MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO Application Process Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
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1:30 pm ET

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'll now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen 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 Accountable Care Organization Application Process. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, subject matter experts cover helpful tips to complete a successful application for the Medicare Shared Savings Program.

Before we get started, I have a couple 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, click National Provider Calls and Events, then select the April 19th 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, Division Director of the Division of Application, Compliance and Outreach of Performance-Based Payment Policy Group.

Presentation

Jonathan Blanar: Thank you, Leah. Welcome to our second call for 2017 applicants for the Medicare Shared Savings Program. As Leah stated, my name is Jonathan Blanar, and I am the director of the Division of Application, Compliance and Outreach in the Performance-Based Payment Policy Group at CMS. Thank you for joining today's call and for your continued interest in the Medicare Shared Savings Program.

You will find today's agenda on slide 3. Today, we will be going over with you a quick recap from the April 5th National Provider Call, the skilled nursing facility 3-day waiver affiliate list and SNF 3-day waiver affiliate agreements, the ACO participant agreements and ACO participant list, and beneficiary assignment. And we will end with a question-and-answer session.

Highlights from the April 5, 2016, NPC

Jonathan Blanar: I will go through the next several slides at a high level since this is a review from our call on April 5th.

I am now on slide 5. Slide 5 provides you with several resources you can explore to gain an understanding of the Medicare Shared Savings Program. I'm not going to go into detail here since this was covered in the April 5th webinar, but I do encourage you to review the webinar and the transcript to learn more.

Moving on to slide 6. Slide 6 provides you with important terms and definitions. We strongly recommend that you read and understand these terms completely as you establish your ACO participant agreements and complete your application.

Slide 7. Slide 7 shows ACOs in the Medicare Shared Savings Program. They span the United States and the District of Columbia. We currently have over 430 ACOs servicing over 7.7 million Medicare beneficiaries. We also – we are also encouraged to report that a significant number of ACOs are now choosing the two-sided risk models, Track 2 or Track 3.

Slide 8 and 9. The graphics on slide 8 and 9 were explained in great detail on the April 5th call. We encourage you to review these slides as well as listen to the transcripts posted on our website. It is critical that you accurately identify your ACO structural category as this will help you answer the attestation questions in your Shared Savings Program Application appropriately.

Moving on to slide 10. Slide 10 lists the upcoming webinar topics, dates, and times. We strongly encourage you and your staff to make every effort to attend the necessary calls as these will provide you with important education and outreach sessions that will help you to prepare and submit a successful application.

The upcoming webinars that are geared toward initial applicants are the June 7th call, where we will go through the application submission process in detail, and the June 13th webinar related to the SNF 3-day waiver application. If you intend to apply as a Track 3 ACO, I encourage you to join the webinar on June 13th as we will review the SNF 3-day waiver requirements in detail and discuss that application. We will also provide a training on July 12th on how to use the Health Plan Management System, otherwise known as HPMS, to submit your application, as well as an application question-and-answer session on July 14th. All of these webinars are very helpful, and again, I encourage you to attend them if you choose to apply.

Moving on to slide 11. Slide 11 is a chart of the key dates in the Notice of Intent to Apply, also referred to that as the NOIA, and application processes. It is critical that you meet all necessary deadlines for the NOIA and the application as we will not accept any

materials beyond the deadlines. If you are unable to meet a deadline, your next opportunity to apply for the Medicare Shared Savings Program would be for a program start date January 1st, 2018.

I want to highlight a few dates in this table. The NOIA period opens on May 2nd and closes on May 31st at 5 pm eastern time. There is a NOIA memo that's posted on our How to Apply webpage that provides instructions for submitting your NOIA.

The How to Apply webpage also includes a link to a questionnaire that you will use to fill out and submit your NOIA that will be available on May 2nd. The application window will be open from July 1st through July 29th at 5 pm eastern time. I want to note that these dates are subject to change, so check our website periodically for updates.

Moving on to slide 12. Slide 12 gives you a synopsis of the application submission steps. If you have any questions regarding the application process, please send an email to sspaco_applications@cms.hhs.gov.

SNF Affiliate List and Affiliate Agreements

Jonathan Blanar: Moving on to slide 13. As I mentioned earlier, please note that we will have a more detailed call about the skilled nursing facility or SNF 3-day waiver on June 13th, 2016. However, we believe it behooves you to be aware of this option now since you will be required to submit a NOIA in May in this regard before the June webinar.

We would also like to note that only Track 3 ACOs are eligible to apply for this waiver. Track 1 and Track 2 ACOs cannot apply for the SNF 3-day waiver. If you have any interest in applying for the SNF 3-day waiver, be sure to select it when you submit your NOIA.

Moving on to slide 14. Slide 14 gives you the background about the SNF 3-day waiver in Medicare. At a high level, the SNF 3-day waiver permits Medicare payment for otherwise covered SNF services when the ACO providers/suppliers participating in eligible Track 3 ACOs admit a qualifying beneficiary to an SNF affiliate without a 3-day prior inpatient hospitalization.

Moving on to slide 15. Slide 15 describes the eligibility criteria for the SNF 3-day waiver. Both the background and eligibility requirements were discussed on our April 5th call. And as mentioned earlier, we encourage you to review those slides as well as listen to this transcript that's posted on our website.

