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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO: Preparing To Apply for 2017 Call
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Contents

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

I will now turn the call over to Amanda Barnes. Thank you. You may begin.

Announcements and Introduction

Amanda Barnes: Thank you, Ronni. I am Amanda Barnes from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Medicare Shared Savings Program ACO: Preparing to Apply for 2017.

MLN Connects Calls are part of the Medicare Learning Network®. During this call, subject matter experts provide information on what you can do to prepare for the Medicare Shared Savings application process for the January 1st, 2017, program start date.

Before we get started, I have a couple of announcements. You should have received a link to today's slide presentation email. If you have not already done so, you may view or download the presentation from the following URL, go.cms.gov/npc. Again, that URL is go.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials are available.

At this time, I would like to turn the call over to Jonathan Blanar.

Presentation

Jonathan Blanar: Thank you, Amanda, and good afternoon, good morning folks. We will begin on 5 for this presentation. So again, welcome to our first call for the 2017 application cycle for the Medicare Shared Savings Program. As Amanda mentioned, my name is Jonathan Blanar, and I am the director of the Division of Application, Compliance and Outreach, and the Performance-Based Payment Policy Group at the Centers for Medicare & Medicaid Services.

First of all, I want to thank you for your interest in the Medicare Shared Savings Program and for joining today's call. Today, we will be going over with you information to prepare you for the application cycle for the upcoming 2017 program performance year. Before we discuss the application process, it's imperative that we provide an overview

of the program and describe what Medicare means by an Accountable Care Organization. We have a lot to cover today, so I'm going to begin.

Introduction to the Medicare Shared Savings Program

Jonathan Blanar: We will now move to slide 5. Anyone who has been involved in our healthcare system, particularly you as providers, knows that our healthcare system is fragmented. It has developed in pieces—hospitals, clinics, post-acute care, etc.—without conscious or well-designed connections among the pieces. Fragmentation of payment, particularly fee-for-service payment, often reinforces beneficiaries' fragmented care. We believe the Medicare Shared Savings Program represents a new approach to the delivery of healthcare in the fee-for-service setting. Its goal is to meet what our former administrator, Dr. Berwick, referred to as the three-part aim: better care for individuals, better health for populations, and lowering growth in overall healthcare expenditures. And we do this by promoting accountability for the care of Medicare fee-for-service beneficiaries, improving coordination for services provided under Medicare Part A and Part B, encouraging investment in infrastructure, and redesigned care processes.

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

By way of background, a large body of research indicates that there are sometimes significant geographic variations in healthcare costs and quality in demonstrating that more care does not equal better care. In fact, often the opposite is true. Additionally, CMS has prior experience with ACO-like efforts through the Physician Group Practice Demonstration project, which showed promise as a model for improvement of quality of care delivered to a Medicare fee-for-service population while controlling growth and expenditures. Congress drew from the work of researchers and CMS experience to establish the Medicare Shared Savings Program through the Affordable Care Act.

The Shared Savings Program is a voluntary program. It is an opportunity for providers to join together in an Accountable Care Organization. Participating providers and suppliers in the ACO continue to bill for and receive fee-for-service payments as they normally do. But at the end of each year, CMS evaluates the ACO's quality and efficiency. If the ACO as a whole has met the quality performance standard and has reduced the growth in per capita cost for its fee-for-service population, the ACO will be eligible to receive a lump sum portion of the savings it generated from Medicare. In turn, the ACO allocates those savings to improve its infrastructure and reward participating providers. To learn more about ACOs, please visit our webpage at www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/ACO.

I'm now moving on to slide 6. Because the Shared Savings Program is a national program, it undergoes the CMS rulemaking process, which involves issuing a proposed rule, accepting public comments during a mandatory public comment period, and then issuing a final rule. Our first final rule was issued in the fall of 2011. We have learned a great deal from our experience to date and have proposed the final – proposed and finalized some changes along the way, for example, quality measure changes through the annual Physician Fee Schedule Rule. In June of 2015, we published revisions to a broader set of program rules to improve the program for both beneficiaries and providers.

This past January 2016, we published a proposed rule, CMS-1644-P, focused on incorporating regional fee-for-service expenditures in the methodology for establishing, adjusting, and updating an ACO's historical benchmark for its second or subsequent agreement period. The proposed rule includes proposed modifications to streamline the methodology used for adjusting the ACO's benchmark for composition changes, encourage the ACOs to transition to participating under a performance-based risk arrangement, and addresses administrative finality around the program's financial calculations. We received comments by the March 28th deadline, and currently we are in the process of addressing the public comments and developing the final rule that will explain – incorporate the changes, many of which are anticipated to take effect through the 2017 performance shares.

We recognize that many of you are anxious to know what the new rules will be. I want to assure you we are working as quickly as possible to publish the final rule. In the meantime, if you have any interest in participating, beginning 2017, keep your options open and fill out the Notice of Intent To Apply. The Notice of Intent To Apply does not obligate you to complete an application. We will discuss the Notice of Intent To Apply later in this presentation.

Moving on to slide 7. Before I get in the details of the program – of the program participation, I'd like to review some very important definitions which are critical to an understanding of the Shared Savings Program rules and the guidance we have posted on our website.

First, an ACO, an Accountable Care Organization, is a legal entity that is recognized and authorized under applicable State or tribal law, as identified by a Taxpayer Identification Number, or referred to as a TIN, and comprised of eligible groups of eligible providers and suppliers that work together to manage and coordinate care for Medicare fee-for-service beneficiaries.

Second, ACO participant means an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare – that alone or

together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants.

A provider or supplier is someone that 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 in accordance with applicable Medicare regulations.

And, lastly, an ACO professional is an individual who is Medicare-enrolled and bills for items and services furnished to fee-for-service bennies under a Medicare billing TIN assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations.

Please make sure you read and understand the differences in 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 participant. That means the ACO must have an agreement between the ACO legal business entity and the ACO participant legal business entity, not with an individual practitioner—for an example, an ACO provider or supplier that bills through the TIN of the ACO participant. If the agreement is not made between the correct parties, the agreement will be rejected, and you will not be permitted to add the participant TIN to your list of ACO participants.

Moving on to slide 8. Slide 8 shows some additional important definitions. In particular, these definitions are important for your understanding of assignment, which will be covered on the next provider call on April 19th, so I won't go into detail here. Before the next provider call, however, I encourage you to have a good working understanding of these definitions, which are described in more detail on our website Q&A and in the final rule.

On slide 9, as of January 2016, we have more than 430 ACOs participating in the Shared Savings Program, serving over 7.7 million Medicare fee-for-service beneficiaries in 49 of 50 states and the District of Columbia. This also includes over 180,000 participating physicians and other practitioners. We also have an increase in ACOs who are taking on risk, with 22 ACOs participating under the two-sided risk model as either a Track 2 or Track 3 ACO.

On slide 10, you will find the current map showing the geographical distribution of ACO-assigned patients by county. This represents over 400 ACOs again, participating in the program, again with over 7.7 million beneficiaries.

