MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO:
Completing the 2018 Application Process Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

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

I will now turn the call over to 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 Call on the Medicare Shared Savings Program – Completing the 2018 Application Process. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, learn helpful tips to complete a successful application for the Shared Savings Program, the Medicare Accountable Care Organization Track 1+ Model, and the Skilled Nursing Facility 3-Day Rule Waiver. A question-and-answer session follows the presentation.

Before we get started, I have a couple of announcements. You should have received a link to today's presentation in previous registration emails. If you have not already done so, please view or download the presentation from the following URL – go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website.

At this time, I would like to introduce our first presenter, Ben Dellva from LMI. I will now turn the call over to Ben.

Presentation

Benjamin Dellva: Thank you, Leah.

Welcome to our second call for the 2018 – for 2018 applicants for the Medicare Shared Savings Program. My name is Ben Dellva, and I support the Shared Savings Program operation.

Please reference slides 3 and 4 for common acronyms used throughout this presentation.

Thank you for joining today's call and for your continued interest in the Shared Savings Program. On slide 5, you can find the agenda for today's call. In today's session, we will summarize the information covered during the April 6th call, go through the Shared Savings Program Skilled Nursing Facility 3-Day Rule Waiver, and Medicare ACO Track 1+ Model applications, the ACO Participant List, and ACO Participant Agreement, the Skilled Nursing Facility 3-Day Rule Waiver Affiliate List, and Skilled Nursing Facility—or SNF—Affiliate Agreement and discuss beneficiary assignment.

In the first portion of this call, we would like to provide an overview of the information presented on April 6th, 2017, during our MLN Connects Call on Preparing to Apply for the 2018 Program Year. For more detailed information, please visit the Shared Savings Program How To Apply webpage. You can download the April 6th slide presentation on the Shared Savings Program Application's Teleconferences and Events webpage.

Highlights from the April 6, 2017, MLN Connects Call

I will go through slides 7 to 11 quickly as this was covered in the April 6th call. Slide 11 introduces the Shared Savings Program, which was established by the Affordable Care Act. Eligible Medicare-enrolled providers and suppliers participate in the program and awarded – are awarded for lowering growth in health care cost while improving quality.

Slide 8 specifies the cohorts CMS will refer to when discussing the Shared Savings Program Application Options. CMS tailors communication to each of these specific cohorts. They are currently participating ACOs, initial applicants, renewal applicants, Skilled Nursing Facility—or SNF—3-Day Rule Waiver applicants, and Medicare ACO Track 1+ Model applicants, also known as Track 1+ Model applicants. For participation and application options per cohort, please refer to the April 6th slide presentation.

We are now on slide 9. The application submission process consists of four different steps.

Step 1. ACOs must submit a Notice of Intent to Apply, or NOIA, to participate as an ACO in the Shared Savings Program, apply for the SNF 3-Day Rule Waiver, and/or apply to the Track 1+ Model. Initial applicants, those ACOs not currently participating in the Shared Savings Program, will submit their NOIA through the questionnaire link found on the

How To Apply webpage. Renewal applicants and currently participating ACOs will submit their NOIA through the Health Plan Management System, or HPMS. The NOIA guidance document posted on the How To Apply webpage provides instructions for how to submit your NOIA.

Step 2. For systems access, a user must have a CMS user ID and at least four users with access to CMS systems. If you do not currently have a CMS user ID, you should submit the forms immediately upon receiving the NOIA Confirmation Notice email as it takes 3 to 4 weeks to process the request. Visit the HPMS User ID webpage for further instructions on how to obtain your user ID.

Step 3. All applicants must submit their applications via HPMS.

Step 4. CMS uses the Electronic Funds Transfer Authorization Agreement Form CMS-588 to validate your banking information so that you may receive payment if you successfully share in savings. All initial applicants must mail Banking Form CMS-588 to CMS. Currently participating ACOs and renewal applicants should submit a new signed Form CMS-588 only if changes are made to the ACO's legal business name, tax identification number, financial institution information, authorized or delegated officials, contact persons, or address.

The Application Toolkit provides additional information on the Banking Form CMS-588 and the rest of the application submission process. The 2017 Application Toolkit is currently posted for your reference on the 2017 Medicare Shared Savings Program Toolkit webpage. Please note that the 2018 Application Toolkit will be available in June via the Shared Savings Program webpage. If you have any questions regarding the application process, use the contact information provided at the end of this presentation.

On slide 10, you will see a chart of the key dates in the NOIA process. Please note that the NOIA period opens on May 1st and closes on May 31st at 12 pm noon eastern time. After receiving the NOIA Confirmation Notice email, users must submit their CMS user ID request form by no later than June 8th, 2017. The NOIA guidance document is posted on the How To Apply webpage. ACOs should reference this guidance document for further details on how and when to submit an NOIA.

Slide 11 shows application submission key dates. Please refer to the How To Apply webpage for 2018 application cycle dates and the 2017 sample applications that are still posted from last year. The 2018 applications will be posted in June, including the Track 1+ Model sample application. These application forms include the initial application for the Shared Savings Program, the renewal application for the Shared Savings Program, the application for the Track 1+ Model, and the application for the SNF 3-Day Rule Waiver, which is available to Track 1+ Model and Track 3- ACOs only. All 2018 applications are accepted July 1st through July 31st, 2017, and the deadline for submission is 12 pm noon eastern time on July 31st. Please note, applications are incomplete without the Banking Form CMS-588.

The next section will cover the different Shared Savings Program application options available for eligible ACOs. For more information, refer to the April 6th slide presentation and transcript.

Shared Savings Program, SNF 3-Day Rule Waiver, and Track 1+ Model Applications

We are now on slide 13. The Shared Savings Program initial application is the most robust application and is intended for ACOs that are not currently participating in the program. Initial applicants can choose to apply for participation in Track 1, Track 1 including the Medicare ACO Track 1+ Model, Track 2, or Track 3. This application requires prospective Shared Savings Program ACOs to describe how they meet program eligibility requirements. Initial applicants are required to submit additional supporting documentation such as organizational charts, governing body templates, an ACO Participant List, sample ACO Participant Agreements, and executed ACO Participant Agreements. ACOs applying to a two-sided risk model, which is Track 2, Track 3, or Track 1+ Model, must also submit a repayment mechanism.