Moving on to slide 16. Slide 16 describes the SNF affiliate list. If you apply for the waiver, you must also submit a SNF affiliate list with your SNF 3-day waiver application. This list includes SNF facilities or affiliates with whom you will partner and enter into a written agreement with.

Later this spring, we will provide you with a template, similar to the ACO participant list template, that you will use to prepare your application. We must stress, however, that these two unique lists that – these two unique lists undergo separate evaluations.

Moving on to slide 17. Slide 17 gives details regarding the elements that must appear on all SNF affiliate agreements. All ACOs applying for the SNF 3-day waiver must establish a SNF affiliate agreement with each SNF on its SNF affiliate list and submit executed agreements to CMS as part of your application. These requirements are found in our regulation at 42 CFR 425.612, and there are no exceptions to this rule.

Moving on to slide 18. We recommend that you pay particular attention to the suggested elements for SNF affiliate agreements we provide for you on this slide to help you with your application. I'm not going to read them in detail but just ask that you review them.

Moving on to slide 19. Slide 19 describes how the CMS 5-star rating is used in terms of the SNF 3-day waiver. You can find more details about this rating system through Nursing Home Compare. Remember, we will hold an indepth call regarding the SNF 3-day waiver application on June 13th, 2016. Make plans now to attend this session if you plan to apply as a Track 3 ACO and are interested in this waiver.

ACO Participant Agreements

Jonathan Blanar: Moving on to slide 21, ACO participant agreements. We are now on slide 21, and I will discuss ACO participant agreements. All ACO participants and all ACO providers/suppliers billing through the TIN of the ACO participant must agree to comply with the requirements and conditions of the program as well as all laws and regulations set forth in 42 CFR Part 425.

Before you submit your ACO participant list, you must execute an ACO participant agreement with any and all entities who will be an ACO participant in your ACO. You cannot include an ACO participant on your ACO participant list unless you have a signed ACO participant agreement. This means that someone with authority to bind the ACO participant TIN must sign the ACO participant agreement. It is your responsibility to ensure that all ACO providers/suppliers billing through the TIN of the ACO participant have agreed to participate in the ACO and comply with program rules.

Moving on to slide 22. In order to meet all of our requirements, your ACO participant agreements must follow good contracting practices. First, your ACO participant agreement must be made directly between the ACO legal entity and the ACO participant legal entity and must be signed by a person authorized to bind these legal entities. As a result, you should not use a third-party intermediary. If you do, we will require you to reexecute direct agreements or remove the ACO participant from your list.

Second, we will also not accept letters of intent. The ACO participant agreement must be a formal agreement signed by parties who have the authority to make decisions for the legal entity.

Third, each agreement should clearly identify the parties entering into the agreement, the agreement date and length as well.

Finally, it is critical that the legal business names of both the ACO legal entity and the ACO participant must be used in the agreement. If you are unsure about the name of the ACO participant's legal business name, ask the participant to give you a screenshot of their PECOS enrollment information.

Slides 23 through 25 list the required elements that must be included in your ACO participant agreement. I'm not going to read all of these requirements, but I recommend that you review them and ensure they are elements in your participant agreements.

Moving on to slide 26. We list some suggestions for additional requirements in your ACO participant agreements. For example, you might include an explicit requirement for the ACO participant and its provider/suppliers to agree to help complete quality reporting for a performance year even if the ACO participant is terminated from the ACO.
In addition, we suggest that you include an explicit requirement for the ACO participant and its providers/suppliers to comply with all relevant statutory and regulatory provisions related to the appropriate use of data. Finally, you should consider including a specific requirement for the ACO participant and each of its providers/suppliers to ensure their Medicare enrollment information in PECOS is kept up to date and is current.

Moving on to slide 27. Slide 27 provides a correct example of an ACO participant agreement found in our guidance document. 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 the program regulations. Also, all practitioners that have reassigned their billings to the TIN of a large group practice have also agreed to participate and follow program regulations. The ACO in this case may include this group practice TIN on its list of ACO participants.

Slide 28 gives two examples of agreements CMS would not approve.

The first example is a large group practice participating in an ACO. Its owner signs an agreement to participate in the program and follow program regulations. However, not all the practitioners that have reassigned their billings to the TIN of the large group practice have agreed to participate and follow program regulations. In this example, the ACO may not include this group practice TIN on its list of ACO participants.

The second example is one in which 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. The ACO may not include this group practice TIN on its list of ACO participants.

Slides 29 through 31 provide you with tips and reminders for submitting complete and accurate executed participant agreements that meet all of our requirements. Among other things, you must make sure (1) all executed agreements match the approved sample agreement that you will submit as part of your application, (2) the start and end dates are accurate, (3) legal business names as listed in the agreements match the names listed in PECOS as well as HPMS, and (4) that all executed agreements are signed by all necessary authorized officials in your ACO and your ACO participants.

Slide 32 makes you aware of some common errors that we have seen ACOs make over previous application cycles. Please review this list closely. Following these basic rules and requirements will help your ACO avoid problems during the review of your application.

I will now turn the presentation back over to our moderator, Leah. Leah?

