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National Provider Call

# Medicare Shared Savings Program Accountable Care Organization: Preparing to Apply for 2017

**April 5, 2016**

**Presented by:**

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

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# Agenda

- Introduction to the Medicare Shared Savings Program
- Accountable Care Organizations, Organizational Structure and Governance
- Skilled Nursing Facility (SNF) 3-day Waiver Application Information
- Antitrust and ACOs
- Application Process - January 2017 Starters

# Introduction to the Medicare Shared Savings Program

Jonathan Blanar
Division Director,
Division of Application, Compliance & Outreach
Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services

# Shared Savings Program: Overview

- The Medicare Shared Savings Program (Shared Savings Program) was established by Section 3022 of the Affordable Care Act.
- Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an ACO.
- ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health, and lower growth in expenditures.
- The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.
- To learn more about ACOs, please visit: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html

# Shared Savings Program: Background

- Shared Savings Program Website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
- 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 Final Rule June 2015, "Medicare Shared Savings Program: Accountable Care Organizations" (80 FR 32691) available online: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=9cbc79f8103dc64535741369912f044f&ty=HTML&h=L&r=PART&n=42y3.0.1.1.12#42:3.0.1.1.12.4.5.5
- Issued Proposed Rule January 2016
- Comment Deadline was March 28, 2016
- Promulgated in regulation at 42 CFR Part 425

Note: The 2014 and 2015 Physician Fee Schedule rules also have certain quality measurement, reporting, and scoring provisions

# Shared Savings Program: Definitions

## Accountable Care Organization (ACO):

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

## ACO Participants:

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 that is required under § 425.118

## ACO Provider/Supplier:

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

## ACO Professional:

An individual who is Medicare-enrolled and bills for items and services furnished 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.

# Shared Savings Program: ACO Professionals

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

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

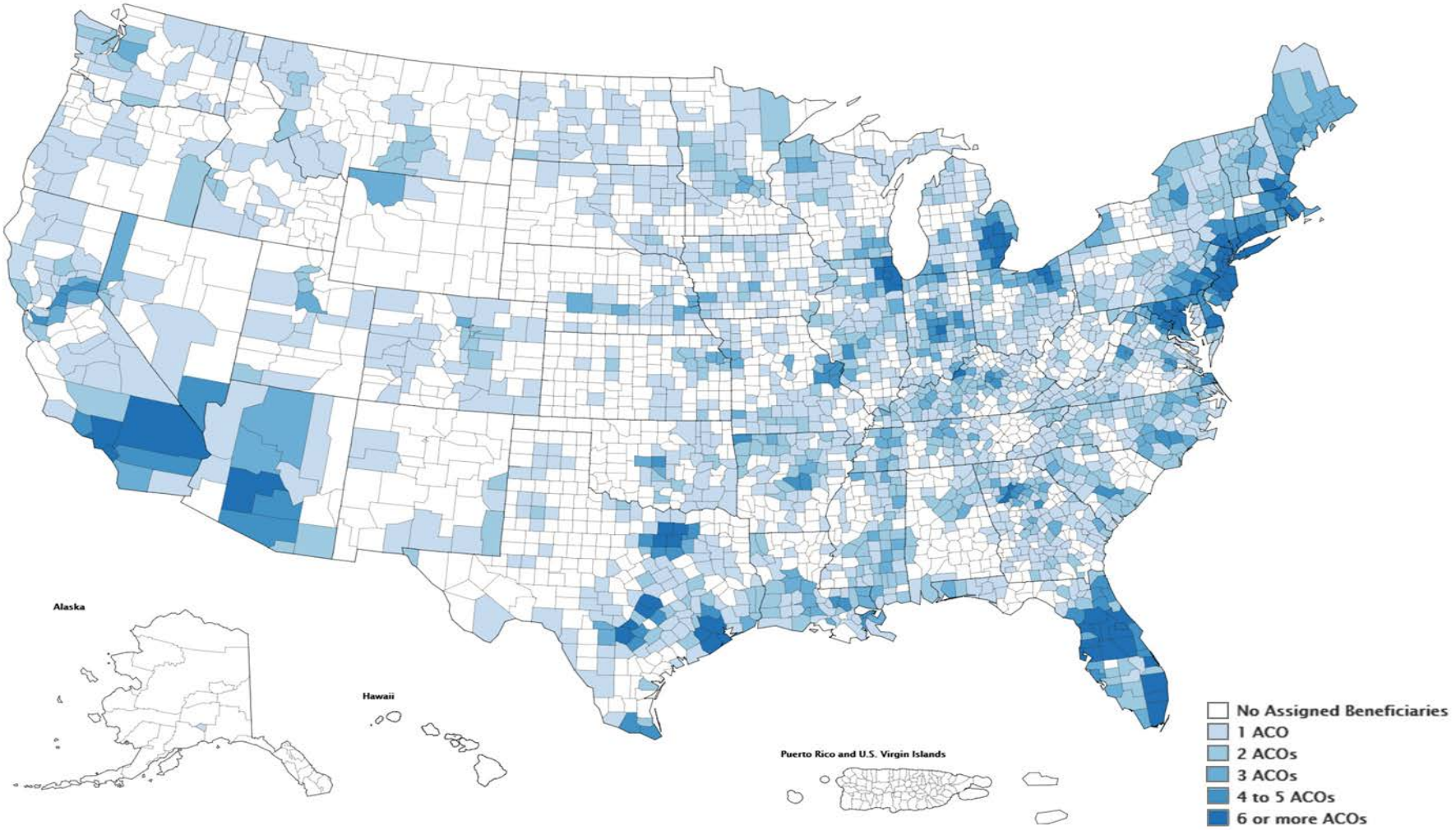
- **Primary Care Services:**
  - Certain Evaluation and Management (E&M) Healthcare Common Procedure Coding System (HCPCS) codes
  - Revenue center codes
  - G codes
  - HCPCS/CPT codes