Slide 14 describes the Shared Savings Program renewal application, which is an abbreviated version of the initial application. The renewal application is for ACOs that are currently participating in the Shared Savings Program with a 2015 program start date that intend to renew their Participation Agreement with CMS. In this application, eligible ACOs attest to meeting program requirements and submit narratives describing any substantive changes to their organization and/or affiliation since the approval of their initial application. Renewal applicants must submit additional supporting documentation such as organizational charts, governing body templates, their ACO Participant List, sample ACO Participant Agreements, and executed ACO Participant

Agreements. Again, ACOs applying to a two-sided risk model must submit a repayment mechanism.

On slide 15, we have information about the Skilled Nursing Facility 3-Day Rule Waiver application, which is for ACOs applying for a Skilled Nursing Facility 3-Day Rule Waiver, which is available to Track 3 and Track 1+ Model ACOs only. In this application, eligible ACOs attest and submit narratives demonstrating they meet eligibility requirements, including the ACO's communications plan, beneficiary evaluation and admissions plan, and care management plan. ACOs are also required to submit their SNF Affiliate List and supporting documentation, such as SNF Affiliate Agreements and the SNF Star Rating, as shown on the Nursing Home Compare website. We will cover the SNF Affiliate Agreement requirements in depth later in this call.

Slide 16 covers the Medicare ACO Track 1+ Model application. This application is for ACOs that are currently participating in Track 1 or applying to enter an initial or renewal agreement period under Track 1 and applying to the Track 1+ Model. For initial or renewal applicant ACOs, please remember that you must complete the Track 1+ Model application in addition to the Shared Savings Program Track 1 application.

If an ACO indicates its intention to apply to the model by submitting an NOIA, then the applicant will have the opportunity to complete a Track 1+ Model application within HPMS, which is the same system used for the Shared Savings Program Application.

In the Track 1+ Model application, applicants attest to meeting model eligibility requirements and to the ownership and operational interest of the ACO participants as necessary for determining the ACO's loss-sharing limit. Track 1+ Model applicants must select a symmetrical minimum savings rate and minimum loss rate and establish an adequate repayment mechanism. Please note that ACOs currently participating in their second agreement period are not eligible to reapply to the Shared Savings Program for their third agreement period under the Track 1+ Model.

We are now on slide 17. The remainder of this call will focus on the ACO Participant List, ACO Participant Agreements, SNF Affiliate List, SNF Affiliate Agreements and beneficiary assignment as these are key components to the application process and an ACO's participation in the Shared Savings Program and Track 1+ Model. As a reminder, the SNF

Affiliate List and SNF Agreements only apply to those ACOs applying for the SNF 3-Day Rule Waiver.

ACO Participant List

Slide 18 discusses the application submission process. During this process, ACOs submit to CMS a list of participants that agreed to be part of the ACO. These participants are identified by a Medicare-enrolled billing taxpayer identification number or TIN. The ACO Participant List is critical to program operations, including but not limited to: assigning beneficiaries to the ACO, establishing a historical benchmark, performing financial reconciliation, determining a sample of beneficiaries for quality reporting, coordinating participation in CMS quality reporting initiatives under the Shared Savings Program, and monitoring the ACO for program integrity issues.

We're now on slide 17. CMS evaluates the ACO Participant List to verify and screen ACO participants for compliance with program requirements. CMS uses the ACO Participant List to verify that ACOs had at least 5,000 beneficiary – beneficiaries in each of the benchmark years and that the ACO participant TINs meet Medicare enrollment requirements.

When an ACO submits an ACO Participant List, they're – when an ACO submits an ACO participant for its ACO Participant List, the ACO must have an executed ACO Participant Agreement and must comply with the Shared Savings Program requirements. One requirement is that the agreement must expressly require the ACO participant to agree and to ensure that each ACO provider and supplier billing through the TIN of the ACO participant agrees to participate in the Shared Savings Program and to comply with the requirements of the Shared Savings Program, including all other applicable laws and regulations.

Slide 20 describes the requirements of the ACO Participant List. ACOs must maintain, update, and regularly submit an accurate and complete list identifying each ACO participant and their Medicare-enrolled TIN. ACOs must include all Medicare-enrolled individuals and entities that have reassigned their rights to receive Medicare payment to the TIN of the ACO participant on the ACO Provider/Supplier List.

These individuals and entities must agree to participate in the ACO and comply with the requirements of the Shared Savings Program before the ACO submits the ACO

participant and the ACO Provider/Supplier List. For additional information on the ACO Participant List, please refer to the regulations and guidance documents links on this slide.

As we see on slide 21, the ACO Provider/Supplier List is a list of all providers and suppliers that bill through the approved ACO participant TIN. A provider or supplier must be on the certified ACO Provider/Supplier List to be considered in the Shared Savings Program. The ACO must include all Medicare-enrolled individuals and entities that have reassigned their right to receive Medicare payment to the ACO participant TIN. Providers or suppliers must agree to participate in the ACO and comply with the requirements of the Shared Savings Program before the ACO submits the ACO Provider/Supplier List.

ACOs must maintain, update, and regularly submit an accurate and complete list identifying each ACO provider or supplier that has reassigned their right to receive Medicare payment to the ACO participant TIN. CMS generates the ACO Provider/Supplier List that reflects PECOS reassignments, and ACOs must modify the list as needed and attest to its accuracy. This occurs at the end of the application review process but prior to the start of the performance year.

We are now on slide 22. The Shared Savings Program requires all ACO participants to be enrolled in Medicare. To assist ACOs in validating the ACO Participant List information, ACO participants can: Use the Provider Enrollment Chain and Ownership System, or PECOS, on the CMS website to confirm enrollment, use the Medicare Revalidation Lookup Tool to search for provider or supplier enrollment status, and visit the CMS Revalidation webpage or have the provider or supplier contact their Medicare Administrative Contractor for more information on provider and supplier revalidation.