Keypad Polling

Leah Nguyen: Thank you, Jonathan. At this time we will pause for a few minutes to complete keypad polling. Kalia, we're ready to start polling.

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 would now like to turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Kalia. I now turn the call over to Jennifer Bates from the Division of Applications, Compliance and Outreach.

ACO Participant List

Jennifer Bates: Thanks, Leah. My presentation begins on slide 34. The ACO participant list is required as part of your application. It includes information about the ACO participants and, in some cases, ACO providers/suppliers. I will discuss what information ACOs are required to provide for the participant list in a few slides. We will use the ACO participant list you submit with your application to determine your eligibility to become an ACO in the Shared Savings Program.

As Jonathan stated earlier, an ACO participant is an individual or group of ACO providers/suppliers that is identified by a Medicare-enrolled Taxpayer Identification Number, or TIN, that alone or together with one or more other ACO participants compose an ACO.

The ACO participant list is the collection of ACO participant TINs, information that we will use to determine an applicant's eligibility to become an ACO. In the case of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) participants, the ACO participant lists also include some additional pieces of information about the providers/suppliers.

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

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

Before you submit your ACO participant list, you must execute an ACO participation agreement with the entity that will be an ACO participant. Start talking with potential ACO participants early, and make sure they are aware of all the program requirements before they sign an ACO participation agreement with you.

Slide 35. A merged or acquired Taxpayer Identification Number, or TIN, is a TIN that was acquired by an ACO participant through purchase or merger. A merged or acquired TIN may be added to the ACO participant list so that we can use the information for beneficiary assignment during the historical benchmark years. The merged or acquired

TIN can be added to the ACO participant list if the ACO participant subsumed the acquired TIN in its entirety, including all the ACO providers/suppliers that billed under that TIN.

All the ACO providers/suppliers that billed through the acquired TIN must have reassigned their billing to the ACO participant TIN, and the acquired TIN must no longer be used. Providers and suppliers can use the Medicare Provider Enrollment, Chain and Ownership System, otherwise known as PECOS, to verify the information.

ACO applicants are not required to include merged or acquired TINs on their ACO participant list, but it is allowable for beneficiary assignment and benchmarking purposes.

Slide 36. It's important to note that merged and acquired TINs are not ACO participants. Since the TIN is being subsumed by another practice in its entirety, a merged or acquired TIN cannot execute a participate – participant agreement with the ACO. Therefore, the ACO applicant must submit other supporting documentation, such as a bill of sale, to provide evidence of the merger or acquisition. See the June 2015 final rule and Application Toolkit for more information about the supporting documentation.

Slide 37. ACO participant TINs are used to identify claims from qualifying physician and nonphysician practitioner practices. CMS Certification Numbers, or 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), and 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.

On slide 38, I will introduce you to the information you will need to provide in a required data field in HPMS to build your ACO participant list. We will provide you step-by-step instructions for completing and providing us your ACO participant list during a future webinar.

We recommend to begin collecting your ACO participant list's required information now because it is very important that you provide accurate and timely data. We will screen every participant you provide on your ACO participant list.

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

Slide 39. This slide is important for anyone who is applying and plans to include a Critical Access Hospital billing Method II or an Electing Teaching Amendment hospital on your ACO participant list. For these types of participants, in addition to all of the required

information listed on slide 38, you will need to provide three additional identifiers. In order to identify Part A claims for these two facility types, you must include their CMS Certification Numbers (CCNs). You will also provide the CCN legal business name as it is listed in PECOS and an identification code of C for a CAH or T for an ETA.

Slide 40. Slide 40 is important for anyone who is applying and plans to include a Federally Qualified Health Center or Rural Health Clinic. For these facilities, you will provide the required information listed on slide 38 as well as the CCN, CCN legal business name, CCN identification code of F for FQHC or R for RHC. You will also provide the organizational National Provider Identifier, or NPI, and the organization NPI legal business name listed in PECOS.

In addition, you must identify the individual physicians who provide primary care services at the FQHCs and RHCs. Identify these physicians by including their individual physician NPI, first name, and last name. This provider/supplier data included on your participation list is known as your attestation list. We will talk more about the attestation list later.

Slide 41. During our screening process, the participant list is used to verify that the ACO would have at least 5,000 assigned beneficiaries in each benchmark year. During the screening process, we will verify if the TINs, CCNs, and NPIs you provided are Medicare enrolled. If a TIN, CCN, or NPI is not approved in PECOS to bill Medicare at the time we begin our screening process, the participant will be denied.

TINs can check current Medicare enrollment status in PECOS. If you plan to submit data for a TIN that is not currently Medicare enrolled, note that it can take 45 to 90 days for a MAC to complete processing and enrollment application. The process takes longer if the enrollment application is incomplete or a survey or certification review is required. If you plan to submit data for a TIN or CCN that is not currently Medicare enrolled, you should let them know the processing time is a minimum 45 to 90 days, and they may want to begin the enrollment process soon.

In addition to verifying enrollment, we conduct a PECOS legal business name match. The purpose of this check is to verify that the TIN or CCN you've provided is correct. Accordingly, you will need to update your executed agreement to acknowledge the correct legal business name.