Slide 11 lists the several statutory criteria ACOs must meet in order to be eligible. First, the ACO must agree to participate for at least a 3-year period. If we determine through the application process that your ACO meets requirements for participation, you will be

offered the opportunity to sign a 3-year agreement beginning January 1st, 2017, and ending December 31st, 2019. Your ACO will be evaluated after each calendar year to determine whether it qualifies to share in savings for that year. Your ACO must also define certain processes and demonstrate that it meets patient-centeredness criteria. As part of the application, your ACO will be asked to submit narratives describing the processes your ACO is developing and will be implementing starting January 1st, 2017.

We are now on slide 12. Today and at the next provider call in April 19th, we're going to focus on the four eligibility criteria and the rules surrounding those criteria in order for your ACO to prepare for your application. I'll cover the first two in detail today. First, your ACO must have a formal legal structure. Second, your ACO must have a mechanism for shared governance and a leadership and management structure. We'll discuss these two later on.

The last two will be described in detail at our next call on April 19th. Your ACO must have at least 5,000 beneficiaries assigned to it. And your ACO must provide information about the ACO professionals that are participating, including the agreement your ACO has executed with each ACO participant.

Slide 13 lists some other key programmatic requirements that I'll quickly review in the next few slides.

On slide 14, the statute states that, if a provider or supplier is participating in another initiative involving shared savings, they may not also participate in the Shared Savings Program. We have identified several existing initiatives involving shared savings, and they are listed on the slide and in the application. The ACO participant submitted by the ACO will be screened during the application review, and we will let you know if there are any overlapping ACO participants with other shared savings initiatives and give you a chance to resolve the overlap. If any of the ACO participant TINs is in an overlapping Shared Savings Program and remains on your participant list, the participant will be denied from participating in your ACO.

On slide 15, CMS will share data with ACOs meeting specific requirements. We give ACOs aggregate information on their assigned population and financial performance at the start of the agreement period and quarterly during the course of the performance year, as well as following the conclusion of each performance year. We will provide historical benchmark reports and financial reconciliation reports annually. And on a quarterly basis, ACOs receive assignment reports and expenditure and utilization reports. Track 1 and 2 ACOs will receive preliminary prospective assignment lists during the performance year, with a final retrospective assignment list during financial reconciliation. Track 3 ACOs will receive a prospective assignment list at the beginning of the performance year, with quarterly exclusion files identifying the beneficiaries no longer eligible for assignment.

We updated our beneficiary identifiable claims data sharing methodology in the June 2015 rule. We will provide a brief overview of the current claims data sharing methodology on the next slide.

On slide 16 – moving on to slide 16, Track 1 and 2 ACOs receive claims data for beneficiaries having an approved primary care service with a physician used in assignment. Track 3 ACOs receive claims data for beneficiaries on their prospectively assigned population. ACO's assignable population is made up of beneficiaries with a qualifying primary care visit with the ACO participants in 12 months prior to their claim's date of service. Beneficiaries who have declined in data sharing will be excluded from the claims data and reflected on the monthly exclusion file.

We are now on slide 17. Patient engagement and shared decisionmaking are important aspects of the Shared Savings Program. We believe this initiative will work best when patients are true partners with their practitioners. To facilitate the transparency of the program, the ACO participants and providers/suppliers must notify beneficiaries at the point of care that they are participating in the program and are required to offer beneficiaries the opportunity to decline data sharing before requesting their claims data. You will notify beneficiaries of participation in the program by posting signs in the facilities and in each setting in which fee-for-service beneficiaries receive primary care services. You must also make standardized written notices regarding your participation available upon a beneficiary's request. Beneficiaries will also receive general information about the program through the Medicare & You handbook. There are also marketing guidelines that your ACO must follow, and ACOs are provided with the Marketing Toolkit once accepted into the program.

We are now on slide 18. The statute requires that ACOs have enough primary care professionals for the assignment of at least 5,000 fee-for-service beneficiaries. We will be using the ACO participant TINs to determine whether the ACO participants bill for at least 5,000 beneficiaries. This means that whenever ACO participants join together to form the ACO, they must be billing for primary care services as defined in Section 425.20 of the rule. The methodology for assignment will be reviewed in detail in the April 19th National Provider Call.

We are now on slide 19. As previously mentioned, in order to participate, the ACO must be willing to be accountable for the Medicare fee-for-service population CMS assigns to it. I again want to emphasize, unlike a managed care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see, regardless of whether that practitioner is participating in the ACO or not. Because of this, when we refer to assignment, we are really talking about the operational necessity of defining a population unique to the ACO for purposes of determining whether the ACO has met the standards necessary during the performance year to receive an incentive payment for improving the quality and efficiency of care delivery.

For Track 1 and 2 ACOs, we will be implementing a preliminary prospective assignment with retrospective reconciliation. What this means is that we will perform a look back at the performance year to determine what beneficiaries chose to receive a plurality of their care from ACO practitioners. But we will also be providing the ACO with information along the way to help them better understand the fee-for-service population that providers care for by providing a list of preliminary prospective beneficiaries. At the end of the year, Track 1 and 2 ACOs will only be held accountable for beneficiaries that chose to receive a plurality of primary care services from the ACO practitioners. These are the beneficiaries for whom the ACO has the greatest opportunity to impact care during the year.

For Track 3 ACOs, we will be implementing a prospective assignment for each benchmark or performance year with annual retrospective reconciliation for prospectively assigned beneficiaries. On a quarterly basis, we will exclude beneficiaries who are no longer eligible for assignment. At the end of the year, Track 3 ACOs will be held accountable for the prospectively assigned beneficiaries who remain eligible for assignment.

Slide 20 touches on how CMS assigns beneficiaries. This two-step process will be described in further detail in the next National Provider Call, again, being held on April 19th. Note that not all fee-for-service beneficiaries in a practice's panel will be assigned. Do not assume that your Medicare-enrolled TIN will meet the 5,000 requirement because the TIN provided services to 5,000 fee-for-service beneficiaries in the past year. The beneficiary must have received a plurality of primary care services by the ACO as a whole during the previous 12 months in order to be assigned.

To identify beneficiaries eligible in the assignment methodology, we identify the beneficiaries who received at least one primary care service from a certain physician billing under ACO participant TIN. We call this the pre-step. Under Step 1 of the assignment methodology, we will assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care practitioner, primary care physician, nurse practitioner, physician assistant, clinical nurse specialist at the participating ACO, or an ACO professional providing services at an FQHC or an RHC within the ACO, or more primary care services furnished by primary care practitioners at the participating ACO than from the same types of providers at any other Shared Savings Program ACO or non-ACO individual or group TIN.

Slide 21 explains how Step 2 applies only for beneficiaries who haven't received any primary care services from a primary care practitioner. We assign the beneficiary to the participating ACO in this step if the beneficiary received at least one primary care service from a specialist physician included in the definition of an ACO professional utilized in assignment at the participating ACO and more primary care services from

specialist physicians utilized in assignment at a participating ACO than from any other ACO or non-ACO individual or group TIN.

