MLN Connects®

National Provider Call

Medicare Shared Savings Program Application Process:

ACO Participant Agreements, Participant List & Assignment: Preparing to Apply for 2017

April 19, 2016

Presented by:

Centers for Medicare & Medicaid Services
RTI International

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Agenda

- Highlights from the April 5, 2016 NPC
- SNF Affiliate List and Affiliate Agreements (Track 3 Only)
- ACO Participant Agreements
- ACO Participant List
- Beneficiary Assignment

Highlights from the April 5, 2016 MLN Connects NPC

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Shared Savings Program: Background

- Shared Savings Program Web site: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
- 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=9cbc79f8103dc645357413699l2f044f&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 at 42 CFR Part 425; Comment Deadline March 28, 2016

Note: The 2014 and 2015 Physician Fee Schedule rules also have certain quality measurement, reporting, and scoring provisions, as well as some beneficiary assignment related 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:

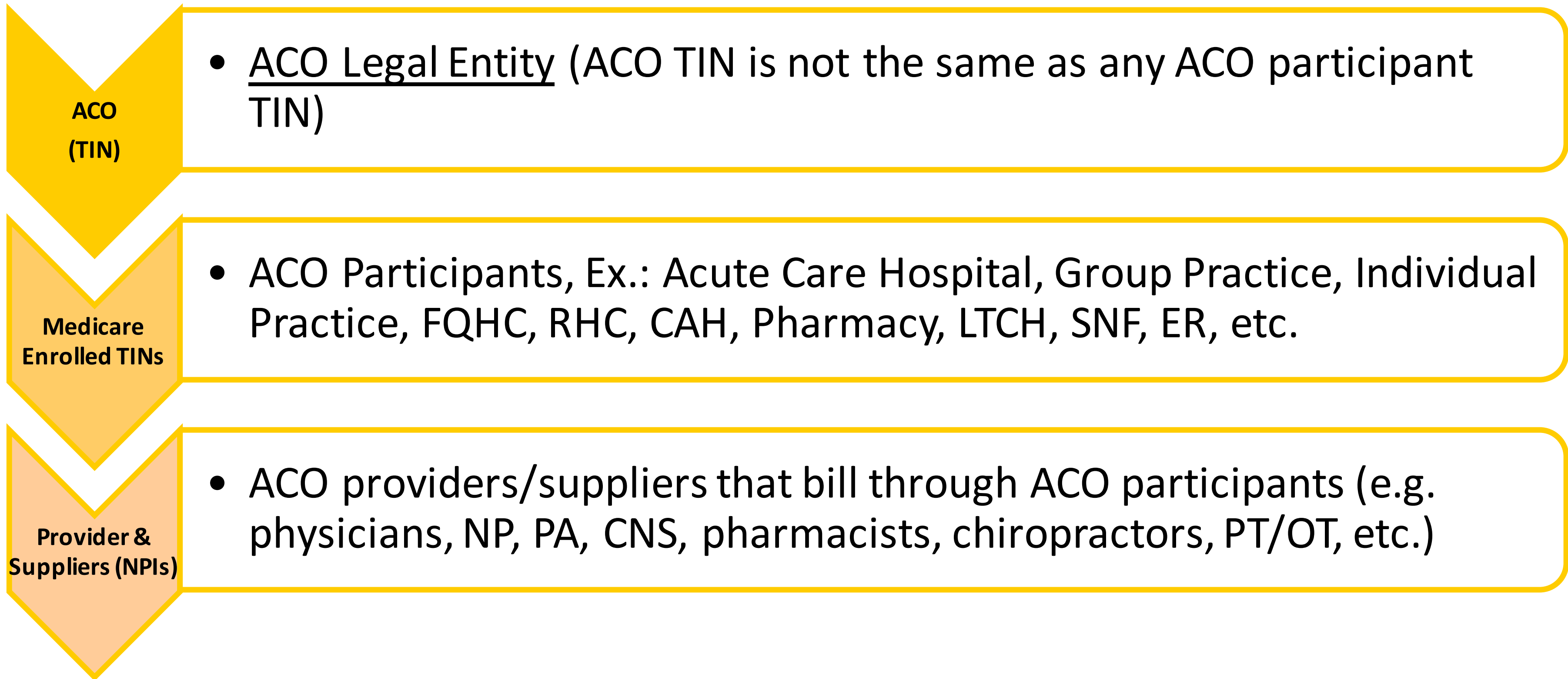
An individual who is Medicare-enrolled and bills for items and services furnished to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations.