# Shared Savings Program: Current Landscape

- As of January 1, 2016, there were 434 ACOs in the program.
- Serving over 7.7 million Medicare fee-for-service beneficiaries in 49 of 50 states and the District of Columbia
- Over 180,000 participating physicians and other practitioners
- 22 ACOs in a two-sided risk model (Track 2 or Track 3)

# Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County

(counties with more than 1 percent of an ACO's assigned beneficiaries



# Shared Savings Program: Statutory Requirements

By statute, ACOs must meet the following eligibility criteria:

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

# Shared Savings Program: Statutory Requirements

By statute, ACOs must meet the following eligibility criteria:

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

# Other Program Requirements

- ACO participants cannot concurrently participate in other Medicare shared savings initiatives
- Data sharing
- Beneficiary communication
- Beneficiary assignment
- Repayment Mechanism for Tracks 2 and 3
- Quality measurement, reporting, and performance
- Financial performance

# Participation in Other Shared Savings Initiatives

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

* Only contracts with shared savings arrangements

# Data Sharing

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

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

- Effective 1/1/2016, ACOs were no longer required to submit Beneficiary Data Sharing Preference Files (BNPRF) or Request Files (DTRQT).

# Data Sharing (cont.)

- Tracks 1 and 2, 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's participant(s) 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 (BNEXC.LIS).

# Beneficiary Communication

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

# Beneficiary Assignment

- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
- Assignment is based on primary care services rendered by physicians used in assignment.
  - This means some of the ACO participants must bill for primary care services (e.g. hospitals employing ACO professionals, group practices of ACO professionals, etc).

# Patient Population

- ACO accepts responsibility for an “assigned” patient population.
- Assigned patient population is the basis for calculating the financial benchmark, determining shared savings and losses, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs.
- Assignment will not affect beneficiaries’ guaranteed benefits or choice of doctor or any other provider.
- Tracks 1 & 2: preliminary prospective assignment with ~~a~~ retrospective reconciliation (retrospective assignment for each benchmark or performance year).
- Track 3: prospective assignment for each benchmark or performance year with annual retrospective reconciliation for prospectively assigned beneficiaries.