Slides 23 and 24 provide information on identification numbers. CMS uses taxpayer identification numbers or TIN, national provider identifiers or NPIs, and CMS certification numbers or CCNs to identify claims from providers and suppliers.

The first slide shows how CMS users each of these identifiers to identify claims for financial and beneficiary assignments. The next slide shows the required information each type of ACO participant must submit. ACOs must include additional required fields

for critical access hospitals, electing teaching amendment hospitals, Federally Qualified Health Centers, and Rural Health Clinics on the ACO Participant List.

Slide 25 describes how, prior to submitting the ACO Participant List, ACOs should communicate with participants about their participation in the program and collect TIN, CCN, and NPI information while understanding that ACO participants may be communicating with multiple ACOs about participating in the program. Please refer to the SSP ACO Participant List Management Module User Guide available in HPMS for more information.

We're now on slide 26. ACOs should communicate with each of their ACO participants to understand how the participant is enrolled in and billing Medicare. For any sole proprietor, ACO participants enrolled in Medicare under a Social Security Number and billing Medicare under a separate employee – Employer Identification Number, the ACO must submit both the Social Security Number and the Employee Identification Number on the ACO Participant List. ACO participants should contact their Medicare Administrative Contractor with any questions regarding their Medicare enrollment.

We are now on slide 27. After the application submission deadline, ACOs only have one opportunity to submit additional ACO participants and correct any TIN, CCN, or NPI digit errors or typos in response to the first request for information. CMS strongly recommends that ACOs submit all TIN, CCN, and NPI information by the application submission deadline of July 31st. If ACOs submit incorrect TIN, CCN, or NPI information in response to the first RFI which is due August 30th, the ACO will not have an opportunity to correct the digits, and CMS will deny those ACOs' participants. After the first RFI, corrections to incorrectly typed TINs, CCNs, or NPIs are considered additions to the ACO Participant List and will not be allowed.

On slide 28, we will discuss merged or acquired TINs. A merged or acquired TIN is a TIN that was acquired by an ACO participant through a purchase or merger. ACOs have the option to include merged or acquired TINs on the ACO Participant List, but it is not required. ACOs may decide to indicate that TINs have merged for the purposes of beneficiary assignment and benchmarking. If ACOs choose to include merged or acquired TINs on their ACO Participant List, they must submit:

- An attestation identifying both the acquired entity's TIN and the ACO participant TIN which acquired it,
- Supporting documentation specifying all ACO providers and suppliers that previously reassigned the right to receive Medicare payment of the acquired entity's TIN have in fact reassigned such right to the TIN of the identified ACO participant and have been added to the ACO Provider/Supplier List,
- Supporting documentation specifying the acquired entity's TIN is no longer used to bill Medicare and, finally,
- Supporting documentation demonstrating that the acquired entity's TIN was merged with or purchased by the ACO participant.

For more information on merged and acquired TINs, see the June 2015 final rule and the 2018 Application Toolkit which will be available in June.

We're now on slide 29. CMS uses the ACO Participant List to determine eligibility for the Track 1+ Model. ACOs are ineligible to participate in the Track 1+ Model if 40 percent or more of its ACO participants had Participant Agreements with an ACO that was participating in a performance-based risk Medicare ACO initiative in the most recent prior performance year. Please refer to the Track 1+ Model application itself for a list of the performance-based risk Medicare ACO initiatives that may affect the calculation of this 40-percent threshold.

As indicated on the next slide, these risk models include the Shared Savings Program Track 2 and Track 3, the Pioneer, and the Next-Generation ACO Models. Ownership and operational interest of ACO participants determine the loss sharing limit that applies to Track 1+ Model ACOs, either a revenue-based or a benchmark-based loss sharing limit. More information on these interests can be found in the detailed Track 1+ Model fact sheet available through the Shared Savings Program website, which is on the News and Updates webpage.

Keypad Polling

Leah Nguyen: Thank you, Ben.

At this time, we will pause for a few minutes to complete keypad polling. Holley, 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 one. 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 nine. Again, if you are the only person in the room, enter one. 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 nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Again, please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

Thank you for your participation. I'll now turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley. I'll now turn the call back over to Ben to continue the presentation.

Presentation (Continued)

Benjamin Dellva: Thank you, Leah.

The next section of this call will focus on ACO Participant Agreements. In addition to submitting ACO Participant Lists, ACOs must create and sign ACO Participant Agreements with each participant in the ACO.

ACO Participant Agreement

Slide 31 addresses ACO Participant Agreements. ACO Participant Agreements are agreements directly between the ACO legal entity and the ACO participant legal entity and confirm that the participant agrees to participate in the program and comply with all program requirements. When establishing your ACO Participant Agreement, please refer to the requirements listed in the final rule and the ACO Participant List and Participant Agreement guidance.

Slide 32 outlines ACO Participant Agreement requirements. Participant Agreements must comply with the Shared Savings Program requirements and include the following. First, the only parties to the agreement are the ACO and the ACO participant. Second, the agreement must be signed by individuals who are authorized to bind the ACO and the ACO participant, respectively.

Third, the agreement must require the ACO participant and each ACO provider or supplier billing through the TIN of the ACO participant to agree to participate in the Shared Savings Program and to comply with the requirements of the Shared Savings Program, including all other applicable laws and regulations. Fourth, the agreement must set forth the ACO participant's rights and obligations, including the quality reporting requirements, the beneficiary notification requirements, and how participation in the Shared Savings Program affects the ability of the ACO participant and its ACO providers or suppliers to participate in other Medicare demonstration projects or programs that involve shared savings.

Fifth, the agreement must describe how the opportunity to receive shared savings or other financial arrangements will encourage the ACO participant to adhere to the quality assurance and improvement program and evidence-based medicine guidelines established by the ACO. Sixth, require the ACO participant to update its enrollment information on a timely basis.

Seventh, the agreement must permit the ACO to take remedial action against the ACO participant and must require the ACO participant to take remedial action against its ACO's providers and suppliers to address noncompliance. Eighth, the agreement must be for a term of at least 1 performance year and must articulate potential consequences for early termination from the ACO. And finally, ninth, the agreement must require 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 address other relevant matters.