Shared Savings Program: 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)

Shared Savings Program: ACO Structure

Most Common ACO Structure



ACO Organization Structures

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

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)	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 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.

Shared Savings Program: Application Submission

- ACOs must submit a Notice of Intent to Apply (NOIA) to submit an Initial Application and Skilled Nursing Facility (SNF) 3-Day Waiver Application (Track 3 ACOs only). A NOIA submission does not bind an organization to submit an application. However, you must submit a NOIA to be eligible to submit an application for the January 1, 2017 program start date.
  - See the NOIA memo on our website for further instructions - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Application.html

- ACOs will submit their application electronically through the Health Plan Management System (HPMS).

- HPMS is also used to manage your ACO's legal entity information (e.g. legal business name, business address, and ACO Tax Identification Number (ACO TIN) and) and your ACO's contact information.

SNF Affiliate List and Affiliate Agreements (Track 3 ACOs Only)

SNF 3-Day Rule 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.
- According 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 Rule Waiver?

- Described 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 Rule Waiver: Eligibility

ACOs Eligible to Apply

- Any Track 3 ACO, and
- Must complete the NOIA for the SNF 3-Day Rule Waiver

Medicare Beneficiaries

- Aligned to a Track 3 ACO,
- Admitted to a SNF at the direction of a Track 3 ACO provider, and
- 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 Rule 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, and
- SNF affiliates may partner with more than one Track 3 ACO

SNF 3-Day Rule Waiver: SNF Affiliate List

- If you apply for the waiver, you must submit a SNF Affiliate List with your SNF 3-Day Waiver application
- The SNF Affiliate List must include all of the SNF facilities that your ACO plans to partner with under the SNF 3-Day Rule Waiver and will need to include all of the below identifiers, per SNF Affiliate:
  - TIN
  - TIN Legal Business Name
  - CMS Certification Number (CCN)
  - CCN Legal Business Name
- SNFs on the SNF Affiliate List are not required to also appear on an ACOs' Participant List, however, if they do, you must add them separately to the SNF Affiliate List and ACO Participant List.

SNF 3-Day Rule Waiver: SNF Affiliate Agreements

- ACOs must execute a SNF Affiliate Agreement with each SNF on its SNF Affiliate List and submit the executed agreements to CMS

- 42 CFR Part 425.612 requires that, among other things, the SNF Affiliate Agreement **must:**
  - Expressly require that the SNF Affiliate agrees to the requirements and conditions of the SNF Waiver, including but not limited to those specified in the participation agreement with CMS.
  - Include the effective dates of the SNF Affiliate Agreement.
  - Expressly require the SNF Affiliate to implement and comply with the ACO's beneficiary evaluation and admission plan and the care management plan.
  - Expressly require the SNF Affiliate to validate the eligibility of a beneficiary to receive covered SNF services in accordance with the waiver prior to admission.
  - Permit the ACO to take remedial action and penalties against the SNF Affiliate to address non-compliance with the requirements of the Shared Savings Program and other program integrity issues, including those identified by CMS.

SNF 3-Day Rule Waiver: SNF Affiliate Agreements Suggested Elements

- We recommend the SNF Affiliate Agreements also include the following:
  - A direct agreement between the ACO and the SNF Affiliate
  - Signed on behalf of the ACO and the SNF Affiliate by individuals who are authorized to bind the ACO and the SNF Affiliate, respectively
  - Legal business names of the parties on the agreement match HPMS and the SNF Affiliate List
  - Executed agreements match the approved sample SNF Affiliate Agreement

SNF Affiliate CMS 5-Star Rating

- Along with your executed SNF Affiliate Agreement, you must provide documentation demonstrating that each SNF affiliate has an overall rating of 3 or higher under the CMS 5-star Quality Rating System.
- You can find the CMS 5-star Quality Rating System through Nursing Home Compare.
- You will upload your star rating documentation along with your executed SNF Affiliate Agreement in HPMS.
- **June 13, 2016** call will be specific to the SNF 3-Day Waiver and application. All Track 3 ACOs and applicants choosing to apply under Track 3 are encouraged to attend this webinar if they are interested in the 3-Day SNF Waiver.