We verify that the TIN is not participating with other shared savings initiatives. ACO participants must remain exclusive to one Medicare shared savings initiative. Any overlaps with another shared savings initiative would need to be resolved.

During the process, we also look to see if the participants are in good standing. An ACO participant cannot have any Medicare exclusion or sanction. Additionally, TINs are screened for program integrity history.

We will also identify if the participant is a sole proprietor. Some sole proprietors have two TINs: an enrollment TIN, which is their Social Security Number, and a billing TIN, otherwise known as the employer identification number, or EIN. You must submit both TINs if they use an SSN and an EIN. We will use the SSN to validate enrollment, and the EIN is used for assignment.

For FQHCs and RHCs, we also verify whether the NPIs you provided are enrolled as physicians in PECOS. We will deny any NPIs that are not identified as a physician.

Now that we have discussed how we will evaluate the participation list information, I'd like to take a minute to discuss the importance of providing accurate data. It's important that you work with your potential participants to gather accurate data. If a TIN, CCN, or NPI is not found in PECOS, it will not go through our screening process. For the ACO participant data you supply by July 29th, you will receive only one opportunity to correct TINs, CCNs, or NPI errors. For TINs, CCNs, or NPIs provided during the application review period, you will not receive an opportunity to correct a mistake.

Let me repeat that. For TINs, CCNs, or NPIs provided during the application review period, you will have no opportunity to correct any mistakes. This is because correcting the numerical TIN, CCN, or NPI is the same as adding a new participant, and those additions would not be considered for program participation until your second performance year.

I encourage you to begin collecting your ACO participant list information early so that you have time to verify its accuracy. We will provide instructions for submitting the ACO participant list data with your application during a future webinar.

Slide 42. The Medicare Shared Savings Program requires all ACO participants to be enrolled in Medicare per 42 CFR Part 425.20. Section 6401(a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

In order to make the revalidation process easier for the providers/suppliers, CMS has implemented several tools to help update your enrollment and find out expiration dates for certain providers/suppliers. We believe these tools are helpful for reminding your ACO providers/suppliers to revalidate timely and maintain their Medicare enrollment in order to minimize any adverse impact to their ACO participant status.

The most efficient way to submit revalidation information is by using the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) on the CMS website. PECOS allows you to review information currently on file, update and submit a revalidation via the Internet. It is important for providers and suppliers to keep their contact information in PECOS up to date so the MAC can contact them as needed.

A listing of all currently enrolled providers/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 due dates. Those on the list due for revalidation will display a revalidation due date. All other providers/suppliers not up for revalidation will display a TBD (to be determined) in the due date field. The revalidation due date will be posted up to 6 months in advance of the revalidation due date to provide sufficient notice and time for the provider/supplier to comply. For more information on provider/supplier revalidation, please visit the CMS revalidation webpage or have the provider/supplier contact their MAC.

Links to the Provider Enrollment, Chain and Ownership System (PECOS), Medicare Revalidation Lookup Tool, and CMS revalidation webpage are all found directly in slide 42.

Slide 43. Once an ACO is accepted into the program, you must notify us of participant additions or removals within 30 days of the change. While you report the changes to us within 30 days, these changes will not take effect for full program participation until the following performance year. For example, if an ACO participant TIN is added in 2016, it will not be included in assignment until 2017.

ACO participants who leave the ACO during a performance year will continue to be used in that performance year's assignment, sampling for quality reporting, financial reconciliation, and quarterly and annual reports. We encourage you to communicate with your ACO participants. If an ACO participant changes their TIN used to bill Medicare and the new TIN is not on your ACO participant list, any claims billed under the new TIN will not be captured in assignment.

Additionally, we cannot approve any participant list change request that did not go through our screening process. If your ACO participants make any changes to this data, ask that they notify you so that you can notify Shared Savings Program staff. To learn more about the impact of changing your ACO participant list, visit the Shared Savings Program website to review the Changes in ACO participants and ACO providers/suppliers during the Agreement Period guidance document.

This brings an end to my portion of the presentation. Now I will turn the slide presentation back over to Jonathan Blanar.

Jonathan Blanar: Real quick, I just wanted to clarify one thing that was said. It goes back to slide 41. And I just want to make it clear that, once you submit your – after you submit your application and after that you receive your first request for information from CMS, you still have the ability to add participants to your participant list as well as correct any mistakes. For example, if you transposed a Tax Identification Number, you can make – you have one opportunity to make those changes, either adding or making

changes to a participant with RFI 1. After RFI 1, there'll be other requests for information by CMS, but at that point you will only be able to delete TINs at that point from your participant list. So, I just want to clarify that in case it wasn't clear for folks on the line.

And with that, I'll turn it over to Walter.

Beneficiary Assignment

Dr. Walter Adamache: Good day. This is Walter Adamache of RTI International. I will be discussing beneficiary assignment today.

Slide 45. 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 must have at least 5,000 preliminarily assigned beneficiaries in each of the 3 years preceding the start of the agreement or 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.

Slide 46. There are two types of beneficiary assignments. One is a preliminary prospective with retrospective reconciliation. This is for Tracks 1 and 2 ACOs. The other is – or prospective, which is for Track 3 ACOs only. In both cases, the beneficiary is assigned to the ACO that provides a plurality of primary care services to the beneficiary. Plurality in this case means the single largest share.

