MLN Connects®

National Provider Call

Medicare Shared Savings Program Application Process: ACO Participant Agreements, Participant List & Assignment:

Preparing to Apply for 2016

April 21, 2015

Presented by:

Centers for Medicare & Medicaid Services
RTI International

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Introduction

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Agenda

This presentation will explain and clarify the following critical elements in the Medicare Shared Savings Program (Shared Savings Program) application for new applicants:

- ACO Participant Agreements
- ACO Participant List
- Beneficiary Assignment

Shared Savings Program: Background

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

ACO Participant Agreements

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Shared Savings Program: Definitions

- **ACO Participant:**
  - Individual or group of ACO provider(s)/supplier(s) that is identified by a Medicare-enrolled taxpayer identification number (TIN), that alone or together with one or more other ACO participants comprise(s) an ACO.
    - E.g. Acute Care Hospital, Group Practice, Individual Practice, Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Critical Access Hospital (CAH), Pharmacy, Long-term Care Hospital (LTCH), Skilled Nursing Facility (SNF), Emergency Room (ER), etc.

- **ACO Provider/Supplier:**
  - A provider (as defined in §425.202) , or a supplier (as defined at §425.202)
  - Enrolled in Medicare
  - Bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant.
    - E.g. Physicians, Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialists (CNS), pharmacists, chiropractors, Physical Therapy/Occupational Therapy (PT/OT), etc.

Shared Savings Program: ACO Structure

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

ACO (TIN)

- ACO Legal Entity (TIN is not the same as any ACO participant TIN)

Medicare Enrolled TINs

- ACO Participants Ex: Acute Care Hospital, Group Practice, Individual Practice, FQHC, RHC, CAH, Pharmacy, LTCH, SNF, ER, etc.

Provider & Suppliers (NPIs)

- ACO providers/suppliers that bill through ACO participants (e.g. physicians, NP, PA, CNS, pharmacists, chiropractors, PT/OT, etc)

ACO Organization Structures

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

ACO Organization Structure Scenarios

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

ACO Participant Agreements

- Reference Final Rule 42 CFR 425.204, 425.210
- Reference ACO Agreement and ACO Participant List Guidance in the Application Toolkit*
- Do not include ACO participant TIN on your ACO Participant List without a signed ACO Participant Agreement
- ACO must confirm that **all** ACO provider/suppliers have also agreed to participate

* *The 2015 Application toolkit will be available on our Web site until the 2016 Application Toolkit is posted*

ACO Participant Agreements: Key Points

- Must be between the ACO legal entity and ACO participant legal entity
- Must be **direct** (no third party intermediary)

- No letters of intent

- Each agreement should clearly identify the parties entering into the agreement, the agreement date, and length of agreement

- Must clearly state the correct legal business name (verified by PECOS) of both the ACO and ACO participant as indicated in HPMS and on the ACO Participant List

ACO Participant Agreements: Required Elements

- Explicit requirement to comply with 42 CFR 425
- ACO participant rights/obligations
- How sharing in savings will encourage compliance with Quality Assessment and Performance Improvement (QAPI) and evidence-based medicine (EBM) guidelines
- Remedial measures that will apply to ACO participants and ACO provider/suppliers in the event of non-compliance with the requirements of their agreement with the ACO.
- Explicit requirement to agree to be accountable for the quality, cost and overall care of Medicare FFS beneficiaries under their care
- Explicit requirement to comply with federal criminal law, False Claims Act, Anti-Kickback statute, civil monetary penalties law, and physician self-referral law

ACO Participant Agreements: Required Elements

- Explicit requirement that all ACO providers/suppliers that bill through the TIN of the ACO participant have also agreed to participate and follow program regulations.

- ACO must also confirm:
  - ACO has a direct agreement with each ACO provider/supplier, OR
  - The ACO has an indirect agreement with each ACO provider/supplier through the agreement the ACO participant has with each ACO provider/supplier

- If direct agreement, must meet same requirements as ACO Participant Agreement

ACO Participant Agreements: Suggested Elements

- Statement that the ACO participant agrees to work with the ACO to meet quality reporting standards.
- Statement to comply with all relevant statutory and regulatory provisions regarding the appropriate use of data including the HIPAA Privacy Rule, HIPAA Security Rule and the terms of the ACO's Data Use Agreement with CMS.
- Statement that the ACO participant must be sure that PECOS is correct and current.

ACO Participant Agreements: Examples

Correct: A large group practice decides to participate in an ACO. Its owner signs an agreement on behalf of the practice to participate in the program and follow program regulations. Also, all practitioners that have reassigned their billings to the TIN of the large group practice have also agreed to participate and follow program regulations.