# Two-Step Beneficiary Assignment Process

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, a NPP, or an ACO FQHC/RHC professional at the participating ACO, and more primary care services (measured by Medicare allowed charges on paid claims) furnished by primary care physicians, NPPs, or ACO FQHC/RHC professionals at the participating ACO than from primary care physicians, NPPs, or ACO FQHC/RHC professionals at any other ACO or non-ACO individual or group TIN.*

*As assigned by the U.S. Internal Revenue Service. There are two types of TINs: Social Security Numbers (SSNs) and Employer Identification Numbers (EINs).

# Two-Step Beneficiary Assignment Process (cont.)

- Assignment Policy Step 2:
  - This step applies only for beneficiaries who remain unassigned after Step 1. CMS will assign the beneficiary to the participating ACO in this step if the beneficiary got at least 1 primary care service from an ACO physician used in step 2 at the participating ACO, and more primary care services (measured by Medicare allowed charges) from ACO physicians at a participating ACO than from any other ACO or non-ACO individual or group TIN.

# Repayment Mechanism – Track 2 and 3

- To be eligible to participate under a two-sided model, applicant must submit documentation to support adequacy of their repayment mechanism:
  - o Funds placed in escrow
  - o Surety bond
  - o Letter of credit
- Repayment mechanism assures CMS that you can repay losses for which you may be liable.
- Repayment mechanism must be capable of repaying an amount equal to at least 1% of your ACO's total per capita Medicare Parts A and B fee-for-service expenditures for your assigned population based on expenditures used to establish the benchmark.
  - o CMS notifies ACOs of the minimum amount required & submission instructions during the application review process

# Quality Measurement Approach

- The quality measurement approach in the Shared Savings Program is intended to:
  - Improve individual health and the health of populations;
  - Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination;
  - Support the Shared Savings Program goals of better care, better health, and lower cost; and,
  - Align with other quality reporting and incentive programs including the Physician Quality Reporting System (PQRS), the Physician Value Modifier (VM), the Medicare Electronic Health Record (EHR) Incentive Program, the Merit-Based Incentive Program (MIPS) and Alternative Payment Models (APMs).*

    *Note: Information on MIPS and APM alignment will be made available later this year.

# Quality Measure Performance

- For Program Year 2016, the Shared Savings Program measure set includes 34 measures covering four key domains:
    1. Patient/Caregiver Experience
    2. Care Coordination/Patient Safety
    3. Preventive Health
    4. Clinical Care for At Risk Populations
- Performance on these quality measures serves as the basis for assessing, benchmarking, rewarding and improving ACO quality performance.
    - Complete and accurate reporting in the first year qualifies the ACO to share in the maximum available quality sharing rate.
    - Pay-for-performance is phased in for the remaining performance years.
    - Incomplete reporting may result in a compliance action such as a corrective action or termination.
    - Shared savings payments are linked to quality performance on a sliding scale so that high performing ACOs receive a higher sharing rate.

# Quality Reporting

- Understand your reporting responsibilities:
  - Identify individuals in your organization who should receive notifications regarding quality reporting, CMS system access, and compliance.
  - Complete and accurate reporting
  - Select a vendor to administer the patient experience of care (CAHPS for ACOs) survey.
- Prepare for quality reporting ***now*** by:
  - Securing providers' commitment to quality reporting.
  - Educating your providers about the role they have in helping the ACO succeed in quality reporting.

# Financial Performance

- ACOs demonstrate savings if the actual assigned patient population expenditures are below the established benchmark **and** by an amount (percentage of updated benchmark) that meets or exceeds the minimum savings rate (MSR).
- The MSR takes into account normal variations in expenditures.
- Under the one-sided model, the MSR varies based on the size of the ACO's population.
- Under a two-sided model, ACOs select a symmetrical MSR/MLR during the application process that is applied throughout the agreement period (selection may not be changed during agreement period).