I'm now on slide 22. Later in this presentation, we will discuss financial performance, and we will go into more detail about Track 2 and Track 3. For now, we will discuss the requirement to establish a repayment mechanism. ACOs must establish a repayment mechanism capable of repaying an amount equal to at least 1 percent of your ACO's total per capita Medicare Part A and B fee-for-service expenditures for your assigned population based on expenditures used to establish the benchmark. Again, a repayment mechanism would only apply to a Track 2 or Track 3 ACO.

To be eligible to participate under a two-sided model, applicants must submit documentation to support adequacy of their repayment mechanism. Possible repayment mechanism includes funds placed in escrow, a surety bond, or a letter of credit. If you elect a two-sided model, you should begin discussion with your organization and a bank regarding the best repayment mechanism for your ACO. I recommend reviewing our repayment mechanism guidance that's available on our Shared Savings Program website. You will receive your repayment mechanism – I'm sorry – you will receive your repayment amount estimate from CMS during the request for information process after you submit your application.

Moving on to slide 23, quality measurement approach. The Shared Savings Program quality measurement approach was developed with the intent to: (1) improve individual health and the health of populations; (2) address quality aims, such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination; also, to support the Shared Savings Program goals of better care, better health, and lower cost; and align the Shared Savings Program with other quality reporting and incentive programs, including the Physician Quality Reporting System, otherwise known as PQRS; the Physician Value Modifier, otherwise known as the VM; the Medicare Electronic Health Record, or EHR, Incentive Program; and the Merit-Based Incentive Program, MIPS; and Alternative Payment Models, APMs.

Moving on to slide 24. Slide 24 provides more information on how quality measurement and performance are another important aspect of the Shared Savings Program. ACOs will not be eligible to share savings, even if they've been generated, if they fail to meet the quality performance standard. The quality measurement approach includes a set of 34 quality measures that support CMS quality strategy and National quality strategy aims for better health and better care. The 34 measures are divided into the following four domains: (1) patient/caregiver experience, (2) care coordination/patient safety, (3) preventative health, and last, clinical care for at-risk populations.

Measures were chosen based on their ability to address high-prevalence conditions, patient safety and prevention, chronic ambulatory conditions, care coordination, and patient experience of care. In addition, in efforts to reduce reporting burden and align

reporting requirements across CMS initiatives, we also have aligned the 34 quality measures with PQRS, the Medicare EHR Incentive Program, and the Value Modifier. Consistent with statute, measures include process, outcome, and patient experience of care measures and are derived and collected from claims data, survey data, and medical records. Performance on these quality measures serves as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance.

In the first performance year, the quality performance standard is defined as complete and accurate reporting of all quality measures. If the ACO reports on all measures, it will qualify for the maximum available quality sharing rate. Incomplete reporting may result in a compliance action such as a correction action or a termination from the program. Pay-for-performance measures are phased in for the remaining performance years of the agreement. Shared savings payments are linked to quality performance on a sliding scale so that ACOs performing higher on quality receive a higher sharing rate.

Slide 25, quality reporting. Before applying to participate and during the application process, your organization should review and understand the quality reporting requirements: identify individuals in your organization who should receive notifications regarding quality reporting, meeting CMS system access, and compliance with quality reporting. They should plan accordingly so that your ACO is prepared to select and contract with the vendor to administer the 2007 patient experience of care (CAHPS for ACOs) survey. Further information on the vendor selection process will be made available in early 2017, but please take a look at 2016 to understand the process.

You can prepare for quality reporting now by clearly explaining and sharing the quality reporting requirement with the ACO participants, including the alignment of other CMS quality reporting programs, like PQRS. Ensuring providers understand the quality reporting requirement and the data collection process will help the ACOs succeed in quality reporting. It may be beneficial for ACO participants to understand the Shared Savings Program and their commitment to quality reporting when joining your ACO. We recommend you review our Shared Savings Program quality webpage where we provide helpful resources, including information on our quality measure set, quality measure benchmarks, and interactions with PQRS.

Moving on to slide 26, financial performance. A historical benchmark is established by taking the claims submitted by ACO participants, assigning beneficiaries to the ACO in each of the prebenchmark years, calculating the average per capita cost to the population for each benchmarking year, and rolling it up to establish a 3-year average per capita cost for the ACO's average fee-for-service population. The historical benchmark is then risk-adjusted and updated by the projected absolute amount of growth in national per capita expenditures for Part A and Part B services. Performance year risk-adjusted expenditures are compared to updated benchmark, and ACOs may share in savings if they meet the quality performance standard that we just discussed

and performance year per capita expenditures for assigned beneficiaries are less than the updated benchmark by at least the minimum savings rate, or MSR.

The MSR is designed to take normal variations into account. The ACO then shares in savings beginning from the first dollar up to the performance payment limit. Excuse me. As mentioned earlier, the ACO will have the opportunity to choose between one of three tracks. Under Track 1, the ACOs will have the opportunity to share in savings but not be put at risk for losses. The maximum sharing rate under this one-sided model is 50 percent of the 10-percent cap on shared savings. The minimum savings rate, or MSR, is variable depending on the number of assigned beneficiaries. Once met or exceeded, the ACO shares from first dollar.

Under Track 2, the ACO will have an opportunity to share in savings and be put at risk for losses and return for a higher sharing rate, a max of 60 percent, and a higher sharing cap of 15 percent of the benchmark. Losses will be calculated to take into account quality performance, such that higher quality performance will protect the ACO from sharing losses maximally. ACOs select a symmetrical MSR/MLR during the application process that is applied throughout the agreement period. The options are (1) no MSR/MLR, (2) symmetrical MSR/MLR and 0.5-percent increment between 0.5 and 2 percent, (3) symmetrical variable MSR/MLR based on number of assigned beneficiaries as in Track 1, and once met or exceeded, the ACO will share savings or losses from first dollar.

Track 3 is another two-sided risk model. The ACOs will have an opportunity to share in savings and be put at risk for losses and return, again for a higher sharing rate—a max of 75 percent and a higher sharing cap of 20 percent of the benchmark. Losses will be calculated to take into account quality performance, such that higher quality performance will protect the ACO from sharing losses maximally.

As in Track 2, ACOs select a symmetrical MSR/MLR during the application process that is applied throughout the agreement period. Once met or exceeded, the ACO will share savings or losses from first dollar. Detailed information on the financial reconciliation methodology is available on the program website in the financial and beneficiary assignment methodology section. I encourage you to review this. Excuse me.

Slide 27, financial performance program tracks. Slide 27 highlights the similarities and differences between the three tracks. One thing to note is the difference in assignment for Track 2 and Track 3, the two-sided risk – the two-sided risk models. Under Track 2, preliminary prospective assignment is used for reports provided during performance year, but retrospective assignment is used for the historical benchmark quality reporting and financial reconciliation. Under Track 3, prospective assignment is used for report historical benchmarks, quality reporting, and financial reconciliation.