ACOs, ACO participants, and ACO providers and suppliers are prohibited from, first, conditioning the participation on referrals of Federal health care program business that the ACO know is being provided to beneficiaries who are not assigned to the ACO and, second, requiring that beneficiaries be referred only to ACO participants or ACO

providers or suppliers within the ACO or to any provider or supplier except under limited circumstances as described in the Shared Savings Program regulations.

Now let us take a look at slide 33. CMS strongly encourages the ACO Participant Agreement address the following. ACOs should agree to comply with the HIPAA Privacy Rule, HIPAA Security Rule, the ACO's Data Use Agreement with CMS, and other relevant regulations. CMS shares beneficiary data with ACOs to improve efficiency and quality of care and expects ACOs to use data appropriately and to protect beneficiaries' privacy. CMS recommends ACOs include a clear statement outlining that the ACO is responsible to report on quality measures on behalf of its ACO's participants and, by extension, the providers and suppliers that bill through the ACO participants. Finally, ACOs should consider including a specific requirement for the ACO participant to confirm its information in PECOS is correct and current and that this information is consisted – consistent with what was included in the ACO Participant Agreement.

On slide 34, we further describe the requirements of Participant Agreements. ACOs must submit their full sample ACO Participant Agreement and completed ACO Participant Agreement template with their application. The ACO Participant Agreement template will be available in the June – in the 2018 Toolkit available in June. You may reference the 2017 Toolkit for an example of last year's ACOs' Participant Agreement template. It identifies where each requirement is met within the sample agreement. ACOs must also submit the first and signature pages of the executed ACO Participant Agreement for each ACO participant. It is important to develop a compliance sample ACO Participant Agreement that meets all Shared Savings Program requirements before executing ACO Participant Agreements for each ACO participant. It is very time-consuming for ACOs to correct deficiencies and noncompliant ACO Participant Agreements.

Moving on to slide 35. To amend a previously-executed ACO Participant Agreement, ACOs must submit the ACO Participant Agreement, the amendment, the completed ACO Participant Agreement template, and the first and signature pages of the executed agreement and the amendment. As previously mentioned, the ACO Participant Agreement must be between the ACO legal entity and the ACO participant legal entity. CMS will not accept agreement that include third party intermediaries or letters of intent. The ACO Participant Agreement must clearly identify all parties and the duration of the agreement. Do not include ACO participant TINs on your ACO Participant List

without submitting a signed ACO Participant Agreement. Again, correcting deficiencies to your ACO Participant Agreements can be very time-consuming.

Slides 37 and 38 provide tips for executing ACO Participant Agreements. CMS suggests reviewing these slides when executing your ACO Participant Agreements. ACOs should confirm the following before submitting executed agreements:

- The sample ACO Participant Agreement meets all requirements and the executed agreement matches the compliant sample agreement submitted with the application.
- Confirm the ACO's Shared Savings Program start date and that the correct ACO legal entity name and the correct ACO participant legal entity name are included in the executed agreement. ACO participants should confirm their legal entity name in PECOS prior to executing the agreement.

Moving to slide 38. The ACO participant TIN is correctly presented on the executed agreement if it's included. Only the ACO executive authorized to sign primary or authorized to sign secondary, as listed in the Contact Data page in HPMS, are authorized to sign on behalf of the ACO. Any changes to the executed agreement include both parties' initials, and that no executed agreement have an effective date more than 1 year before the change requests were entered or submitted to HPMS.

Slide 39 shows some examples for ACO Participant Agreements. In the first example, all practitioners that have reassigned their billings to the TIN of the large group practice have agreed to participate in the Shared Savings Program and follow program regulations. The ACO may include this group practice TIN on its list of participants. In the second and third examples, the ACO may not include the group practices on the list of ACO participants. CMS only accepts ACO Participant Agreements between an ACO and an ACO participant in which the ACO participant and all practitioners billing through the ACO participant TIN agree to participate in the program and follow program regulations.

Slide 40 presents common ACO participant errors and include an incorrect ACO legal entity name, incorrect ACO participant legal entity name, missing signatures, and incorrect participant TINs. Please reference this slide for errors to avoid when submitting your application, and remember to use the compliant sample ACO Participant Agreement when executing your ACO Participant Agreement.

Slide 41 provides a summary of what we just covered on the Participant List and ACO Participant Agreements. ACOs must confirm that the ACO participants are Medicare-enrolled and have a valid Participant Agreement.

All fully executed ACO Participant Agreements must match the sample agreement. ACOs must confirm that TINs, CCNs, NPIs, legal entity names, and doing-business-as names are included on the ACO Participant List and Agreements are accurate. Note that ACOs will only have one opportunity after they submit their application during the first request for information to add participants to their list or to correct transposed TINs, CCNs, or NPIs. And, finally, CMS strongly suggests that ACOs submit all TIN, CCN, and NPI information by the application submission deadline.

In the next section, we will discuss the skilled nursing facility, or SNF, Affiliate List and its requirements. Only ACOs applying for a SNF 3-Day Rule Waiver need to submit a SNF Affiliate List and SNF Affiliate Agreement.

SNF Affiliate List

We're now on slide 43. The SNF Affiliate List is the list of all skilled nursing facilities the ACO plans to partner with when using a SNF 3-Day Rule Waiver. The SNF Affiliate List is only applicable to Track 1+ Model ACOs and Track 3 ACOs applying for the SNF 3-Day Rule Waiver. CMS uses the SNF Affiliate List to identify claims, monitor for proper usage of the SNF 3-Day Rule Waiver, and review waiver compliance requirements.

Moving on to slide 44. To add SNF affiliates to the SNF Affiliate List, ACOs must provide the SNF's TIN and CCN. The TIN and the CCN for the SNF must be Medicare-enrolled. The SNF Affiliate List is different from the ACO Participant List. ACOs submit them through two different modules in HPMS. It is important to note that SNF Affiliates are not required to be ACO participants. Additionally, SNF affiliates may partner with more than one Shared Savings Program ACO and/or participate in other Medicare shared savings initiatives. To be eligible to use the SNF 3-Day Rule Waiver, a SNF must be enrolled in Medicare, included on the ACOs certified SNF Affiliate List, and sign the SNF Affiliate Agreement with the ACO and meet all other requirements.