# Financial Performance – Program Tracks Performance Years 2016 and Onward

| | One-Sided Risk Model | Two-Sided Risk Model | Two-Sided Risk Model |
|---|---|---|---|
| **Issue** | **Track 1** | **Track 2** | **Track 3** |
| Assignment | Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation | Same as Track 1 | Prospective assignment for reports, quality reporting and financial reconciliation |
| Final Sharing Rate | Up to 50% based on quality performance | Up to 60% based on quality performance | Up to 75% based on quality performance |
| Minimum Savings Rate | 2.0% to 3.9% depending on number of assigned beneficiaries | Choice of symmetrical MSR/MLR:<br>(i) no MSR/MLR;<br>(ii) symmetrical MSR/MLR in 0.5% increment between 0.5% - 2.0%;<br>(iii) symmetrical variable MSR/MLR based on number of assigned beneficiaries (as in Track 1) | Same as Track 2. |
| Minimum Loss Rate | Not applicable | See options under MSR | See options under MSR |
| Performance Payment Limit | 10% | 15% | 20% |
| Shared Savings | First dollar sharing once MSR is met or exceeded | Same as Track 1 | Same as Tracks 1 and 2 |
| Shared Loss Rate | Not applicable | One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate may not be less than 40% or exceed 60% | One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate may not be less than 40% or exceed 75% |
| Loss Sharing Limit | Not applicable | Limit on the amount of losses to be shared phases in over 3-years starting at 5% in year 1; 7.5% in year 2; and 10% in year 3 and any subsequent year. Losses in excess of the annual limit would not be shared | 15%. Losses in excess of the annual limit would not be shared |
| Payment and Program Rule Waivers under Part 425 | Not applicable | Not applicable | ACOs may elect to apply for a waiver of the SNF 3-Day Rule (applicable PY2017 & subsequent years) |

# Interagency Coordination

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

- Federal Trade Commission (FTC) and Department of Justice (DOJ): Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program
- Internal Revenue Service (IRS): Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations
- Office of the Inspector General (OIG) and CMS: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center Interim Final with Comment

# Accountable Care Organizations, Organizational Structure and Governance

# What is an ACO?

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

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

# Shared Savings Program: Statutory Requirements for Organization Structure

By statute, ACOs must meet the following eligibility criteria:

- Have a formal legal structure to receive and distribute payments
- Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems

# Shared Savings Program: ACO Structure

## Most Common ACO Structure

**ACO (TIN)**

- ACO Legal Entity (ACO 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.<br>• The ACO is a separate legal entity from the ACO Participants.<br>• Submit sample ACO participant agreement and all executed ACO participant agreements. |
| **Single TIN ACO** | • The ACO is comprised of one ACO Participant.<br>• The ACO and ACO Participant are the same legal entity.<br>• This structure does not permit participation of other ACO participants.<br>• 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.<br>• The ACO and ACO participant are different legal entities.<br>• This structure allows the ACO to add ACO participants in the future.<br>• Submit sample ACO participant agreement and executed ACO participant agreement. |

# ACO Organization Structures (cont.)

- The next slide is to help ACO's understand their organization structure and how it applies to the Shared Savings Program application.

- The slide summarizes the ACO structure requirements and correlates the requirements to the application questions (refer to the sample application posted on the Shared Savings Program website).

- We will also review the next slide in our June webinars.

# 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*** (employed TINs) | 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*** (contracted TINs) | NO | N/A | NO | NO | Must submit sample ACO provider/supplier agreement | YES | N/A - SKIP |
| 2 - Single TIN ACO **C*** (employed & contracted TINs) | NO | N/A | NO | Yes – Must submit a copy of the employment agreement | 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<br><br>TIN Legal Name & ACO participant TIN on the ACO Participant List must be different |