I am now on slide 28. As part of a coordinated interagency effort, CMS works with the FTC and Department of Justice antitrust agencies, as well as the IRS and Office of Inspector General. The antitrust agencies have concurrently released an antitrust policy statement that complements the final rule. It addresses stakeholder antitrust concerns and offers a voluntary expedited antitrust review and guidance on avoiding running afoul of antitrust laws for newly formed ACOs that wish to participate in the program. The IRS released a response to comments for those tax-exempt entities that wish to participate. The OIG jointly with CMS issued an interim final rule with comment regarding CMPs, kickback, and referrals for ACOs. Later in this presentation, Mr. Robert Canterman from the Federal Trade Commission will give a brief overview of the antitrust policy statements.

Accountable Care Organizations, Organizational Structure, and Governance

Jonathan Blanar: We are now moving on to slide 29. We will now review information related to accountable care organizational structure and governance.

Slide 30, what is an ACO? We went over this definition earlier, but I wanted to reiterate it again so that we are familiar with the term. An ACO is a legal entity that is recognized and authorized under applicable State or tribal law, as identified by a TIN, and comprised of eligible groups of eligible providers and suppliers that work together to manage and coordinate care for fee-for-service beneficiaries.

An ACO participant is an entity identified by a Medicare-enrolled billing TIN, through which one or more ACO providers/suppliers bill Medicare that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants.

Moving on to slide 31. As we reviewed earlier in this presentation, in order for your ACO to be eligible for the program, it must have a formal legal structure that has a mechanism to receive and distribute payments. Additionally, an ACO must have a mechanism for shared governance and a leadership and management structure consistent with the requirements of our program.

I'm on slide 32. Let's take a deeper dive on the legal entity and governing body requirements. The statute states that the ACO must have a formal legal structure to receive and distribute shared savings and a mechanism for shared governance. We further refine these requirements in the Shared Savings Program rule. 42 CFR 425.20 defines an ACO as a legal entity that is recognized under applicable State, Federal, or tribal law and identified by a TIN. 425.104 states that this legal entity has responsibility for receiving and distributing shared savings; repaying any shared losses; establishing, reporting, and ensuring provider compliance with healthcare quality criteria; and fulfilling the other ACO functions described in the program rules.

The legal entity must also be separate and distinct from any of the ACO participants when two or more Medicare-enrolled participant TINs have joined to form it. In other words, the tax ID number of the ACO legal entity must not be the same tax ID number as any of the ACO participants. This slide illustrates the typical structure, but not the only structure, of a Shared Savings Program ACO, where a collection of ACO participants have joined together to create an ACO. Remember, the Medicare-enrolled billing TIN defines the ACO participant, so an ACO participant could be a hospital, multispecialty group clinic, primary care clinic, specialty clinic, solo practice, a pharmacy that is Medicare enrolled and bills Medicare directly, rural health center, or virtually any legal entity that bills Medicare directly for services it renders to fee-for-service beneficiaries.

Under each Medicare-enrolled TIN are the individual practitioners that have reassigned their billings to the TIN of the ACO participant. These practitioners are called ACO providers/suppliers and are identified by a national provider identifier, or NPI. An ACO provider/supplier could be a physician, nurse practitioner, physician assistant, CNS, or any other practitioner that has reassigned his or her billings to the TIN of the ACO participant.

When the ACO is formed by two or more participants, the ACO must have a TIN that is different than any of the ACO participant TINs. In other words, when an ACO is formed by multiple Medicare-enrolled TINs, none of them can act as the ACO legal entity. The reason for this is because the ACO must function as a mechanism for shared governance for the ACO participants that have joined to form the ACO. Note that it is possible for an existing legal entity to be the ACO and apply for participation. For example, it is possible for a large multispecialty group or other Medicare-enrolled TIN to participate on its own. However, the entity must meet all the eligibility requirements, including the requirement that the ACO be assigned over 5,000 Medicare fee-for-service beneficiaries.

As we will review in the next National Provider Call, there is no easy way to determine which Medicare beneficiaries or practices will have had enough primary care services to be assigned, so it would be difficult for anyone to determine in advance if your practice would meet this requirement. So some, what we call single-entity TINs, might choose to set up as a separate legal entity to be the ACO in case they need to invite other ACO participant TINs to join them in order to meet the program requirements.

Moving on to slide 33. It's important that you be able to identify your ACO's structural category. This will ultimately help you fill out your application appropriately. The first category is the typical, or what we refer to as a traditional, ACO. It is the most common structure we see. This type of ACO is formed by many ACO participant TINs that have joined together to form the ACO. To meet program rules, they establish a separate legal entity to be the ACO for the governing body that is the mechanism by which the ACO participants share governance of the organization.

For your application, you will be required to submit a sample of the agreement the ACO has with each ACO participant. You will also be required to submit an executed copy of each ACO participant agreement that has been signed by the ACO and each ACO participant. We will discuss agreement requirements in detail on the next provider call on April 19th.

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

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

The third category is what we refer to as a single-TIN ACO set up as a traditional ACO. This is a single Medicare-enrolled TIN, also known as an ACO participant, that has chosen to set up a separate legal entity as the ACO. Initially, it may be the only representative on the new ACO's governing body because it is the only ACO participant. The advantage of this arrangement is that the sole ACO participant TIN has flexibility to invite others to participate in case, for example, the entity is unable to have 5,000 assigned beneficiaries.

Moving on to slide 34. Multiple questions are asked within the application that directly relate to how you set up your ACO's organizational structure. The ACO organization structure scenario chart on the next slide is intended to crosswalk the application questions to the ACO structure scenarios we discussed in this section of the presentation.

I am now on slide 35. As I mentioned previously, understanding your ACO's organizational structure will help you determine how best to answer the application

questions. I'm not going to go into detail on this slide, but it's a good reference for you when you submit your application.

The chart on this slide lists the various organizational scenarios we just discussed in the left-hand column and how you should answer certain questions in the application. The application question numbers are listed across the top row. This chart is provided as a guide to help you understand how to answer questions related to your organizational structure.

Note that this slide crosswalks to last year's application, the 2016 application. The 2017 initial application we posted to our website in June.

We'll also update this chart, if necessary, in our 2017 application reference manual that will be posted on our website in June. And we'll discuss the application questions in detail during our June webinars.

The 2016 application reference manual is currently posted on our website, and I encourage you to review it to get a sense of the application questions and application process.

Moving on to slide 36. Per the regulation, ACOs are required to have an identifiable governing body with the ultimate authority to execute the functions of your ACO. The governing body must be the same governing body as the legal entity that is the ACO, it must be separate and unique to the ACO and must not be the same as a governing body of any ACO participant for ACOs that comprise two or more ACO participants, must have a responsibility for oversight and strategic direction of the ACO, it must have a transparent governing process, and it must ensure that members have the fiduciary duty to the ACO, including the duty of loyalty, and must act consistent with that fiduciary duty.

On slide 37, the ACO legal entity must have a governing body that is representative of the ACO participants and have meaningful beneficiary input. The governing body must have a Medicare beneficiary on it that – and serves on its governing body that it serves and is not a provider/supplier of the ACO.

The program rules require that ACO participants retain 75-percent control over the governing body. We believe this is very important to demonstrate clinical integration.

