchmark year 1, benchmark year 2. So within those 12 months, when we're looking to set the years, then they can't have had any months of Medicare Advantage enrollment.

Jenny Reinhart: And then they can have traditional Medicare as primary but something else secondary? Is it just primary coverage?

Tricia Rodgers: With traditional fee-for-service coverage, if there is a Medicare secondary payer, that's fine. It's just they can't have any group health insurance like — such as Medicare Advantage.

Jenny Reinhart: OK, perfect. Thank you.

Additional Information

Amanda Barnes: Thank you. Unfortunately, that's all the time we have for questions today. On slide 54, you will find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. But we hope you'll take a few moments to evaluate your MLN Connects Call experience.

I'd like to thank our subject matter experts and all participants who joined us for today's MLN Connects Call. Have a great day, everyone.

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

-END-


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