# Statutory Requirements: Governance & Leadership

- Identifiable Governing Body with ultimate authority to execute the functions of your ACO
  - Same governing body of the legal entity that is the ACO
  - Separate and unique to the ACO and must not be the same as the governing body of any ACO participant for ACOs that comprises two or more ACO participants
  - Responsibility for oversight and strategic direction of the ACO
  - Transparent governing process
  - Members have a fiduciary duty to the ACO, including the duty of loyalty, and must act consistent with that fiduciary duty

# Statutory Requirements: Governance & Leadership

- Shared governance through a governing body with representation by ACO participants and beneficiaries
  - ACO participant representation
  - ACO participants hold at least 75% control of the governing body
  - Beneficiary on the governing body
  - Flexibility for organizations to meet requirements
- Demonstrate an organizational commitment, leadership, and resources necessary to achieve the three-part aim and demonstrate clinical integration
  - Experienced leadership team
  - Medical Director
  - Qualified health professional to lead the quality assurance/improvement process

# Skilled Nursing Facility 3-Day Waiver Application (Track 3 ACOs Only)

# SNF 3-Day Waiver: Background

## What is the SNF 3-day rule?

- The Medicare skilled nursing facility (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(i) 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.

## What is covered by the SNF 3-Day waiver?

- Promulgated in the June 2015 Final Rule (42 CFR 425.612).
- 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 of stay of less than 3 days.
- 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 skilled nursing and/or rehabilitation care without a 3 day prior inpatient hospitalization.

# SNF 3-Day Waiver: Eligibility

## ACOs Eligible to Apply

- Any Track 3 ACO
- You must complete the Notice of Intent to Apply for the SNF 3-day waiver

## Medicare Beneficiaries

- Aligned to a Track 3 ACO
- Admitted to a SNF at the direction of a Track 3 ACO provider
- Meet the regulation requirements at 42 CFR 425.612(a)(1)(ii)

## SNFs Eligible for the Waiver

- SNFs included on the ACO SNF affiliate list who have agreed to partner with the ACO to implement the SNF 3-day waiver by signing a SNF affiliate agreement.
- SNFs with a quality rating of 3 or more stars under the CMS 5-Star Quality Rating System as reported on the Nursing Home Compare website.
- SNF affiliates may partner with more than one Track 3 ACO.

# SNF 3-Day Waiver: Application

The SNF 3-Day Waiver Application must be submitted separately from your Initial Application.

- Both your Initial Application and SNF 3-Day Waiver Application are evaluated during the same time period.
- If you choose to apply to the waiver, you are required to respond to application requests for both applications during the same timeline.

SNF 3-Day Waiver Application requires you to submit materials including, but not limited to:

- Attestations and narratives
- SNF affiliate list that includes SNF affiliates with whom the ACO will partner
- SNF affiliate agreements for each SNF affiliate that appears on the list.
- Documentation showing 3 or higher on the CMS 5-star Quality Rating System, as reported on the Nursing Home Compare Website

# Antitrust and ACOs

Patrick Kuhlmann, Attorney, Antitrust Division,
U.S. Department of Justice

Rob Canterman, Attorney
Federal Trade Commission

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

# Key Antitrust Issues for ACOs

- Antitrust agencies recognize many ACOs are procompetitive and may benefit patients by improving quality of care and lowering costs.

- But, under certain conditions, ACOs may raise antitrust concerns, and participation in the MSSP does not confer antitrust immunity.

  - Price-fixing
    - Agreements among competing providers on price or other competitive terms not part of a legitimate provider joint venture.
    - Improper sharing of competitively sensitive information among competing ACO participants could facilitate collusion in providing services outside ACO.

  - Monopolization
    - Power profitably to raise prices above competitive level or reduce output, and exclusionary or other anticompetitive conduct to achieve or maintain power.

  - Mergers
    - Consolidations that may lessen competition in a relevant market.