Slide 47. For retrospective assignment, we have preliminary prospective assignment with final retrospective assignment. So, what does that mean? After the completion of a performance year, beneficiaries for Tracks 1 and 2 are retrospectively assigned using claims from the performance year. So, for beneficiaries who – or ACOs that have a start date of January 1st, 2017, when we get to 2018 to reconcile in – your performance, we will use claims from the performance year to calendar year 2017.

However, in order to establish benchmark year counts and produce quarterly reports, beneficiaries are preliminarily assigned to Track 1 and 2 using claims from the assignments windows prior to the performance year. So this is where the preliminary comes in.

Slide 48. For Track 3, it's prospective assignment. A beneficiary is assigned to an ACO prior to the start of any given performance year. This is unlike Tracks 1 or 2. Track 3's ACO's performance is assessed on their prospective assigned – prospectively assigned beneficiaries. The performance of Track 3 ACOs is not assessed on beneficiaries who were not prospectively assigned, even if the beneficiary received the plurality of their primary care from the ACO during the performance year.

Slide 49. Here we discuss the resources used in beneficiary assignment. First off, both prospective and retrospective beneficiary assignments use the same algorithm and resources for assigning beneficiaries to the ACOs.

CMS uses claims submitted to Medicare for primary care services in the assignment process. We would primarily use paid claims. The other types of claims we would be using would be where the – there was an approved payment, but because a beneficiary hadn't satisfied their Part B deductible, there may be no payment to the provider but the beneficiary is picking up the bill. In that case, we count that as in use for assignment. CMS uses information your ACO submitted and certified on the ACO participant list to determine which claims to attribute to your ACO.

Next, we talk about beneficiary eligibility. These are the things about the beneficiary that must be satisfied so we can consider this beneficiary to be assignable to an ACO or not. We have several requirements. First, there must be a record of Medicare enrollment. The beneficiary has to have at least 1 month of both Part A and Part B enrollment and cannot have any months of only Part A or only Part B enrollment. Beneficiary cannot have any months of Medicare group health plan enrollment; that means, in this case, like Medicare Advantage Programs. The beneficiary must reside in the United States, which includes not only the normal 50 states and District of Columbia, but also includes Puerto Rico and other overseas territories.

Then finally—and this is most critical—the beneficiary must have had a primary care service with a qualified physician at the ACO. If the beneficiary doesn't have this primary care service, then they won't be considered for assignment. And the qualified physician is an ACO physician used in assignment or a physician on an FQHC or RHC attestation list.

Slide 51. We have a two-step beneficiary assignment process. And again, this is – you'll only go into this process if the conditions on the previous slide have been met, including having a contact at the – beneficiary having a primary care service at the ACO. The Assignment Policy Step 1 is: 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 nonphysician provider – practitioner, excuse me, or an ACO FQHC/RHC professional at the participating ACO, and more primary care services—and we define primary care services as measured by Medicare allowed charges on claims—that are furnished by the primary care physicians, NPPs, ACO FQHC/RHC professionals at the participating ACO than from any other entity.

Slide 52. So, what are the provider types used in assignment in Step 1? For primary care physicians, we have five groups—and we refer to the primary care physicians as PCPs—internal medicine, family practice, general practice, geriatric medicine, and pediatric medicine. The selected nonphysician practitioners—there are three of them—nurse practitioners, clinical nurse specialists, and physician assistants.

Slide 53. The second part of the assignment process is what's called Assignment Policy Step 2. This step applies only for those beneficiaries who were – who remain unassigned after Step 1. CMS will assign the beneficiary to the participating ACO in this step if the beneficiary got at least one primary care service from a – an ACO physician used in Step 2 at the participating ACO, and more primary care services from the ACO than from any other given entity.

Slide 54. Slide 54 shows professionals used in assignment in Step 2. They include cardiologists, neurologists, psychiatrists, endocrinologists, hematologists, among others.

Slide 55. Here we're going to spend a couple slides dealing with the FQHC/RHC physician attestation list. First, the reason we do this is because the Act requires assignment to be based on services furnished by physicians. The issue here is that FQHC/RHC claims contain limited data on the type of practitioner providing a service. We know who is responsible for the overall care but not necessarily who provided the care. We use the ACO participant list in combination with claims data to identify the provider who furnished services.

Slide 56. The attestation list is required only for those FQHCs and RHCs that belong to ACOs. The list is comprised of physicians who deliver or direct primary care services at FQHCs and RHCs. Should include not only physicians who currently provide primary care services but also those who delivered primary care services during the assignment window. And, to remind you, for new ACO applicants, the assignment periods of 3 benchmark years prior to the July application period, and for other assignment runs – all others – assignment period's the preceding 12 months. You cannot put on your attestation list any nurse practitioners, physician assistants, or any other nonphysician practitioner.