Continuing on slide 45. For every SNF affiliate listed, ACOs are required to submit a corresponding executed SNF Affiliate Agreement. The Agreements must include the TIN,

the TIN legal entity name, and doing-business-as name and CCN, CCN legal entity name, and/or the CCN doing-business-as name.

We're now on slide 46. After the application submission deadline, ACOs only have one opportunity to submit additional SNF affiliates and correct TIN and CCN digit typos in response to the first RFI. CMS strongly recommends that ACOs submit all TIN and CCN information by the application submission deadline of July 31st. If ACOs submit incorrect TIN or CCN information in response to the first request for information, which is due August 30th, the ACO will not have an opportunity to correct the digits, and CMS will deny those SNF affiliates. After the first RFI, corrections to incorrectly typed TINs and CCNs are considered additions to the SNF Affiliate List and will not be allowed.

In the next section, we'll cover details of the SNF Affiliate Agreement and its requirements. Again, these requirements only apply to ACOs applying for a SNF 3-Day Rule Waiver.

SNF Affiliate Agreement

We're now on slide 48. CMS requires ACOs to execute contractual agreements with each SNF affiliate so that the ACO clearly articulates, understands, and agrees with the requirements regarding the SNF 3-Day Rule Waiver. An ACO may not include a SNF on its SNF Affiliate List unless an individual authorized to bind the SNF affiliate's Medicare-enrolled TIN has signed a SNF Affiliate Agreement with the ACO.

During the application period, ACOs must submit supporting documentation demonstrating that an agreement is in place between the ACO and each proposed SNF affiliate. ACOs must execute a SNF Affiliate Agreement with each SNF on its SNF Affiliate List for the SNF affiliate to the eligible for the SNF 3-Day Rule Waiver. Letters of commitment or intent are not acceptable.

The TIN should notify all providers and suppliers billing through each of the TINs and CCNs on the SNF Affiliate List of the Shared Savings Program requirements before the SNF affiliates begin to admit beneficiaries under the SNF 3-Day Rule Waiver.

The table on slide 49 details SNF Affiliate Agreement requirements. SNF Affiliate Agreements must comply with the following criteria:

- The ACO and the SNF Affiliate are the only parties to the agreement.
- Agreements must be signed by individuals who are authorized to bind each party respectively.
- Require the SNF affiliate to agree to the SNF 3-Day Rule Waiver requirements.
- Include the agreement effective date.
- Require the SNF affiliate to implement and comply with the ACO's beneficiary evaluation and admission plan and the care management plan.
- Require the SNF affiliate to conduct beneficiary eligibility validations before admission – the beneficiary eligibility criteria is provided in section (a)(1)(ii) of the SNF 3-Day Rule Waiver.
- Include remedial processes and penalties that may apply for noncompliance with the requirements and conditions of the Shared Savings Program and the SNF Affiliate Agreement.
- And, finally, there are two recommendations ACOs should consider in their SNF Affiliate Agreements: Require training for both the ACO Beneficiary Evaluation and Admission Plan and the Care Management Plan for beneficiaries admitted to the SNF affiliate in accordance with the waiver and require the ACO to notify the SNF affiliate within 60 days after the SNF 3-Day Rule Waiver has ended.

On slide 50, we see that ACOs must submit executed agreements to CMS via the HPMS SNF Affiliate List Management Module during the application period. The SNF Affiliate Agreement must be a direct agreement between the ACO and the SNF affiliate and should include a signature page signed by individuals who are authorized to sign on behalf of the SNF affiliate and ACO. Note that CMS do not accept electronic signatures. The person signing on behalf of the ACO must be listed in HPMS as the ACO executive or in one of the authorized assigned contact roles, and each executed SNF Affiliate Agreement must match the sample SNF Affiliate Agreement.

Now, look to slide 51. The signature page must clearly identify the ACO and SNF affiliate and be consistent with the legal entity names listed on the first page of the SNF Affiliate Agreement. The signature page of the agreement should also list the SNF affiliate's CCN and CCN legal entity name and the CCN doing-business-as name for each SNF affiliate under the Medicare-enrolled TIN that agree to be SNF affiliates with the ACO. ACOs should also include a statement that the Medicare-enrolled TIN, along with all SNF affiliates, agree to the terms and conditions of the SNF Affiliate Agreement on behalf of

each CCN listed. Please refer to the SNF 3-Day Rule Waiver guidance for additional information on the requirements.

We're now on slide 52. CMS requires ACOs to submit a sample of the SNF Affiliate Agreement for approval. Note that CMS does not provide a boilerplate agreement for ACOs, but instead reviews the sample agreement to ensure it meets all regulatory requirements. CMS provides the sample agreement template for ACOs to indicate where each requirement is addressed in the SNF Affiliate Agreement. The SNF Affiliate Agreement template will be available in the June – in the 2018 Toolkit in June. You may reference the 2017 Toolkit for an example of last year's SNF Affiliate Agreement template. ACOs with multiple sample SNF Affiliate Agreements must populate and submit one template for each sample agreement. If CMS identifies any deficiencies, ACOs must modify the sample agreement and re-execute the SNF Affiliate Agreement. Executed agreements must match the approved sample SNF Affiliate Agreement.

Slides 53 and 54 provide tips for submitting executed SNF Affiliate Agreements. CMS suggests reviewing these slides before executing SNF Affiliate Agreements. ACOs should confirm the following before submitting executed agreements: the sample agreement meets all Shared Savings Program requirements; there are accurate spelling of names and TINs and CCNs; communication plans, beneficiary evaluation and admission plans, and care management plans are up to date; SNF affiliate CCN, CCN legal entity names, and CCN doing-business-as names are accurate and match what was submitted to HPMS.