ACO Participant Agreements

ACO Participant Agreements

- Reference 2015 Final Rule 42 CFR 425.204, 425.210
- Reference ACO Agreement and ACO Participant List Guidance in the Application Toolkit*
- Do not include ACO participant TIN on your ACO Participant List without a signed ACO Participant Agreement
- ACO must confirm that **all** ACO provider/suppliers have also agreed to participate

* The 2016 Application toolkit is available on our Web site for reference. The 2017 Application Toolkit will be posted later this spring

ACO Participant Agreements: Key Points

- Must be between the ACO legal entity and ACO participant legal entity
- Must be **direct** (no third party intermediary)
- No letters of intent
- Each agreement should clearly identify the parties entering into the agreement, the agreement date, and length of agreement
- Must clearly state the correct legal business name of both the ACO (as indicated in HPMS) and ACO participants (as indicated in the Provider Enrollment Chain and Ownership System, or PECOS)

ACO Participant Agreements: Required Elements

- Expressly state the only parties to the agreement are the ACO and the ACO participant. §425.116
- Signed on behalf of the ACO and the ACO participant by individuals who are authorized to bind the ACO and the ACO participant, respectively. §425.116
- Expressly require that the ACO participant agrees, and asserts that each ACO provider/supplier billing through the TIN of the ACO participant agrees, to participate in the Medicare Shared Savings Program and will comply with the requirements of this Program and all other applicable laws and regulations (including, but not limited to, those specified in 42 CFR Part 425, the participation agreement with CMS, federal criminal law, False Claims Act, anti-kickback statute, civil monetary penalties law, and physician self-referral law). §425.116

ACO Participant Agreements: Required Elements (cont.)

- Set forth the ACO participant's rights and obligations in, and representation by, the ACO, including without limitation, the quality reporting requirements set forth in 42 CFR Part 425, the beneficiary notification requirements in §425.312, and how participation in the Shared Savings Program affects the ability of the ACO participant and its ACO providers/suppliers to participate in other Medicare demonstration projects or programs that involve shared savings. §425.116

- Describe how the opportunity to receive shared savings or other financial arrangements will encourage the ACO participant (and ACO providers/suppliers) to adhere to the quality assurance and improvement program and evidence-based medicine/clinical guidelines established by the ACO. §425.116

- Require the ACO participant to update its Medicare enrollment information, including the addition and deletion of ACO professionals and ACO provider/suppliers billing through the TIN of the ACO participant, on a timely basis in accordance with Medicare program requirements and to notify the ACO of any such changes within 30 days after the change. §425.116

ACO Participant Agreements: Required Elements (cont.)

- Permit the ACO to take remedial action against the ACO participant, and must require the ACO participant to take remedial action against its ACO providers/suppliers, including imposition of a corrective action plan, denial of incentive payments, and termination of the ACO participant agreement, to address non-compliance with the requirements of the Medicare Shared Savings Program and other program integrity issues, including those identified by CMS. §425.116

- A term of at least one performance year and must articulate potential consequences for early termination from the ACO. §425.116

- Completion of a close-out process upon termination or expiration of the agreement that requires the ACO participant to furnish all data necessary to complete the annual assessment of the ACO's quality of care and addresses other relevant matters. §425.116

ACO Participant Agreements: Suggested Elements

- Statement to comply with all relevant statutory and regulatory provisions regarding the appropriate use of data including the HIPAA Privacy Rule, HIPAA Security Rule and the terms of the ACO's Data Use Agreement with CMS.

- Statement that the ACO participant must confirm that PECOS is correct and current.