In limited circumstances, it may not be possible for an organization to meet these requirements. So, we have built in flexibility for the ACO to describe how it will ensure meaningful representation by the ACO participants and meaningful input from beneficiaries if it cannot satisfy these requirements. CMS may ask for a narrative from the ACO explaining any deviation to these requirements.

According to statute, the ACO must also have a leadership and management structure that includes clinical and administrative systems. In the final rule, we have stated the ACO's leadership and management must demonstrate an organizational commitment to the goals of the ACO, must have an experienced leadership team which includes the medical director and a qualified health professional leading its quality assurance and improvement process. Consideration will be given to ACOs that have innovative leadership and management structures that meet the goal of the ACO.

I'd like to go over some common errors that we often see in applications: one, not having enough ACO participant representation on the governing body, in other words, not meeting the 75-percent requirement; second, not demonstrating shared governance among ACO representatives, for example, overweighted representation by one at the expense of the others; third, not having a beneficiary designated appointed to the governing body or having a suitable alternative; fourth, control for executing the functions of the ACO as described in the program rules resides with a parent or subsidiary organization and not with the ACO legal entity, for example, the power to designate board members, power to hire/fire key administrative personnel, power to ensure compliance of ACO participants, etc.; and lastly, the applicant's governing body does not have a fiduciary duty to the ACO alone. Particularly vulnerable are existing organizations such as IPAs that attempt to apply with a subset of practices rather than all.

I strongly encourage you to review the guidance on our website and our final rule for more information on the requirements for your ACO's governance, leadership, and management, and to have this prepared and in place in advance of your application.

Please reference regulation Sections 422.106 and 422.108. Please email us in advance if you have any questions or concerns.

*****Post-Call Clarification*****

Please reference regulation Sections 425.106 and 425.108. Please email us in advance if you have any questions or concerns.

Skilled Nursing Facility 3-Day Waiver Application Information

Jonathan Blanar: Moving on to slide 38, skilled nursing facility 3-day waiver application. We will now discuss, at a high level, the skilled nursing facility 3-day waiver requirements and application process. You'll hear this repeated often, but the SNF 3-day waiver is only available to Track 3 ACOs, since they receive prospective assignment. Additionally, we will host a webinar on June 13th specific to the SNF 3-day waiver application. If you are applying as a Track 3 ACO, I encourage you to join this webinar, as it will provide valuable detailed information on the 3-day SNF waiver requirements and application process.

I am now on slide 39. The Medicare Skilled Nursing Facility, again also known as SNF, benefit is designed for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing and/or skilled rehabilitation care.

Pursuant to Section 1861 of the act, beneficiaries must have a prior inpatient hospital stay of no fewer than 3 consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. It may be medically appropriate for some patients to receive skilled nursing care and/or rehabilitation services provided at SNFs without prior hospitalization or with an inpatient hospital-length stay of less than 3 days.

Track 3 Shared Savings Program ACOs only may apply a waiver in these circumstances if approved for the waiver by CMS. The waiver permits Medicare payment for otherwise covered SNF services when ACO providers/suppliers participating in eligible Track 3 ACOs admit a qualifying beneficiary to a SNF affiliate for a skilled nursing or rehabilitation care without a 3-day prior inpatient hospitalization.

This was promulgated in the June 2015 final rule and will become effective for approved SNF waiver applicants in 2017. See Regulation 422.612 for further details.

*****Post-Call Clarification*****

This was promulgated in the June 2015 final rule and will become effective for approved SNF waiver applicants in 2017. See Regulation 425.612 for further details.

I'm now on slide 40. Beneficiaries eligible for SNF admission under the terms of this waiver will include only Medicare beneficiaries who meet the following requirements: they are prospectively assigned to a Track 3 ACO and the Shared Savings Program; they do not reside in a SNF or other long-term care setting; they are medically stable; they do not require inpatient hospital evaluation or treatment; they have certain and confirmed diagnosis; they have an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient or home health service; and last, have been evaluated and approved for admission to the SNF within 3 days prior to the SNF admission by an ACO provider/supplier who is a physician, consistent with the ACO's beneficiary evaluation and admission plan.

I am now on slide 41. The SNF 3-day waiver application must be submitted separately from your initial application. We will evaluate both your initial application and your SNF 3-day waiver application during the same time period. In addition, you'll receive feedback on your application in the form of a consolidated request for information, otherwise known as an RFI. The RFI will contain requests for both your initial and SNF 3-day waiver applications. You will have one deadline to respond to both applications. We strongly recommend that, if you intend on submitting the 3-day SNF

waiver the – application, that you maintain staff throughout the application evaluation period to respond timely and accurately to all requests.

The SNF 3-day waiver application requires you to submit materials including, but not limited to, the following: attestations and narratives that allow you to describe how you met program requirements through the 3-day SNF waiver, an SNF affiliate list that includes SNF affiliates with whom the ACO will partner. We will provide you with the format to submit this list similar to how we provide you with the template for the ACO participant list. Please be mindful that these are two separate lists that undergo separate evaluations.

SNF affiliate agreements for each SNF affiliate that appears on your list will also be required. Your SNF affiliates must agree to participate in your ACO under the SNF 3-day waiver according to the program rules and regulations.

Documentation showing 3 or higher on the CMS 5-star Quality Rating System as reported on the Nursing Home Compare website.

Again, we will host a webinar on June 13th specific to the SNF 3-day waiver application. If you are thinking about applying as a Track 3 ACO, I encourage you to join this webinar as it will provide valuable information on the SNF 3-day waiver requirements and application process.

With that, I'll conclude my portion of the presentation and turn the presentation back over to Amanda Barnes, who will now take keypad polling. After Amanda is finished, she will hand the presentation over to Mr. Robert Canterman from the Federal Trade Commission who will give a brief overview of the antitrust policy statement. Amanda?

Keypad Polling

Amanda Barnes: Thank you, Jonathan. At this time, we will pause for a few moments to complete keypad polling. Ronni, we're ready to start.

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

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

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

Amanda Barnes: Thank you, Ronni. Now I'm going to turn the presentation over to Robert Canterman. Robert?

Antitrust and ACOs

Robert Canterman: Thank you. Good afternoon. I'm going to provide a brief overview of antitrust issues for accountable care organizations. Also here today is Pat Kuhlmann from the Antitrust Division of the Department of Justice. The FTC and DOJ coordinate on these issues.

First, I just need to give you the standard disclaimer that the views I share with you reflect my own personal views and not necessarily those of the FTC.

The key takeaway from my discussion is this: As you form and operate your ACOs, remember to consider potential antitrust issues. The FTC and DOJ have provided guidance in this area, including the antitrust enforcement policy statement for ACOs participating in the Shared Savings Program that Jonathan mentioned earlier. I will discuss the statement in just a few moments. You also may want to consider seeking antitrust counsel.

Slide 43 outlines key antitrust issues for ACOs. The antitrust agencies recognize that many ACOs do not raise antitrust concerns and may benefit patients by improving quality of care and lowering costs. But under certain circumstances, ACOs may raise antitrust issues. Keep in mind, there is no antitrust immunity for ACOs participating in the Shared Savings Program. As listed on slide 43, there are three antitrust concerns that ACOs should be aware of and consider.