Moving to slide 54. Any changes to the signed SNF Affiliate Agreement must be initialed by both parties. The ACO and SNF affiliate must sign the signature page within 12 months of the date of the agreement that was entered in HPMS. The individual who signs for the ACO must be listed on the Contact Data page in HPMS as the ACO executive or an authorized assigned contact. Please make sure the copy of the agreement is eligible. Additionally, ACOs may refer to other tips and common errors in the ACO Participant Agreement section of this presentation.

Let's move to slide 55. Each proposed SNF affiliate must be Medicare-enrolled and have a signed and valid SNF Affiliate Agreement with the ACO that meets Shared Savings Program requirements. Additionally, the ACO must demonstrate that each proposed SNF affiliate has an overall quality rating of three or more stars under the CMS Five-Star

Quality Rating System. If SNFs do not meet all requirements, CMS will reject the ACO's request to include the SNF on the ACO's SNF Affiliate List.

We're now on slide 56. Legal entity names, doing-business-as names, CCNs, and TINs included in the SNF Affiliate Lists and Agreements must be accurate. And as previously stated, ACOs will only have one opportunity during the first request for information to add affiliates to their list, including correcting any transposed or incorrectly typed TINs and CCNs.

Now I will turn the presentation over to Ramandeep from RTI International, who will discuss the beneficiary assignment methodology.

Beneficiary Assignment

Ramandeep Kaur: Thanks, Ben. Good afternoon. This is Ramandeep Kaur with RTI International. We're going to review the assignment of Medicare beneficiaries to the ACO. Assignment refers to an operational process used to determine whether a Medicare beneficiary can be assigned to the ACO.

Slide 58 provides background information on beneficiary assignment. In the Shared Savings Program, beneficiaries are assigned to ACOs using a claim-based attribution methodology. In order to be in the Shared Savings Program, an ACO needs to have at least 5,000 preliminary assigned beneficiaries in each of the three years preceding the start of the agreement or performance year.

Slide 59 outlines the beneficiary eligibility requirement. 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 1 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 health plan enrollment.

The beneficiary must reside in the United States, including Puerto Rico and U.S. territories. Finally, the beneficiary must have a primary care service, or PCS, with a qualified physician at the ACO. These include ACO physicians used in assignment, a physician on Federally Qualified Health Center or FQHC, or Rural Health Clinic or RHC Attestation List.

Slide 60 shows a list of professionals used in assignment Step 1. There are two categories of professionals used in assignment Step 1: primary care physicians and selected non-physician practitioners. Primary care physicians include internal medicine, family practice, general practice, geriatric medicine, and pediatric medicine. Selected non-physician practitioners include nurse practitioner, clinical nurse specialist, and physician assistant.

Slide 61 shows a list of professionals used in Step 2. These include professionals such as cardiology, neurology, nephrology, and endocrinology, etc. Please note that surgeons are not included here.

Slide 62 provides information on physician attestation requirement for Federally Quality Health Centers and Rural Health Clinics. Section 1899 of the Social Security Act requires assignment to be based on services furnished by physicians. Federally Qualified Health Center and Rural Health Clinic claims contain limited data on the type of practitioner providing a service. CMS knows who's responsible for the overall care but not necessarily who provided the care. CMS uses the ACO Participant List in combination with claims data to identify the provider who furnished services.

We are now on slide 63. Attestation List is required only for Federally Qualified Health Centers and Rural Health Clinics that belong to ACOs. The list is comprised of physicians who deliver direct primary care service at Federally Quality Health Centers and Rural Health cClinics. Attestations List should include not only physicians who currently provide primary care services but also those who deliver primary care services during the assignment window. For new 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.

Moving on to slide 64. Here we have the definition of primary care services. The first set are evaluation and management services provided at office or other outpatient settings, and these are identified by CPT codes 99201 to 99215; nursing facility care settings, CPT codes 99304 to 99318, excluding claims that have the place of service 31 modifier. Place of service 31 denotes skilled nursing facility. Domiciliary, rest home, or custodial care settings, CPT codes 99324 to 99340; home services, CPT codes 99341 to 99350; chronic care management services, CPT code 99490; transitional care management

services, CPT codes 99495 and 99496; hospital outpatient clinics identified by HCPCS code G0463. This code is only used for Elective Teaching Amendment or ETA hospitals.

The other type of primary care services are wellness visits. These are identified by HCPCS codes G0402, G0438, and G0439. For clinic visits at Rural Health Clinics or by their providers in selected settings, we sometimes use Uniform Billing revenue center codes 0521, 0522, 0524, and 0525.

Slide 65 presents information on pre-screening assignment estimates. Assignment numbers refer to number of beneficiaries attributed to ACOs during the first three pre-screening rounds are estimates and may change across rounds and with final assignment. An ACO may be above or below 5,000 during the early rounds but either fall below or climb above the threshold during final assignment.

Some reasons for assignment numbers changing include, but not limited to:

- ACOs adding or removing overlapping TINs or CCNs. TINs and CCNs need to be enrolled in Medicare to be included in assignment. If a TIN or CCN is not enrolled, it will not be included in assignment.
- If a TIN or CCN gains enrollment, it would then be included. A TIN or CCN's enrollment status may change in between pre-screening rounds.
- ACOs in markets adding or removing TINs will impact other ACOs in the same market.
- Finally, changes in participants and beneficiaries to other Shared Savings Program can also impact assigned numbers.

Now, I will turn the presentation back to Ben.

Benjamin Dellva: Thank you, Ramandeep. We're now on slide 66, which contains helpful resources for ACOs as they complete their applications. CMS asks applicants to continually monitor the Shared Savings Program website for updates. For questions regarding the application throughout the process, contact us by email at sspaco_applications@cms.hhs.gov.

This slide also provides email addresses and phone numbers to contact if you are having problems with your CMS user ID form, password resets, or technical issues of HPMS. Please use the Medicare Revalidation Lookup Tool for searching for a provider or

supplier by last name, first name, organization name, or NPI and to download a list of revalidation due dates.

This concludes the prepared portion of the Shared Savings Program application call. We will accept questions for the remainder of the time.

Question-and-Answer Session

Leah Nguyen: Thank you, Ben.

Now our subject matter experts will take your questions. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants 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, press star, one to get back into the queue, and we'll address additional questions as time permits.