ACO Participant Agreements: Examples

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

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

ACO Participant Agreements: Examples

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

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

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

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

Tips for Executed Participant Agreements

- Confirm the executed agreements must match the approved sample agreement.
- Confirm the ACO's start date in the Medicare Shared Savings Program is correct
  - If the ACO's start date is January 1, 2017 the agreement should refer to a January 1, 2017 ACO start date.
- Confirm the ACO legal business name matches the name in the Basic Agreement Data page in HPMS.

Tips for Executed Participant Agreements (cont.)

- Confirm the ACO participant legal business name matches the legal business name in the Provider, Enrollment, Chain and Ownership System (PECOS).
  - Note, Medicare Fee-For-Service public provider enrollment data is now available at https://data.cms.gov/public-provider-enrollment
- Confirm the ACO participant TIN matches PECOS.
- Confirm that the ACO participant TIN is correctly entered into the HPMS Participant List Management module change request, and correctly presented on the executed agreement.

Tips for Executed Participant Agreements (cont.)

- Confirm the individual who signs for the ACO is listed in the Contact Data page in HPMS as the ACO Executive, Authorized to Sign Primary or Authorized to Sign Secondary.
- Confirm any changes to the executed agreement include both parties' initials.
- Do not submit agreements that were executed or have an effective date more than one year before the change request was entered into HPMS
  - Example: If the ACO Participant Agreement effective date is August 1, 2015 the change request must be submitted by July 31, 2016.

Common Errors to Avoid

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

ACO Participant List

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ACO Participant List

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

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

- Once approved, CMS uses the ACO Participant List to:
  - Assign beneficiaries to the ACO
  - Establish the historical benchmark
  - Perform financial reconciliation
  - Determine a sample of beneficiaries for quality reporting
  - Coordinate participation in the Physician Quality Reporting System under the Shared Savings Program
  - Monitor the ACO for program integrity issues

Merged and Acquired TIN

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

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

Merged or Acquired TIN (cont.)

- Merged or acquired TINs are not ACO participants
  - A merged or acquired TIN cannot execute a participant agreement with the ACO since the entity no longer exists
  - Instead, the ACO applicant must submit other supporting documentation, such as a bill of sale (see Application Toolkit for more information)

Medicare Identification Numbers

- ACO participant TINs are used to identify claims from qualifying physician and non-physician practitioner practices.

- CMS Certification Numbers (CCNs) are needed to identify the following entities in claims:
    - Federally Qualified Health Centers (FQHCs)
    - Rural Health Clinics (RHCs)
    - Method II Critical Access Hospitals (CAHs)
    - Electing Teaching Amendment (ETA) hospitals

- RHCs and FQHCs also must submit attestation lists for the physicians providing direct primary care services. Any M.D. or D.O. specialty may appear on an FQHC/RHC attestation list.

ACO Participant List Requirements

Required Fields for most ACO Participants:

- ACO participant TIN
- ACO participant legal business name (verified by PECOS)
- Merged or acquired TIN? Y or N

CAH and ETA Participants

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

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

FQHC and RHC Participants

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

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

Evaluation

CMS evaluates the ACO Participant List to:

- Verify that your ACO would have at least 5,000 assigned beneficiaries in each of the benchmark years
- Verify that ACO participants meet program requirements:
  - TIN is enrolled in Medicare
  - Information matches Medicare enrollment information
  - TIN is not participating in another Medicare initiative involving shared savings
- Screen the ACO participants and ACO providers/suppliers for program integrity history

Medicare Revalidation Requirements

- The Shared Savings Program requires all ACO Participants to be enrolled in Medicare (§425.20)
- The most efficient way to submit revalidation information is by using the Internet-based PECOS on the CMS Website
- A listing of all currently enrolled provider/suppliers is now available
- Using the Medicare Revalidation Lookup Tool, you can search for a provider/supplier by last name, first name, organization name, or by NPI, or download a list of revalidation dates
- For more information on provider/supplier revalidation, please visit the CMS Revalidation webpage or have the provider/supplier contact their Medicare Administrative Contractor (MAC)