First, whenever competitors get together, you want to avoid an agreement on price or other sensitive terms of dealing. Price fixing among competitors, for example, competing providers jointly negotiating with commercial payers, is considered a per se or automatic violation of the antitrust laws unless it is part of some legitimately integrated joint venture.

One such legitimate joint venture is an ACO participating in the Shared Savings Program. An ACO participates in the Shared Savings Program and uses the same governance and leadership structures in clinical and administrative processes to provide services to patients in commercial markets, then an ACO that jointly negotiates with commercial payers does not raise per se price-fixing concerns. Instead, the agencies will take a closer look at the ACO to evaluate any potential harm to competition.

Under this closer look, the agencies would weigh the efficiencies created by the ACO against any anticompetitive effects. Under this closer look, referred to as a

rule-of-reason analysis under the antitrust laws, the key issue is whether the ACO has so many of the providers in a geographic area that it raises monopolization concerns. That is, does the ACO have market power to get anticompetitive prices with commercial payers? Whether an ACO has market power will depend on the size of the ACO and how many competing providers are in the market.

The third antitrust concern listed on slide 43 is consolidation that may lessen competition. An ACO formed through a merger or acquisition of a competitor may raise antitrust concerns. The main question is whether the merger creates or enhances market power. Keep in mind that, although providers may form an ACO through a merger, a merger is not required under the Affordable Care Act or under the Shared Savings Program regulations.

On slide 44, we've provided an outline of the key provisions of the FTC-DOJ policy statement for ACOs that I referred to just a few moments ago. The purpose of the policy statement is to provide guidance for collaborations among otherwise independent providers and provider groups that are eligible and intend, or have been approved, to participate in the Shared Savings Program. Note that an ACO formed through a merger would be evaluated under the FTC-DOJ horizontal merger guidelines.

As I mentioned earlier, ACOs that use the same governance and leadership structures and clinical administrative processes to provide services to patients in commercial markets will be evaluated under a rule of reason rather than treated as a per se price-fixing concern.

The policy statement includes a safety zone for ACOs unlikely to raise significant antitrust concerns. The agencies will not challenge, absent extraordinary circumstances, an ACO that has a 30-percent or less share of services in its primary service area, and also that meets the other requirements under the safety zone. ACOs not meeting the safety zone requirements do not necessarily raise antitrust concerns; it just means that we need to take a closer look at the operation of the ACO in the market.

The policy statement provides guidance for ACOs outside the safety zone. A key issue is market power and whether the market participants are exclusive to the ACO. The policy statement provides some conduct that the ACO may wish to avoid if it has indicia of market power. The statement also provides for voluntary expedited review by the antitrust agencies for ACOs seeking further guidance.

I've covered a lot of information in the short time here today. If you remember nothing else, remember to consider potential antitrust issues as you form and operate your ACOs, and remember to consult the agencies' guidance. Links to the guidance is included on slide 44.

We will be happy to answer any antitrust questions at the end of the program. Thank you for your attention, and I will now turn the program over to Karmin.

Application Process—January 2017 Starters

Karmin Jones: Thank you, Robert. My name is Karmin Jones, Technical Advisor with the Division of Application, Compliance and Outreach of the Performance-Based Payment Policy Group in the Centers for Medicare and Medicaid Services. And we'll review the application process.

On slide 45, we provide you a list of upcoming webinars, topics, and the dates and times for each call. Please plan to have staff from your organization to attend these calls, as they provide you with information necessary to help you submit a successful application.

I am now on slide 47. We encourage you to take steps now to prepare yourself for the application submission phase. This application requires you to establish your governing body and obtain signed agreements with your providers as discussed earlier. Most of these requirements can take a substantial amount of time. In addition, you are required to submit several detailed narratives explaining how your ACO meets program requirements. We strongly encourage you to not wait until July 1st to begin preparing your application but to begin now.

As discussed earlier in this presentation, prior to submitting an application you should establish your organizational structure, establish your governance and leadership structure, prepare a sample participant agreement for submission with your application that meets program requirements and utilizes the ACO participant list worksheet, listing all of your ACO participants. Please note that this worksheet is not required for submission but is available for you to use as a guide.

If you are a Track 3 ACO applying for the skilled nursing facility 3-day waiver, you will also need to prepare a sample SNF affiliate agreement that meets all program requirements and provide a list of your SNF affiliates with your SNF 3-day waiver application.

Later this spring, we will provide a SNF affiliate list template for you to use for your submission. Make certain that all participants of SNF affiliate agreements are finalized and signed by both parties. The ACO participant agreements must be signed by both the ACO and ACO participants. And the SNF affiliate agreement must be signed by both the ACO and the SNF affiliates.

Begin establishing your repayment mechanism only if you have chosen to apply under Tracks 2 or 3 of two-sided risk model that had shared losses. We strongly encourage you to work on these elements immediately. These issues have historically taken a significant amount of time for previous applicants to complete. By working on these

topics now, you will likely avoid many of the issues previous applicants have encountered. The time that you spend now preparing for the application process will save you time in the long run.

I am now on slide 48. Now, let's walk through the actual application process for program year 2017 as well as the key deadlines you must meet.

Slide 49 is a chart of the key deadline dates in the application process for ACOs applying for the January 1, 2017, program start date. Please understand that we require – we are required by statute to start each new cycle on January 1 of each year. So, it is imperative that all of the deadlines are met in order to be compliant with the law. I will go through each of these steps more thoroughly later in the presentation.

But for now know that, before you can submit an application, you must first submit a Notice of Intent To Apply, or NOIA. Please note that we posted our NOIA memo on our How-to-Apply application webpage last Friday, April the 1st. The memo provides detailed instructions about the NOIA process, a sample of NOIA question – with sample NOIA questions. You may access the NOIA web – you may access the NOIA questionnaire and start your submission beginning May 2nd. The deadline for your NOIA submission is 5:00 pm eastern standard time on Tuesday, May 31st, 2016. We will not accept late NOIA submissions. If you fail to meet the deadlines, your next opportunity to apply for the Medicare Shared Savings Program will be the next year for the 2018 cycle.

Following the NOIA submission, you are required to submit a CMS User ID form for all individuals who will submit an application and for those who may utilize CMS data if your ACO is approved. These forms must be submitted by June 3rd, 2016.

We would like to emphasize that this step should be taken immediately upon receiving your ACO ID number, which is included in your NOIA receipt notice that we submit to you by email. You must have an ACO ID to request a User ID. Directions on completing the CMS User ID access are also included in your NOIA receipt email. Since it takes 3 to 4 weeks for CMS to process your User ID request, we again stress the importance of completing this step as soon as you receive your NOIA email.

Additionally, if you previously submitted an application for the Medicare Shared Savings Program and your application was either denied or withdrawn, you must complete the process again from the beginning. This means that you must submit a 2017 Notice of Intent To Apply and receive a new ACO ID. After this has been completed, you must submit a 2017 application using the appropriate 2017 templates and naming conventions, as well as responding to attestation questions in the 2017 application.