All right, Holley, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone 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.

And our first question comes from the line of Jennifer Teeter.

Jennifer Teeter: Yes. Can you hear me?

Leah Nguyen: Yes. Go ahead.

Jennifer Teeter: Yes. I'm looking at slide 64, and I'm just wondering if you can explain a little bit further how the – for example, the nursing facility care settings, excluding claims that have the POS 31 modifier – how would that impact an ACO's attribution of patients who are residents at a skilled nursing facility? I'm interpreting this to mean that those would not be attributable. But, I'm just – I'm not sure. Thank you.

Kari Vandegrift: Hi. This is Kari Vandegrift. It's the provider who actually puts the place of service on the claim. So it's going to depend on your providers and whether they indicated 31 or 32 on the claim.

Jennifer Teeter: So, if they indicate 31 on the claim, then that patient would be excluded from being attributed, the same with home visiting primary care services, if home...

Kari Vandegrift: The patient wouldn't – sorry, the patient wouldn't necessarily be excluded. The claim would not be used in assignment. But they may have other claims that are eligible for use in assignment.

Jennifer Teeter: Right. Okay. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question comes from the line of Teresa Jennewein.

Teresa Jennewein: Hi. My name's Teresa and I'm calling from National Endeavors. I have a question about slide 60. On slide 60, we're referring to the attribution process of selected non-physician practitioners, including nurse practitioners, etc. Does the non-selected physician practitioners apply to RHC and FQHC in the Step 1 of the assignment process? And, if so, is this change from last year? Thank you.

Kari Vandegrift: Yes. For non-physician practitioners, for any participant type, they are used to help determine plurality under Step 1 of assignment. And that is not a change.

Leah Nguyen: Thank you.

Teresa Jennewein: Thank you.

Operator: And our next question is going to come from the line of Diana Bridgebat.

Diana Bridgebat: Hi. Thank you so much for all that information. I have a question. My system was being rebooted and fixed this morning, and I did lose your email. Would it be possible to send me the handout on my email again, but this time, to use my gmail address?

Leah Nguyen: Thank you. The presentation is posted on the CMS website. If you go to go.cms.gov/npc, then just select the date of the call from the list, and the presentation is posted there.

Diana Bridgebat: Okay. I'm sorry. It's go.cms. ...

Leah Nguyen: .gov/npc for National Provider Call.

Diana Bridgebat: Okay. Awesome.

Leah Nguyen: All right. Thank you.

Diana Bridgebat: You're welcome. Thank you so much for the information.

Operator: And our next question will come from the line of Vanessa Schatzberg.

Vanessa Schatzberg: Hi. I'm calling about slide 61 where you discuss the second step in the beneficiary assignment. Can you help me understand how CMS determines these types of physicians, for example, a multi-specialty clinic or a group practice?

Kari Vandegrift: Sure. This is Kari Vandegrift again. They're actually, on the Part B claims, they appear on the claim that's attached based on the specialty identified in PECOS.

Vanessa Schatzberg: Okay. Based on the specialty identified in PECOS?

Kari Vandegrift: Yes. For the multi-specialty clinics, that's actually been retired. That's a historical code.

Vanessa Schatzberg: So are you saying multi-specialty is no longer going to appear in PECOS?

Kari Vandegrift: Right. So there's an initiative within CMS to have all of those NPIs update their specialty to another designation.

Vanessa Schatzberg: Okay.

Leah Nguyen: Thank you.

Operator: And our next question is going to come from the line of Christine Miller.

Christine Miller: Yes. Hi. I have a question regarding to the RHC and FQHC for the initial attestation. How, along the lines there was a question asked earlier. We still have to put in each MD and DO that's at that – the RHC and the FQHC. So we don't have to add the non-specialties as well, right?

Jennifer Bates: Hi. This is Jennifer Bates. That's correct. You would not have to add those.

Christine Miller: Okay.

Leah Nguyen: Thank you.

Operator: And now, our next question will come from the line of Jay Williams.

Jay Williams: Hi. Thank you. My question is in reference to slide number 52 regarding the sample SNF Affiliate Agreement. In preparation for the application submission, do we have an opportunity to provide the Affiliate Agreement in advance for review prior to our application submission?

Jonathan Blanar: Hi. This is Jonathan at CMS. Unfortunately, no. Right now, there is not a process to submit your sample agreement ahead of your application for pre-approval. But, thank you for the question. It is something we are looking into for future years.

Jay Williams: Great. Thank you so much.

Leah Nguyen: Thank you.

Operator: And our next question is going to come from the line of Willie Hock.

Lori Hack: Hi. It's Lori Hack from the Empire State ACO. So, just a followup to that to be clear, then we're to submit the sample agreement as we amend it with our application with all of the signed agreements from our providers only to find out that it's deficient and we have to go back and get new signatures? Is that the process? Because I know that was the process in the past. We thought we might get some more guidance prior to distributing all the agreements for signature.

Benjamin Dellva: Hi. This is Ben Dellva. Going back to the previous question and this one, if you are a current ACO, you do have the ability to work with your CMS coordinator to address any questions you may have about a sample Participant or SNF Affiliate Agreement. Otherwise, if you have specific questions, you can submit them to the sspaco_applications inbox.

Otherwise, yes, it is correct that if you do submit agreements that are found to be noncompliant during the application process as they're reviewed, you will have to go back and re-execute them in order for those participants or SNF affiliates to be approved to be a part of your ACO.

Lori Hack: Okay. Thank you very much.

Operator: And our next question will come from the line of Bruce McDonald.

Bruce McDonald: Yes. Thank you. We are in the second year of our agreement as a Track 1 and we intend to apply for Track 1+. Is there an expedited application process for us, or do we have to resubmit everything, including those provider agreements, again?

Benjamin Dellva: So, you're – you'll be applying for the Track 1+ Model – that's correct? No, you will not need to submit Participant Agreements again. No. You'll just need to fill out the Track 1+ Model application.

Bruce McDonald: Thank you.

Leah Nguyen: Thank you.