- The ACO **may** include this group practice TIN on its list of ACO participants.

ACO Participant Agreements: Examples

Incorrect: A large group practice decides to participate in an ACO. Its owner signs an agreement to participate in the program and follow program regulations. However, not all practitioners that have reassigned their billings to the TIN of the large group practice have agreed to participate and follow program regulations.

- The ACO **may not** include this group practice TIN on its list of ACO participants.

Incorrect: Several practitioners in a large group practice decide to participate in an ACO. However, the group practice as a whole has not agreed to participate in the program.

- The ACO **may not** include this group practice TIN on its list of the ACO participants.

Use Good Contracting Practices

- Opening – clearly identify parties to the contract by their legal business name
- Include required ACO Participant Agreement elements
- Signature page – **required** elements:
  - Signature of person with authority to bind ACO participant
  - ACO signature from ACO Executive or Authorized to Sign (verified in HPMS)
- Signature page – **suggested** elements:
  - Date
  - ACO participant legal business name (verified in PECOS)
  - ACO participant TIN
    - If participant is a sole proprietor, list both enrollment TIN and Billing TIN, if different

Common Errors to Avoid

- Provide the correct ACO legal business name
- Provide the correct ACO participant legal business name. Be sure to include any name extensions such as “LLC,” “Incorporated,” “M.D.,” or “P.A.”
- Confirm the ACO participant’s legal business name matches PECOS
- Make sure the ACO and the ACO participant have each signed the ACO Participant Agreement signature page
- Legal business names on signature page must match legal business names identified in opening of agreement
- Make sure the proper party signs. These names must match what’s in HPMS and on the ACO Participant List
- Any changes are initialed by both parties
- If the ACO participant TIN is listed in the agreement, be sure it is listed correctly

ACO Participant List

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ACO Participant List

- Includes information about the ACO participants and, in some cases, ACO providers/suppliers

- Used to determine an applicant's eligibility to become an ACO in the Shared Savings Program

- Once approved, CMS uses the ACO Participant 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 under the Shared Savings Program
  - Monitor the ACO for program integrity issues

ACO Participant List (cont.)

- Once accepted into the Shared Savings Program, ACOs must tell CMS within 30 days of a change to their ACO participants or ACO providers/suppliers

- Changes to ACO participants after the start of the agreement period affect some program operations (Refer to the Changes in ACO participants and ACO providers/suppliers during the Agreement Period Web page)

Merged and Acquired TIN

- TIN that was acquired by an ACO participant through purchase or merger
  - The ACO participant must have subsumed the acquired TIN in its entirety, including all the ACO providers/suppliers that billed under that TIN
  - All the ACO providers/suppliers that billed through the acquired TIN must reassign their billing to the surviving ACO participant TIN. Verify this information at: https://pecos.cms.hhs.gov
  - The acquired TIN must no longer be used

- Not required on the ACO Participant List, but applicant may choose to include for retrospective beneficiary assignment and benchmarking purposes

Merged or Acquired TIN (cont.)

Merged or acquired TINs are not ACO participants

- A merged or acquired TIN cannot execute a participant agreement with the ACO since the entity no longer exists
- Instead, the ACO applicant must submit other supporting documentation (see Application Toolkit for more information)
- See our FAQ page for questions about merged or acquired TINs

ACO Participant List Requirements

Required Fields for most ACO Participants:

- ACO participant TIN
- ACO participant legal business name (verified by PECOS)
- Medicare enrolled TIN? Y or N
- Merged or acquired TIN? Y or N
- First and last name of the individual authorized to sign the ACO Participant Agreement on behalf of the TIN

CAH and ETA Participants

Additional fields for method II Critical Access Hospitals (CAHs) and Electing Teaching Amendment (ETA) Hospitals:

- CMS Certification Number (CCN)
- CCN legal business name (verified by PECOS)
- CCN identification code: C or T

FQHC and RHC Participants

Additional fields for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs):

- CCN
- CCN legal business name (verified by PECOS)
- CCN identification code: F or R
- Organizational NPI
- Organizational NPI legal business name (verified by PECOS)
- Provider/Supplier data:
  - Individual **physician** NPI (physician specialty verified by PECOS)
  - Individual NPI first and last name

Evaluation

CMS evaluates the ACO Participant List to:

- Verify that your ACO would have at least 5,000 assigned beneficiaries in each of the benchmark years