CMS will not evaluate any previous submissions. We will accept applications from July 1 through July 29th, 2016. Again, the deadline for application submissions will be 5:00 pm eastern time on July 29th. We plan to issue application dispositions in November 2016.

And if an applicant is denied and would like to seek reconsideration, the applicant will have up to 2 weeks after the final determinations are issued to request a review of that denial.

For the skilled nursing facility 3-day waiver application, please note that it is only available to apply for two-sided risk – for ACOs applying under the two-sided risk model Track 3, or those who are already participating in the program under Track 3.

I am now on slide 50. Your first step in the application process is to prepare and submit your Notice of Intent To Apply as discussed earlier. You may access your NOIA on the How-to-Apply website at www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/application.html. That link is also provided in this presentation.

Step 1 of this page will direct you to the link of the NOIA memo. The NOIA memo provides detailed instructions about the NOIA process and provides sample NOIA questions as previously discussed.

After you submit your NOIA, you will receive the email as previously identified. Again, it is important to note that submitting a NOIA does not require you to submit an application. However, you must submit a NOIA prior to submitting an application.

Slide 51. Your NOIA receipt notice will provide you with the detailed instructions as previously provided, and the link there on slide 51 also provides you with the CMS User ID access form and also the address to where you would send that form.

Please note that each individual form must include the requested Social Security number, your ACO ID, the date, and original signature. We recommend you initially obtain a CMS User ID for the following contacts: your application primary and secondary, your ACO executive, authorized-to-sign primary, and IT contact primary.

Please note that if your ACO is approved to participate in the program, the following contacts will be required to electronically sign documentation in HPMS on your ACO's behalf: your ACO executive, authorized-to-sign primary/secondary, your DUA custodian, and DUA requester. These contacts must have a valid CMS User ID with access to HPMS to complete these tasks.

Again, we want to identify – make certain that you submit these forms as soon as possible.

Slide 51 provides you with individuals who may have a – currently have a CMS User ID and/or may request to obtain access to your new ACO ID. Please follow those instructions there as we move through the slides pretty quickly to open up the Q&A session. So, I'm going to quickly go over the next set of slides and highlight some of the key information that you need.

Again, if you are an existing user that needs a CMS User ID, please follow those instructions, and send an email to the HPMS access team.

On slide 53, we give you detailed information about consultants that you may use within your ACO. We recognize the ACOs typically have multiple consultants that are associated with them, and we want to make sure that we are appropriately identifying them within our system. So, please follow the instructions that we have on slide 53 and is also detailed fully within the Notice of Intent To Apply memo. These notices should be sent to the HPMS_access@cms.hhs.gov email address.

Lastly, on page 54, we want to highlight that it is fraudulent to use, or to allow someone else to use, your CMS User ID. So, please be mindful of that. If you are found in violation of that, you will lose your User ID.

Lastly again on slide 55, we go through the process of how you submit your application. If you have questions about your application submission, please send your email to SSPACO_applications@cms.hhs.gov. Please keep in mind that we do not accept paper applications. So, when that application is made available to you in the spring of 2016, you will need to access the Health Plan Management System to submit your application. Again, applications are accepted July 1 through July 29th.

We also provide a lot of helpful information on 56 through our application toolkit. And it gives you some guidance as to what's included in there.

It's also very important that you establish your banking information as described on slide 57. Detailed information about your banking information is there, as well as key FAQs are provided on the toolkit.

Lastly, to recap important application steps on slide 58: act early. Time is of the essence to submit and complete all steps as early as possible according to the timeframes provided. Attend all webinars as we provided earlier in this presentation. Those webinars are also provided in the NOIA memo. Ensure your participant agreements meet all Shared Savings Program requirements to save resources from having to revise or resign agreements. List at least four contacts for your ACO so that we may reach out to you and you have timely responses and you do not miss your deadline. These contacts must be made available throughout the NOIA and application phase, which runs from May through November 2016. All correspondences between the ACO and CMS must include your ACO ID so we can identify you and your entity. Please never share your CMS User ID, and of course contact us with any email.

Slide 59 provides the next upcoming calls that we have. And as previously identified, we – our next call is April 19th when we will discuss the beneficiary assignments, the participant list, and agreements between ACOs and providers. Please note these times

may change, so please monitor our teleconference and events webpage for updates on those things.

Again, slide 60 also provides you our contact information.

This concludes the prepared portion of the Shared Savings Program application call. We will accept questions for the remainder of the time. Our lines are now open. Amanda?

Question-and-Answer Session

Amanda Barnes: Thank you. Our subject matter experts will now take your questions. But before we begin, I would like to remind everyone this call is being recorded and transcribed.

Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit to just one. If you would like to ask a followup or have more than one question, you may press star 1 to get back in the queue.

Ronni, 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, please press the pound key. 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.

And your first question comes from the line of Cheryl Kelly.

Cheryl Kelly: Hi, this is Cheryl Kelly joining from MD Partners in Englewood. I have two questions, actually. First, we are new to joining an already-existing ACO. Our TIN is joining a preexisting ACO. What is the purpose of the CMS ID?

Karmin Jones: So we have – there is a CMS User ID, which your ACO contact will use to access your ACO's data with an HPMS to submit your application throughout the program year. We also have information that's provided on the ACO internal portal that is specific to your ACO. And we also transfer information to your ACO, such as claims and claims IC and other reports directly to your ACO, and you will use your User ID to access that information.

Cheryl Kelly: OK, thank you. The second question I have is, what are the PQRS reporting requirements for us now given the fact that we are now participating in an ACO?

Sarah Fogler: We have a – this is Sarah Fogler at CMS. We have a lot of available information that we can point you to that talks specifically about the intersection between PQRS quality reporting and participation in the Shared Savings Program. But essentially, ACOs report PQRS on behalf of their participating TINs. And so where – that information is easily available if you were just to look on our website, our cms.gov/sharedsavingsprogram website, you'd click on Quality Reporting, I believe it's the flyout, and there's specific guidance that speaks to that.

Cheryl Kelly: If I heard you correctly, the ACO will take care of our PQRS reporting for us. So, it's one reporting obligation for us on behalf of the ACO.

Sarah Fogler: Right. So our program rules and regulations outline the responsibility of the ACOs to their participant TINs, but it would behoove you to have conversations with your ACO early on about just to make sure you understand the relationship and the role that they play in meeting your CMS quality reporting requirements.

Cheryl Kelly: OK, great. Thank you so much.

Sarah Fogler: Sure.

Dr. Terri Postma: Yes. And this is Terri. I just want to add, you're going to want to make sure that you understand what the effective date of your joining the ACO is. So for example, if your TIN is joining this year, you may not be a part of their ACO participant list until January 1st, 2017. It's for the 2017 performance year, then, that the ACO would be reporting PQRS on your behalf. If you joined last year and you're on the ACO's participant list starting January 1st for 2016, then the ACO is going to be reporting on your behalf for 2016. So, just make sure that you check those dates and understand...

Cheryl Kelly: Certainly. Certainly.

Amanda Barnes: Thank you.

Cheryl Kelly: Thank you.