Slide 57. So, what are the primary care services that we consider for use in assignment? First, we have several types of evaluation and management services. And the first category is office or other outpatient settings, which are covered by CPT codes 99201 through 99215. Next is nursing facility care settings, CPT codes 99304 through 99318, with the following exclusion: that if there is a place of service code equal to 31 on the physician claim, then we exclude that claim from assignment. This is a new rule that's taking effect in 2017. The next category is rest home and custodial care settings, CPT codes 99324 through 99340; home services, CPT codes 99341 through 99350; chronic care management services, CPT code 99490; transitional care management services, CPT codes 99495 and 496; and for the ETA hospitals only—and only them—we use your hospital outpatient claims and look for a special code G0463.

The other types of categories are for wellness visits, HCPCS codes G0402, G0438, G0439, and for RHCs' clinic visits or by their providers at selected settings; in this case, we don't

use the HCPCS codes but rather uniform billing revenue center codes 0521, 0522, 0524, and 0525.

Slide 58. We're going to provide you with some examples as notes before we get in. We have several items here. One is the organizational ID, and in this case, all TINS and CCNs on an ACO's participant list are associated with the ACO's ID number. For those organizations which do not belong to an ACO, we – the organizational ID will be their TIN or CCN. And this is what we use when we compete the ACOs versus other organizations. In the examples – for each beneficiary assignment example, the top row indicates the ACO or non-ACO provider to which the beneficiary was assigned.

Slide 59. Slide 59 is – actually goes back to what we had discussed on slide 50; namely, when we look at beneficiaries, we ask the question, are they eligible to be assigned to an ACO? And so, what this slide does is show that – what's called a pre-step. And I have several potential beneficiaries, and I've labeled them A1, A2, etc. That's the leftmost column in slide 59. A second column, ACO, is the ACO where they have a contact. And then we talk about the physician's specialty type. And then finally, the final column is: we determine whether they're eligible for assignment on the basis of this contact.

So, first off they all have to have a primary care service. So, next key thing is a specialty type. So for beneficiary A1, we found a couple claims for physician practices or other providers associated with ACO 9999. In the first case, row 1, we have a primary care physician; that is, beneficiary is eligible on the basis of that contact regardless of any other contacts they have. But this beneficiary also had another contact with the ACO, this time with a cardiologist. That also made the beneficiary eligible for assignment.

For beneficiary A2, rows 3 and 4, we have two contacts with the same ACO, A9999. The first case—it was with a nonphysician practitioner. It could be a nurse practitioner or some other NPP, but that contact alone does not make the beneficiary eligible for assignment. And with the second row for A2, where we have "Surgeon," the Table 5 exclusion refers to the June 2015 final rule. And again, having contact only with a surgeon does not make the beneficiary eligible for assignment. So, beneficiary A2 is not going to be eligible assignment to ACO A9999, because, in that sense, the beneficiary didn't see the specialty type that's used in assignment.

For beneficiary A3, we have a split case where, in the first of the two rows, A9999 was – the beneficiary had a primary care service with an FQHC- or RHC-attested physician. So, that made them eligible for assignment. They also had a contact with a nonphysician practitioner, but that particular contact did not stand much eligibility. But beneficiary A3 only needs one eligible contact, so they're into assignment on the basis of the first of their two.

For beneficiary B1, they went to ACO A5656 and got some primary care services from a pathologist; however, it's a Table 5 exclusion, so that beneficiary B1 would not be considered for assignment with A5656, and so forth.

Slide 60. So, we go through the beneficiary assignment and Example 1. And it's beneficiary A1; the second column is the organizational ID. So we have three entities competing for beneficiary A1: the ACO A9999 and then two other physician practices—one with identifier all 5's and the other with a TIN of 456, etc.

We now look at the allowed charges for primary care services. What we have here is, in the first column, which is labeled "PCP, NPP or FQHC ACO Professional," these are what we're using in this – the Step 1 assignment, because all those values are greater than zero. In this case, the beneficiary is assigned to ACO A9999 because it had the highest allowed charges for primary care of $454, even though the other two non-ACO practices had higher allowed charges for – provided by physicians using Step 2. In that sense, because the beneficiary was assigned in Step 1, we don't look at the Step 2 numbers—they're ignored.

Slide 61. In this case, we have another beneficiary, B3, who is, again, seen by three organizations. One was – and the first one listed is a non-ACO physician practice and then by two ACOs.

Beneficiary B3 is not assigned to an ACO, because an A – non-ACO provider had the highest allowed charges for primary care services provided by a primary care physician, NPP, or an FQHC/RHC ACO professional. And in this case, the – it was $1,200. There is a typo in the final column of the slide, in the first row, where it says – should be $1,250. But anyway, we didn't get to step 2, because the beneficiary was assigned in Step 1.

Example 3. Beneficiary A3 was eligible for assignment. But they are not assigned in Step 1, because when we look at the column that says, "PCP, NPP, or FQHC/RHC ACO Professional," there're all zeros in that column.

So, we go to Step 2. In this case, the largest amount of allowed charges was with ACO A9999. So ACO – a beneficiary A3 is assigned to ACO 9999 on the basis of the highest allowed charges are provided by an ACO physician.

Slide 63. What we're trying to do with this one and the next three slides is to give you an idea of how many providers you might need to generate your – at least your 5,000 beneficiaries. And these first two slides are based on some ACOs that successfully met the 5,000-beneficiary threshold. And I'm going to take you in detail through a couple of these columns here.