Changes to ACO Participant List

- Once accepted into the Shared Savings Program, an ACO must maintain, update, and annually submit the ACO Participant List before the start of any given performance year.
- ACO Participants are considered to be participating in the program for the duration of the performance year.
- ACOs must tell CMS within 30 days of a change to their ACO participants (effective for the subsequent performance year) or ACO providers/suppliers.
- Changes to ACO participants after the start of the agreement period affect some program operations (Refer to the Changes in ACO participants and ACO providers/suppliers during the Agreement Period Web page)

Beneficiary Assignment

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Beneficiary Assignment

- In the Shared Savings Program, beneficiaries are assigned to ACOs using a claims-based attribution methodology.
- In order to be in the Shared Savings Program, an ACO needs to have at least 5,000 preliminarily assigned beneficiaries in each of the three years preceding the start of the agreement (performance) period.
- A beneficiary assigned in one time period of the program may or may not be assigned to the same ACO in the following or preceding time periods.

Types of Beneficiary Assignment

- There are two basic types of beneficiary assignment:
  - Preliminary Prospective with Retrospective Reconciliation (Tracks 1 and 2)
  - Prospective (Track 3)

- In both cases, a beneficiary is assigned to the ACO that provides a plurality of primary care services to the beneficiary.

Retrospective Assignment (Tracks 1 & 2)

- For Tracks 1 and 2, we have preliminary prospective assignment with final retrospective beneficiary assignment.

- After the completion of a performance year, beneficiaries for Tracks 1 and 2 are retrospectively assigned using claims from the performance year.

- However, in order to establish benchmark year counts and produce quarterly reports, beneficiaries are preliminarily assigned to Track 1 and 2 ACOs using claims from assignment windows prior to the performance year.

Prospective Assignment (Track 3)

- A beneficiary is assigned to an ACO prior to the start of any given performance year.
- Track 3 ACOs' performance is assessed on their prospectively assigned beneficiaries.
- The performance of Track 3 ACOs is not assessed on beneficiaries who were not prospectively assigned, even if they received the plurality of their primary care from the ACO during the performance year.

Resources Used in Beneficiary Assignment

- Both prospective and retrospective beneficiary assignment use the same algorithm and resources for assigning beneficiaries to ACOs.
- CMS uses paid claims submitted to Medicare for primary care services in the assignment process.
- CMS uses information your ACO submitted and certified on the ACO Participant List to determine which claims to attribute to your ACO.

Beneficiary Eligibility

A beneficiary is eligible to be assigned to an ACO if the following criteria are satisfied during the assignment window. The beneficiary must:

- Have a record of Medicare enrollment
- Have at least one month of Part A and Part B enrollment, and cannot have any months of only Part A or only Part B
- Not have any months of Medicare group (private) health plan enrollment
- Reside in the United States including Puerto Rico & Territories
- Have a primary care service with a qualified physician at the ACO
  - ACO physician used in assignment
  - A physician on an FQHC/RHC attestation list

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 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.

Provider Types Used in Assignment – Step 1

- Primary Care Physicians (PCP)
  - Internal Medicine
  - Family Practice
  - General Practice
  - Geriatric Medicine
  - Pediatric Medicine

- Selected non-physician practitioners (NPP)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialist (CNS)
  - Physician Assistant (PA)

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.

Professionals Used in Assignment – Step 2

- Step 2:
  - Cardiology
  - Osteopathic manipulative medicine
  - Neurology
  - Obstetrics/gynecology
  - Sports medicine
  - Physical medicine and rehabilitation
  - Psychiatry
  - Geriatric psychiatry
  - Pulmonary disease
  - Nephrology
  - Endocrinology
  - Multispecialty clinic or group practice
  - Addiction medicine
  - Hematology
  - Hematology/oncology
  - Preventive medicine
  - Neuropsychiatry
  - Medical oncology
  - Gynecology/oncology

FQHC/RHC Physician Attestation

- 1899 (c) of the Act requires assignment to be based on services furnished by physicians.
- FQHC/RHC claims contain limited data on the type of practitioner providing a service. We know who is responsible for the overall care, not necessarily who provided the care.
- We use the ACO Participant List in combination with claims data to identify the provider who furnished services.