# FTC/DOJ Antitrust Enforcement Policy Statement

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

# Key Application Webinars

| Webinar Topic | Date | Time |
|---|---|---|
| Medicare Shared Savings Program ACO: Preparing to Apply to Become an ACO (Audience: initial applicants) | 4/5/16 | 1:30 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO: Application Process - ACO Agreements, Participation List, and Assignment (Audience: initial applicants, registration required) | 4/19/16 | 1:30 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO: Renewing Your Agreement for 2017 (Audience: renewal applicants) | 5/3/16 | 1:00 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO: Initial Application Submission Review (Audience: initial applicants) | 6/7/16 | 1:00 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO: Renewal Application Submission Review (Audience: renewal applicants) | 6/9/16 | 1:00 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO: SNF 3-Day Waiver Application Submission Review (Audience: Track 3 SNF 3-Day Waiver applicants) | 6/13/16 | 1:00 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO: Training on the Health Plan Management System (HPMS) ACO Application Module (Audience: all applicants) | 7/12/16 | 1:00 p.m.-3:00 p.m. Eastern Time |
| Medicare Shared Savings Program ACO Application Q&A Session (Audience: all applicants) | 7/14/16 | 1:00 p.m.-3:00 p.m. Eastern Time |

# Application Process – January 2017 Starters

Karmin Jones
Technical Advisor
Division of Application, Compliance & Outreach
Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services

# Before Submitting Your Application

- Prior to submitting an application, you should:
  - Establish your organizational structure
  - Establish your governance and leadership structure
  - Prepare:
    - Sample participant agreement for submission with application
    - Worksheet listing all your ACO participants (not required for submission)
    - If Track 3 ACO applying for the SNF 3-Day Waiver – you will also need a sample agreement for your SNF affiliates
  - Ensure all participant agreements meet requirements, are finalized and signed by both parties (and SNF affiliate agreements if applying for the SNF 3-Day Waiver)
  - Begin establishing your repayment mechanism, **only for 2-sided performance based risk tacks (Tracks 2 and 3)**

# Application Submission Process

- Key Application Webinars
- Notice of Intent to Apply and Application Deadlines
- Step 1 – Submit Your Notice of Intent to Apply (NOIA)
- Step 2 – Obtain a CMS User ID
- Step 3 – Submit Your Application
  - Application Toolkit
  - Banking Information

# Application Cycle: Deadlines to Apply for Program Year 2017

| Notice of Intent to Apply Process | Deadlines |
|---|---|
| NOIA Memo Posted to CMS Website (provides detailed information on the requirements for submitting a NOIA) | April 1, 2016 |
| NOIA Submission Period | May 2, 2016 – May 31, 2016 |
| **NOIA Deadline** | **May 31, 2016 at 5:00 pm Eastern Time** |
| CMS User ID Forms Submission Period (new users only) | May 5, 2016 – June 3, 2016 |
| **Application Process** | **Deadlines** |
| 2017 Application Form Posted on CMS Web site (sample only for all applications*) | Spring 2016 |
| Applications Submission Period (for all applications*) | July 1, 2016 – July 29, 2016 |
| **Applications Due (for all applications*)** | **July 29, 2016 at 5:00 pm Eastern Time** |
| Application Approval or Denial Decision Sent to Applicants | Fall 2016 |
| Reconsideration Review Deadline | 15 Days from Notice of Denial |

*Note: The SNF 3-Day Waiver application is available to initial applicants, current ACOs requesting to renew their agreement, and current ACOs. Your ACO must be applying for the two-sided risk model under Track 3 or already in Track 3 to be eligible to apply for the SNF 3-Day Waiver.

# Step 1 – Submit A Notice of Intent to Apply

- The first step in the application process is to submit a Notice of Intent to Apply (NOIA) to the Medicare Shared Savings Program
- We posted the NOIA Memo on the How to Apply Web site on April 1, 2016.
- NOIA Process:
  - Complete NOIA questionnaire starting May 2, 2016 and submit by **May 31, 2016 at 5:00pm Eastern Time**
  - You will get a confirmation notice e-mail containing your ACO ID and instructions on how to complete CMS Form 20037 Application for Access to CMS Computer Systems in order to obtain a CMS User ID.
    - You must have an ACO ID and CMS User ID to access the Health Plan Management System (HPMS) to complete the application.
    - No Paper Applications are accepted.
  - Submitting an NOIA **does not** require you to submit an application for the 2017 program start date.