- Verify that ACO participants meet program requirements:
  - TIN is enrolled in Medicare
  - Information matches Medicare enrollment information
  - TIN is not participating in another Medicare initiative involving shared savings

- Screen the ACO participants and ACO providers/suppliers for program integrity history

Beneficiary Assignment

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ACO Beneficiary Assignment

- Preliminary prospective assignment with final retrospective beneficiary assignment
  - An ACO needs to have at least 5,000 preliminarily assigned beneficiaries in order to be in the Shared Savings Program in each of the three years preceding the start of the agreement period (2013, 2014, 2015)
  - 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 claims submitted to Medicare for primary care services in the assignment process

- CMS uses information you provide to us on the ACO Participant List to determine which claims to attribute to your ACO

ACO Participant TINs

- ACO participant TINs are used to identify qualifying physician practice claims

- There are two types of TINs:
  - Employer Identification Number (EIN)
  - Social Security Number (SSN)

- Physician group practices use EINs on their claims

- For solo-physician practices, CMS needs the ACO participant TIN submitted on the claims
  - Some of these practices use SSNs while others (professional corporations) use EINs

Other Participating Entities

- These include:
  - RHCs
  - FQHCs
  - Method II CAHs
  - Electing Teaching Amendment (ETA) hospitals

- CMS CCNs are needed to identify the above entities in claims

- RHCs and FQHCs also must submit attestation lists for the physicians providing primary care services

ACO Assignment: Individual Provider Types

- Primary Care Physicians (PCP)
  - Internal Medicine
  - Family Practice
  - General Practice
  - Geriatric Medicine
- Other physicians (M.D., D.O.)
- ACO Professionals include both of the above types of physicians plus:
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialist (CNS)
  - Physician Assistant (PA)

FQHC/RHC Physician Attestation

- 1899 (c) of the Act requires assignment to be based on services furnished by physicians.

- FQHC/RHC claims contain limited data on the type of practitioner providing a service. We know who is responsible for the overall care, not necessarily who provided the care.

- Required as part of the ACO participant list only for FQHCs and RHCs that belong to ACOs.

Attestation List

- The list is comprised of physicians who deliver PCSs at FQHCs and RHCs. During assignment, these physicians will be considered as PCPs for FQHC/RHCs. If they are non-PCP specialists in other settings, they will retain that status for the other settings.
- Should include not only physicians who currently provide PCSs but also those who delivered PCSs during the assignment period
  - For new ACO applicants, the assignment period is the 3 benchmark years prior to the July application period
  - For all other assignment runs, the assignment period is the preceding 12 months

ACO Assignment: Definition of Primary Care Services

- Evaluation & Management Services provided at:
  - Office or Other Outpatient settings (CPT 99201 – 99215)
  - Nursing Facility Care settings (CPT 99304 - 99318)
  - Domiciliary, Rest Home, or Custodial Care settings (CPT 99324 - 99340)
  - Home Services (CPT 99341-99350)

- Wellness Visits (HCPCS G0402, G0438, G0439)

- Clinic visits at RHC/FQHCs or by their providers in selected settings (UB revenue center codes 0521, 0522, 0524, 0525)

ACO Assignment: Beneficiary Eligibility

- A beneficiary is eligible to be assigned to an ACO if the following criteria are satisfied during the assignment period:
  - Beneficiary must have a record of Medicare enrollment
  - Beneficiary must have at least one month of Part A and Part B enrollment, and cannot have any months of only Part A or Part B
  - Beneficiary cannot have any months of Medicare group (private) health plan enrollment
  - Beneficiary must reside in the United States including Puerto Rico & Territories
  - Beneficiary must have a primary care service with a physician at the ACO

Assignment of a Beneficiary to an ACO

If a beneficiary meets the eligibility criteria, the beneficiary is assigned to an ACO using a two-step process:

Assignment Policy Step 1:

CMS will assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care physician at the participating ACO, and more primary care services (measured by Medicare allowed charges) furnished by primary care physicians at the participating ACO than from primary care physicians at any other Shared Savings Program ACO or non-ACO individual or group TIN.

Assignment of a Beneficiary to an ACO (cont.)

Assignment Policy Step 2:

This step applies only for beneficiaries who haven't gotten any primary care services from a primary care physician. CMS will assign the beneficiary to the participating ACO in this step if the beneficiary got at least 1 primary care service from a physician at the participating ACO, and more primary care services (measured by Medicare allowed charges) from ACO professionals (physician regardless of specialty, NP, PA, or CNS) at a participating ACO than from any other ACO or non-ACO individual or group TIN.