The first row shows the number of beneficiaries that had at least one primary care service provided by a physician at the – this particular ACO. So for ACO1, it had

delivered services to at least 11,839 beneficiaries; ACO2, they had 28,127; and ACO3, 24,297.

The next row down is those that were ultimately assigned—the number of beneficiaries ultimately assigned. So for ACO1, although they had nearly 12,000 beneficiaries, they had at least – provided at least one primary care service, they ultimately had only 7,570 who were assigned.

The next row, the excluded beneficiaries, shows the total number of unique individuals who were excluded. So, the 4,269 were those who weren't assigned. And if you add 4,269 and the 7,570, you get the 11,839 in the top row. Of those excluded beneficiaries, you will see that of the – most of them were not assigned, because the ACO did not provide a plurality of primary care services. As I say, 4,008 beneficiaries were not assigned to ACO1, because some other provider had provided the plurality of primary care services to those beneficiaries.

Other reasons were—and they are much more minor—is some of them had only had at least 1 month of Part A or – only or Part B-only coverage (93); 241 beneficiaries had at least 1 month in a group health plan; 1 beneficiary had at least 1 month in non-U.S. residence; and 17 beneficiaries had received services in other shared savings initiatives, which took priority over the ACO Program.

Notice that, just because you have a lot of beneficiaries whom you've had contact in, doesn't mean you automatically get as many beneficiaries assigned. If you compare the numbers in columns ACO1 and 2, you know, so ACO2 had more than twice as many beneficiaries who received at least one service from the ACO as did ACO1 but not twice as many assigned beneficiaries—10,000 vs. 7,600.

Slide 64. These same three ACOs—this is their composition of physician types. ACO1 had 65 primary care physicians, ACO2 had 188, and ACO3, 244. Physicians in Step 2 assignment—ACO1 had 81, and so forth. And again, the last line shows of – the three nonphysician practitioners that we use in assignment. So, there was, like, 22 at ACO1, 107 at ACO2, and only 10 at ACO3.

Slide 65 shows what happened to three ACOs that didn't achieve this threshold, so we have some sample numbers here. And as you can see here in Row 1, all of them had many fewer number of beneficiaries that they had initial contact with.

If you go down to the excluded, again, the major reason that they're not being included in the ACO is that the ACO did not provide a plurality of primary care services. For instance, in ACO B, they ultimately had 3,766 beneficiaries who were not assigned, and of them, 3,413 were not assigned to them, because other providers provided the plurality of primary care services.

Slide 66 shows the composition of beneficiaries – excuse me, of physicians, and the specialty types at these three ACOs denotes, for instance, that the number of primary care physicians for ACOs A, B, and C are much lower than for ACOs 1, 2, and 3—and the same for the other categories of specialists, so size matters. You need to have a reasonable number of primary care physicians and other physicians and nurse practitioners…what have you.

OK, I'm now turning this over to Leah.

Question-and-Answer Session

Leah Nguyen: Thank you, Walter. Our subject matter experts will now take your questions. But before we begin, I would like to remind everyone that 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 your question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits.

All right, Kalia. 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.

Your first question will come from the line of Priscilla Goode.

Priscilla Goode: This is Priscilla Goode with UT Southwestern in Dallas, Texas. In our market, our NPs, PAs, and CNPs often work for more than one TIN. Is this allowed if one of the TINs is affiliated with an ACO?

Kari Vandergrift: Yes, this is Kari Vandergrift. Our exclusivity rule is at the TIN level. So, your TIN, if it's used in assignment, can only appear on one ACO participant list, but the actual NPIs that bill underneath the TIN are not restricted to one ACO.

Priscilla Goode: Great, thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Idaho Primary Care.

Yvonne Ketchum: Hi, this is Yvonne Ketchum with Idaho Primary Care Association. We represent FQHCs in Idaho and have a question about how the TIN and the physician work. So, I understand that we would submit the FQHC's TIN and then a list of physicians but not a list of nurse practitioners and PAs. So, if the preponderance of primary care service is what for a patient was done by a nurse practitioner, would they get assigned to our ACO?

Dr. Walter Adamache: Kari, you want me to handle that?

Kari Vandergrift: Go ahead, Walter.

Dr. Walter Adamache: OK. There is a two-step process you have to consider. One is, the beneficiary has to have at least one primary care service at the FQHC from a physician on the attestation list. Once they get into the eligibility pool, then—and then we go to Step 1 assignment—then we will look at other claims that include services provided by the nurse practitioners, physician assistants, and what have you. So, they will be considered, but only if that beneficiary had at least one primary care service from a physician on the attestation list. Does that answer your question?

Yvonne Ketchum: It does. It's going to eliminate a lot of our patients, though, because you have mostly NPs and PAs that work at FQHCs.

Kari Vandergrift: This is Kari again. I just want to clarify that, in the statute, it requires the physician visit. So, we had to interpret the statute so that NP/PA claims are used in assignment, but we have to start at the physician level.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Lauren Suttell. Lauren, your line is open. If you're on speakerphone, please pick up your handset.