# Step 2 – Obtaining a CMS User ID

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

    CMS
    Attention: HPMS Access
    7500 Security Boulevard
    Mail Stop: C4-18-13
    Baltimore, MD 21244-1850
  - It takes 3-4 weeks to process the requests. **Submit the form(s) immediately upon receiving your NOIA confirmation notice E-mail.**
  - CMS Form 20037 is due no later than **June 3, 2016**.

# Individuals with Existing CMS User IDs

- CMS User IDs are unique to the individual, not the ACO.
- For a user that already has a CMS ID and you want to add that user to your ACO, an ACO authorized contact must send an email to HPMS_Access@cms.hhs.gov that includes the following*:
  - The User's name and existing CMS issued User ID.
  - The ACO Legal Business Name and CMS Issued ACO ID(s) that the user needs access to.
  - A statement that authorizes the user to gain access to the ACO's data maintained in CMS systems.

*Refer to the **HPMS User ID Process** web page for additional guidance. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/UserIDProcess.html

# Existing CMS User IDs for Consultants

- For a Consultant that already has a CMS ID needing access to your ACO, the ACOs authorizing official must submit an email to HPMS_Access@cms.hhs.gov including*:
  - A .pdf letter on ACO letterhead that authorizes the consultant to gain access to the ACO's data maintained in CMS systems.
  - Clearly indicate the consultant's name, role, and CMS issued User ID.
  - ACO Legal Business Name and CMS Issued Identification Number(s) (ACO ID) the User is authorized to access.
  - If multiple users from the same consulting firm are authorized to gain access, include all names, roles, and User IDs.
  - If the consultant is working with multiple ACOs, one letter is required from each ACO. These .pdf letters can be attached in one email.
  - Letter must be signed by the ACO's authorizing official.

*Refer to the **HPMS User ID Process** web page for additional guidance. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/UserIDProcess.html

# Fraudulent Use of CMS User IDs

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

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

# Step 3 – Submit Your Application

- The 2017 Sample Applications will be posted on the How to Apply Web page in the Spring of 2016. Application forms include:
  - Initial Application for the Shared Savings Program
  - SNF 3-Day Waiver Application (Track 3 ACOs only)

- All 2017 applications are accepted July 1 through July 29, 2016. The deadline is at 5:00pm Eastern Time.

- Track 2/3 applicants must submit and execute a repayment mechanism as part of the application process.

- You may review the 2016 Application materials on the How to Apply Web page for reference until the 2017 Application is posted.

# Application Toolkit

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

# Banking Information

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

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

- **Applications are incomplete without CMS Form 588**

# Recap Important Application Steps

- Act early and do not wait until the deadlines
- Attend the webinars for important information about the application process
- Ensure your participant agreements meet all SSP requirements to save resources from having to revise/resign the agreements
- List at least 4 contacts for your ACO (Primary and Secondary Application Contacts and Primary and Secondary IT Contacts)
- Include ACO ID number and legal business name on all correspondence to CMS
- Never share CMS User IDs and passwords
- Contact CMS: SSPACO_Applications@cms.hhs.gov if you have any questions about the application process

# Upcoming Application Calls

- **April 19: Shared Savings Program ACO Application Process - ACO Agreements, Participant List, and Assignment**
  - Topics
    - Beneficiary assignment
    - Participant List
    - Agreements between ACOs and providers
  - Registration information and complete call details

- **Save the date:**
  - June 7: 2017 Initial Application Submission Review
  - June 13: SNF 3-Day Waiver Application Submission Review
  - July 12: Training on HPMS ACO Application Module Submission
  - July 14: ACO Application Question & Answer Session

# Contacts for Assistance

Shared Savings Program Application Web site

For NOIA 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

# Evaluate Your Experience

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

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

# Thank You

- For more information about the MLN Connects® National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html.

- For more information about the Medicare Learning Network®, please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.