ACO Assignment: Notes for Following Examples

- Organizational ID
  - Is the A# for each ACO—All TINs and CCNs on an ACO's Participant List are associated with the ACO's A#
  - TIN or CCN for non-ACO practices and providers

- For each beneficiary assignment example, the top row indicates the ACO or non-ACO provider to which the beneficiary was assigned

ACO Assignment: Example 1

		Allowed Charges for Primary Care Services	
Beneficiary	**Organization ID**	**PCP**	**ACO Professional**
A1	A9999	$454	$654
A1	555555555	$300	$1,900
A1	456565656	$250	$2,500

Beneficiary A1 is assigned to ACO A9999 because A9999 had the highest allowed charges for primary care services provided by a primary care physician ($454) even though two other non-ACO practices had higher allowed charges provided by ACO professionals

ACO Assignment: Example 2

		Allowed Charges for Primary Care Services	
Beneficiary	**Organization ID**	**PCP**	**ACO Professional**
B3	333333333	$1,200	$1.250
B3	A5656	$800	$800
B3	A9999	$600	$700

Beneficiary B3 is not assigned to an ACO because a non-ACO provider (333333333) had the highest allowed charges for primary care services provided by a primary care physician ($1,200).

ACO Assignment: Example 3

		Allowed Charges for Primary Care Services	
Beneficiary	**Organization ID**	**PCP**	**ACO Professional**
A3	A9999	$0	$300
A3	555555555	$0	$250
A3	333333333	$0	$200

Beneficiary A3 did not receive any primary care services from a primary care physician. So A3 is assigned to ACO A9999 on the basis of the highest allowed charges for primary care services provided by ACO professionals ($300)

Assigned Beneficiaries for Three Typical ACOs

	ACO 1	ACO 2	ACO 3
Beneficiaries provided at least one primary care service by a physician in this ACO (beneficiaries assignable to this ACO)	11,839	28,127	24,297
Assigned Beneficiaries	7,570	10,245	16,588
Excluded Beneficiaries	4,269	17,882	7,709
ACO did not provide a plurality of primary care services	4,008	17,211	6,703
At least one month of Part A-only or Part B-only coverage	93	284	810
At least one month in a group health plan	241	986	619
At least one month of non-US residence	1	2	6
Included in other shared savings initiatives	17	2	12

ACO Professionals Affiliated with the Three Typical ACOs

Type of ACO Professional	ACO 1	ACO 2	ACO 3
Primary care physicians	65	188	244
Other specialist physicians (e.g., cardiologists)	81	193	182
PAs, NPs, Clinical Nurse Specialists	22	107	10

Assigned Beneficiaries for Three ACOs that did not Achieve the 5,000 Threshold

	ACO A	ACO B	ACO C
Beneficiaries provided at least one primary care service by a physician in this ACO (beneficiaries assignable to this ACO)	7,064	8,486	14,130
Assigned Beneficiaries	4,817	4,720	4,452
Excluded Beneficiaries	2,247	3,766	9,678
ACO did not provide A plurality of primary care services	2,004	3,413	9,187
At least one month of Part A-only or Part B-only coverage	99	59	608
At least one month in a group health plan	198	480	368
At least one month of non-US residence	4	2	4
Included in other shared savings initiatives	16	27	5

ACO Professionals Affiliated with the Three ACOs that did not Achieve the 5,000 Threshold

Type of ACO Professional	ACO 1	ACO 2	ACO 3
Primary care physicians	26	33	33
Other specialist physicians (e.g., cardiologists)	16	3	43
PAs, NPs, Clinical Nurse Specialists	8	4	4

Application Reminders

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Application Cycle: Deadlines to Apply for Program Year 2016

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

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

Upcoming Application Calls

- **Save the date:**

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

*__NOTE:__ These calls are only available to potential applicants that successfully submitted and NOI by the deadline, which is May 29, 2015 at 8pm Eastern Time. We will send out information about these calls via email to the contacts you listed on your NOI.

Contacts for Assistance

- Shared Savings Program Application Web site
- For NOI submission and application questions: SSPACO_Applications@cms.hhs.gov
- For help with Form CMS-20037 and CMS User ID (e.g. new access to HPMS, trouble finding the HPMS Web site): HPMS_Access@cms.hhs.gov or (800) 220-2028
- For password resets and if your account is locked: CMS_IT_Service_Desk@cms.hhs.gov or 1-800-562-1963
- For help using HPMS and technical assistance: HPMS@cms.hhs.gov or (800) 220-2028

Question & Answer Session

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