Lauren Suttell: Yes. Hi, this is Lauren Suttell from Hodgson Russ in Buffalo, New York. We're wondering whether or – it was indicated previously that the ACO participating – participant agreements—that they would be included with the application, those that were executed up and through the application submission date. And then it was indicated that additions to that list could be added through the first request for information. And then after that, you could only delete it. Is that essentially indicating that they are – that an ACO can't go out and continue to bring on additional providers for the ACO until after its application has been approved?

Kari Vandergrift: You are correct that, after the first RFI, we will not allow new TINs, new CCNs, new NPIs. So yes, after the first RFI, you should not – if you are expecting to add

them for your 2017 list, you should not be partnering with these folks. There's always the opportunity to add it through your agreement period, but that would be 2018, 2019.

Lauren Suttell: OK, and just as a related to that, how long between the application and the first request for information is generally expected?

Jonathan Blanar: Sure, so this is Jonathan. Once we receive your application, you know, we're going to try and send out the first request for information in September. So, you know, it'll be a month or so before you get your first request.

Leah Nguyen: Thank you.

Lauren Suttell: OK, thank you.

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

Your next question will come from the line of Sarah Blumenthal.

Sarah Blumenthal: Hi, this is Sarah Blumenthal at Ropes & Gray in Washington, DC. My question relates to ACO participants who may be participating currently in a Medicare Shared Savings Program ACO where the agreement period is ending this coming December, and the ACO participant may be interested in joining a different or starting their own ACO going forward for the period beginning in 2017. How does that participant provide an application? I'm concerned that listing the TIN on the ACO participant TIN template will get the TIN kicked because they're already included with an existing ACO.

Kari Vandergrift: Sure. We check for overlaps multiple times throughout the year, so – throughout the application cycle, apologies. But what the TIN should do is reach out to the ACO that they are currently working with and have that discussion with them now. Let them know if they no longer wish to participate with that ACO in the next agreement period so that ACO can go ahead and provide us with that information. They're supposed to notify us within 30 days of a change. So, if the TIN identified that they no longer want to participate, then the ACO can let us know timely also.

Sarah Blumenthal: And if the termination of that TIN's participation is not effective until the end of the current performance year, when did – when does notification need to be made to CMS?

Kari Vandergrift: So, it's a similar date. So, we adjudicate multiple times for our existing ACOs as well. One of those dates actually lines up with the application. So, if they tell us

now, then the TIN would be end dated for the end of this performance year, and we would not flag it as an overlap if you add them to your application.

Sarah Blumenthal: OK, thanks.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Sharon Zang.

Sharon Zang: Hello, this is Sharon Zang with White River Health System, and I have a question about a participant that has one TIN and more than one Rural Health Clinic. So, they have more than one CCN number, and individual physicians travel to more than one CCN or our Rural Health Clinic. Will we be able to add the providers that travel to more than one site?

Kari Vandergrift: Yes, so for each TIN that has these additional FQHCs or RHCs, since they have so many rows of data, you're going to add all of those CCNs and all of those NPIs that provide direct primary care service to those physicians. This year we've actually upgraded our system so that you can upload them into the system. This is only for an individual TIN—let me clarify—and we will go through how to use our HPMS system for this data. But you can add all of those records through an upload at one time.

Sharon Zang: So, I can have an individual physician NPI to more than one location?

Kari Vandergrift: Yes, again …

Sharon Zang: I love you, thanks.

Kari Vandergrift: … the NPIs are not required to be exclusive. It is only the TIN that would …

Sharon Zang: Right.

Kari Vandergrift: … be required to be exclusive.

Sharon Zang: It's one TIN, several Rural Health Clinics.

KariVandergrift: Right, yes.

Sharon Zang: Oh, thanks.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Scott Williams.

Scott Williams: Hi, this is Scott Williams from Legacy Health. My question is in regards to the application. Once we apply, do we have the ability to retract the application and no longer go through MSSP, or are we committed to the application?

Karmin Jones: So, this is Karmin – Karmin Jones, and once you submit your application, if at any time you determine that you want to withdraw it, we have instructions that provide you information on how to withdraw your application by simply sending up an email. And we will withdraw that, and you will receive a confirmation email that your application has been withdrawn. Thank you.

Scott Williams: Great, thank you.

Leah Nguyen: Thank you.

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

Your next question comes from the line of Jennifer Connor.

Jennifer Connor: Hi. I have a question about page 29 – slide 29. It said that you have – executed agreements must match the approved sample agreement. Have you shared that sample agreement?

Karmin Jones: So, this is Karmin. What we have on our – currently, what we have on the application webpage—on the How to Apply and on the Toolkit page—is our sample of what we provided last year. There is a document called Managing Your ACO Participant List and Agreement Guidance document, which provides sample information within that.

Keep in mind that this year we will be updating that information in the spring. You want to focus on all the requirements that are associated with Table B of the ACO participant agreement sample. All of those requirements are now reflective of the requirements that are with any performance year 2017 agreement. So, samples are out there. We will be updating our application materials later. But you should have –you can use that at this time. Thank you.

Jennifer Connor: Thank you.

Leah Nguyen: Thank you.

Operator: Thank you. I will now turn the call back over to Leah Nguyen.

Additional Information

Leah Nguyen: Thank you, Kalia. 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 are available.

On slide 69 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on the Medicare Shared Savings Program. Have a great day, everyone.

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

-END-


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