Operator: Your next question comes from the line of Emily Brower.

Emily Brower: Hi. This is Emily Brower from Atrius Health. I'm wondering about the timing of the changes to the benchmarking methodology that were in the proposed rule and how that might affect a pioneer ACO that would be moving to MSSP. In other words, would we be coming in as, effectively, our third contract period and benefit from the changes to the benchmarking methodology that incorporate regional components to that – in that methodology?

Elizabeth November: Hi, this is Elizabeth November with CMS. So, as was mentioned at the beginning of the call, we're in the process of developing a final ruling. We're very limited in terms of what we can discuss in relation to the proposed or final policies. So, we just urge you to keep a lookout for the issuance of the final rule and any other related information. You'll be able to check for updates through the program's website. Thanks.

Emily Brower: So, my question was about timing. You can't address questions about timing?

Sarah Fogler: Right. There's effective date information. What we are able to say was in the proposed rule, and so there's effective date table of all the provisions that we're contemplating in the proposed rule. But beyond that, we're not able to comment.

Amanda Barnes: Thank you. Next question, please.

Operator: Your next question comes from the line of Rene Moret.

Rene Moret: This is Rene Moret with Tandigm Health in Philadelphia. My question is, if an ACO starts out in a Track 1 mode, can it go to Track 2 or Track 3 within the first 3-year agreement?

Elizabeth November: Hi, this is Elizabeth again. So, you need to select the track as part of your application. And once you enter an agreement, you enter that agreement under that track for the duration of your agreement period. So under the current regulation, you cannot switch tracks.

Rene Moret: OK, thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Tania Sharp.

Tania Sharp: Hello, my name is Tania Sharp, and I'm with Heartland Physicians Corporation in Kirksville, Missouri. And my question has to do with Mr. Blanar's presentation. I apologize if I mispronounced his last name. He mentioned that CMS doesn't like Track 1 applications coming from IPAs that apply with a subset of their practices. Could you explain that further to me, please?

Dr. Terri Postma: Hi, this is Terri. It's not that we don't – I don't think this is what Jonathan said. It's not that we don't like applications coming from IPAs. But we just wanted to give IPAs that wanted to submit an application a heads up. If the IPA wants to use their existing legal entity as the ACO legal entity, then the IPA has to make sure that all the ACO – or all the Medicare-enrolled TINs that are a part of that organization have

agreed to participate and comply or the ACO may run afoul of the fiduciary duty requirements.

So, we wanted to flag that because we do have a number of applicants coming in that don't quite understand that and then it's discovered midway to the application process and it's just too late at that point to shift gears and set up a new legal entity as the ACO. So, that was the point that was being made there.

Tania Sharp: OK. I understand, and I appreciate that.

Just to quickly tell you, what we struggle with is, we're a rural IPA and several of our practices do not have electronic medical records, which is because they usually have one or two providers in the practice and simply can't afford that. I know – we know there are some free options out there for electronic records and we're checking into that, but we're finding out that we have trouble connecting everyone, all of our practices. So, that's what we're struggling with. I just wanted to make sure, you know, the intent is there for all of our practices. They want to join this effort, but we just – we have some very big hurdles and, you know, financial reasons are the reason for most of them. So, that's why I wanted you to further explain that. So, I appreciate that. Thank you.

Dr. Terri Postma: Yes, it's no problem. And with regards – I think you're referring to the requirement that the ACO has to have a process in place to coordinate care using enabling technology such as EHR. And when you submit that narrative, I mean, you can talk about – I think it would be completely valid to talk about your plan for getting that in place over time. You don't necessarily have to have all practices on EHR technology at the time of application.

Tania Sharp: Great. Thank you very much.

Dr. Terri Postma: Sure.

Operator: Your next question comes from the line of Jennifer Schilpp.

Jennifer Schilpp: Hi, my name is Jennifer Schilpp. I'm from White Horse Village in Newtown Square, Pennsylvania. We're a continuing care retirement community with a skilled nursing facility. How will it work if we are not participating in an ACO if at some point in time our star ratings are below three stars? Our residents, will they still come back from the hospitals, or will the hospitals send them out somewhere else?

Dr. Terri Postma: Hi, this is Terri. Can you explain your question a little bit further?

Jennifer Schilpp: Yes. We're a continuing care life care community where we have independent living residents. We also have skilled nursing personal care memory

support. If we are not part of an ACO, if we can't be part of an ACO because we have a star rating below three stars, how will the hospitals – will our residents, if they go to the hospital, normally they would just come back to us. Will the hospitals then send them somewhere else if we're not part of their ACO?

Dr. Terri Postma: OK. So yes, thank you for raising that. I want to make sure that folks understand what the three-star rating applies to.

So first, any ACO – or any Medicare-enrolled TIN, that is any TIN that bills Medicare for fee for service is welcome to join an ACO that's applying for a program or an existing ACO as an ACO participant. So, that's first and foremost.

The three-star rating applies specifically to use of a SNF 3-day waiver. And so, it's very, very narrow. And so, if you are a SNF – if you're a Medicare-enrolled SNF that wants to partner with a Track 3 ACO for purposes of using the SNF 3-day waiver, the SNF has to have a three-star rating or better in order to do that.

Jennifer Schilpp: So, if you don't have a three-star rating and you can't get the waiver, why would the ACO want to partner with you?

Dr. Terri Postma: Well, if the ACO wants – if the ACO is a Track 3 ACO that wants to use the SNF 3-day waiver, then they can only apply with SNF affiliates that have a three-star rating or better. Now, that doesn't mean that the SNF – if it's in a region where there is an ACO, it doesn't mean that that SNF can't participate in the ACO, it just can't – you just can't be a part of that waiver process.

Jennifer Schilpp: So, if our residents had a 2-day hospital stay for, let's say, a hip replacement, and they came back to us, we just wouldn't get any Medicare payment.

Sarah Fogler: No. So, I just wanted to add – this is Sarah Fogler. I just wanted to add one additional point onto what Terri said in response. And I think it's specific to the statement you made about hospitals potentially making referrals to SNFs that were participating with an ACO. So just to be really clear, beneficiaries that are admitted to a hospital or have any visit with any Medicare provider continue to maintain their freedom of choice of provider because the ACO program is, you know, it is built upon the Medicare fee-for-service structure. So just because a SNF is partnering with the hospital within the Medicare Shared Savings Program, whether on an ACO participant list or on a SNF affiliate list, does not suggest—and it shouldn't in any future state of this program—that beneficiaries would only have a choice to go to certain SNFs that were participating with an ACO. So, freedom of choice is maintained for beneficiaries, throughout this program and for this very narrow policy and programmatic option, that were reporting ACOs, SNFs have to have a three-star rating or above.

Jennifer Schilpp: OK, thank you.

Amanda Barnes: Thank you.

Additional Information

Amanda Barnes: Unfortunately, that's all the time we have for questions today. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these become available.

Also, on slide 62 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your experience.

Again, my name is Amanda Barnes. And I'd like to thank our presenters and also thank you for participating in today's call. Have a great day, everyone.

Operator: This concludes today's call.

-END-


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