Attestation List

- Required only for FQHCs and RHCs that belong to ACOs.
- The list is comprised of physicians who deliver direct primary care services (PCS) at FQHCs and RHCs.
- Should include not only physicians who currently provide PCSs but also those who delivered PCSs during the assignment window
  - For new ACO applicants, the assignment period is the 3 benchmark years prior to the July application period
  - For all other assignment runs, the assignment period is the preceding 12 months

Definition of Primary Care Services

- Evaluation & Management Services provided at:
    - Office or Other Outpatient settings (CPT 99201 –99215)
    - Nursing Facility Care settings (CPT 99304 -99318, excluding claims including the POS 31 modifier)
    - Domiciliary, Rest Home, or Custodial Care settings (CPT 99324 -99340)
    - Home Services (CPT 99341-99350)
    - Chronic care management services (CPT 99490)
    - Transitional care management services (CPT 99495-99496)
    - Hospital Outpatient Clinic (G0463) for ETA hospitals only
- Wellness Visits (HCPCS G0402, G0438, G0439)
- Clinic visits at RHC or by their providers in selected settings (UB revenue center codes 0521, 0522, 0524, 0525)

Notes for Following Examples

Organizational ID

- All TINs and CCNs on an ACO's Participant List are associated with the ACO's ID number
- TIN or CCN for non-ACO practices and providers

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

PRE-STEP: Identifying Eligible Beneficiaries (Beneficiaries who had Contact with an ACO)

Beneficiary	ACO	Specialty Type	Eligible for Assignment?
A1	A9999	PCP	Yes
A1	A9999	ACO Professional-Cardiologist	Yes
A2	A9999	NPP	No
A2	A9999	Surgeon (Table 5 exclusion)	No
A3	A9999	FQHC/RHC attested physician	Yes
A3	A9999	NPP	No
B1	A5656	Pathologist (Table 5 exclusion)	No
B2	A9999	Urologist (Table 5 exclusion)	No
B3	A5656	ACO Professional-Cardiologist	Yes
B3	A9999	PCP	Yes
B3	A9999	NPP	No

Beneficiary Assignment: Example 1

		Allowed Charges for Primary Care Services	
Beneficiary	**Organizational ID**	**PCP, NPP or FQHC/RHC ACO Professional**	**Physician in Step 2**
A1	A9999	$454	$654
A1	555555555	$300	$1,900
A1	456565656	$250	$2,500

Beneficiary A1 is assigned to ACO A9999 (Step 1) because A9999 had the highest allowed charges for primary care services provided by a primary care physician, NPP, or FQHC/RHC ACO Professional ($454) even though two other non-ACO practices had higher allowed charges provided by physicians used in Step 2.

Beneficiary Assignment: Example 2

		Allowed Charges for Primary Care Services	
Beneficiary	**Organizational ID**	**PCP, NPP, or FQHC/RHC ACO Professional**	**Physician in Step 2**
B3	333333333	$1,200	$1~~.~~,250
B3	A5656	$800	$800
B3	A9999	$600	$700

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

Beneficiary Assignment: Example 3

		Allowed Charges for Primary Care Services	
Beneficiary	**Organizational ID**	**PCP, NPP, or FQHC/RHC ACO Professional**	**Physician in Step 2**
A3	A9999	$0	$300
A3	555555555	$0	$250
A3	333333333	$0	$200

Beneficiary A3 did not receive any primary care services from a primary care physician, NPP, or FQHC/RHC ACO professional. So A3 is assigned to ACO A9999 on the basis of the highest allowed charges for primary care services provided by ACO physician used in Step 2 ($300).

Assigned Beneficiaries for Three Example ACOs

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

Note: A beneficiary can be excluded for more than one reason so the number of beneficiaries in each subcategory may exceed the total number of excluded beneficiaries.

ACO Professionals Affiliated with the Three Example ACOs

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

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

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

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

Type of ACO Professional	ACO A	ACO B	ACO C
Primary care physicians	26	33	33
Physicians in Step 2 (e.g., cardiologists)	16	3	43
PAs, NPs, Clinical Nurse Specialists	8	4	4

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

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