Operator: And as a reminder, to ask a question, press star followed by one on your touch-tone phone. To remove yourself from the queue, please press the pound key. In an effort to ensure that we can hear your line, please remember to pick up your handset to both ensure clarity and volume. Our next question will come from the line of Tiana Korley.

Tiana Korley: Thanks for taking my question. My question is whether an ACO on slide 35, the Participant Agreement, can amend and restate its entire Participant Agreement. And

if so, does the ACO then just submit the entire amended and restated Participant Agreement rather than the executed agreement plus the amendments?

Benjamin Dellva: If – hi, this is Ben. If you're making changes to a currently approved agreement or if you're amending your sample agreement, you would need to submit the sample agreement, the amendment to that sample agreement, the – an updated template, the sample agreement template.

And then you would still have to submit the new executed agreements or the amendments that are associated with those executed agreements for each ACO participant that is using the new sample agreement.

Tiana Korley: Yes. So – and thanks for that. But when you amend and restate the agreement, it's basically making changes throughout the entire participant agreement. So it wouldn't correspond to section by section, so it's broader changes. Is that permitted?

Benjamin Dellva: Yes.

Tiana Korley: Okay. Great. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Libby Plunkett.

Libby Plunkett: Hello. We are in our second contract – our second year of our second contract. And earlier one of the presenters stated that it wasn't possible to start Track 1+ after we had fulfilled our second contract. Is that correct?

Leah Nguyen: Hold on one moment.

Elizabeth November: Hi. This is Elizabeth November. So, I understand you're in your second agreement period now under Track 1.

So, your ACO could apply to enter the Track 1+ Model for the remainder of your current agreement period if that timing works out or your ACO could apply to renew for its third

agreement period under the Track 1+ Model if the timing corresponds with one of the Track 1+ Model application cycles.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Sheree Love.

Sheree Love: Yes. I just had a question regarding the renewal process for the SNF waiver. Can you possibly explain whether or not we have an annual renewal process for that where we have to do the NOIA and get new agreement signed and so forth?

Benjamin Dellva: No, you don't need to apply for the SNF waiver on an annual basis. Once you apply for it, it's good until your agreement period would end, and then, you would need to reapply for it.

Sheree Love: Okay. So there's nothing annual and it's good until the end of our contract period.

Benjamin Dellva: So, you'll have to certify your SNF list before the beginning of the next performance year. We'll do that in the November/December timeframe this year.

Sheree Love: Okay. Sounds perfect. Thank you.

Leah Nguyen: Thank you.

Operator: Our next question comes from the line of Ois Yu.

Ois Yu: Hi. I just wanted to find out how CMS defines a data breach and when does the clock start ticking to report the breach within the hour?

Leah Nguyen: Hold on a moment.

Benjamin Dellva: So I would take a look at your Data Use Agreement if you're current ACO, your Data Use Agreement that you have in place with CMS now, I think, may stipulate that. If not, email us that question. We'll get you a response.

Leah Nguyen: Thank you.

Ois Yu: Okay. Thank you. I have sent in the email.

Leah Nguyen: Okay. Great. Thanks.

Operator: Our next question comes from the line of Morie Mehyou.

Morie Mehyou: My question is relating to slide number 49. You mentioned something about 90 days, and it's not on the slide itself. Would you please repeat what you'd – you had two recommendations.

Leah Nguyen: Hold on a minute.

Benjamin Dellva: Hi. Yes. This is Ben. It's the ninth requirement. It's: Require the ACO to notify the SNF affiliate within 60 days after the SNF 3-Day Rule Waiver has ended.

Morie Mehyou: I got you.

Benjamin Dellva: And that is a recommendation to include in your SNF Affiliate Agreement, not a requirement.

Morie Mehyou: Recommendation. Okay. Got you. Thanks.

Jonathan Blanar: Yes. And I will just add – this is Jonathan – that there's SNF Affiliate Agreement guidance on our website. If you go to that guidance document, it'll list all those requirements as well as the recommended requirements as well.

Morie Mehyou: Excellent. Thanks.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Marianne DeJesus.

Marianne DeJesus: Hi. Thanks for this conference call. I have a question. And that is, as part of the application, is the ACO required to estimate and attest to the number of beneficiaries they expect to be attributed. And if that is the case, what's the mechanism for us to do so?

Benjamin Dellva: No. The ACO does not have to attest to the number of assigned beneficiaries. When you get each of your RFI letters – if you look at our How To Apply page, we have a schedule on each RFI. You'll get your deficiencies with your application along with an estimated preliminary assignment number. So, CMS will provide that number to you.

Marianne DeJesus: Okay. Thanks very much.

Benjamin Dellva: Sure.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Jennifer Gasperini. Jennifer, your line's open. And her question has been withdrawn.

Our next question will come from the line of Yvonne Ketchum Ward.

Yvonne Ketchum Ward: Thank you. My question has to do with slide 37 on tips for the executed Participant Agreement. In the middle, it says if the ACO start date is January 1st, the agreement should refer to January 1st. It uses the word "should." Is that going to be a requirement? And the second part, is there any other requirements that are changing from the guidance that was put out for the agreement for last year?

Leah Nguyen: Hold on a minute.

Benjamin Dellva: Hi. This is Ben. That tip is that if you include your ACO start date – for example, if you're an initial applicant applying to start January 1st, 2018, you should reference the correct agreement period, which would begin January 1st, 2018. But, it's not a requirement.

Leah Nguyen: Thank you.

Yvonne Ketchum Ward: Okay, great. The second part was, is there any other – for those of us that wanted to make sure that our agreements were compliant, can we use the 2017 as a guide? Is there anything else that you know that's changing?

Benjamin Dellva: No. Those requirements last year should be the same as this year.

Yvonne Ketchum Ward: Okay. Thank you.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Erin DeLoreto.

Erin DeLoreto: Hi. Thank you for taking my question. Just a followup on slide 60 relative to the non-physician practitioners that are included in Step 1 of assignment. Is that sensitive down to the taxonomy code? So, for example, nurse practitioner, while it shares the same specialty code of 50, within that there's multiple taxonomy codes that identify nurse practitioners that specialize in family medicine or mental health or OB. And I'm wondering if any of those taxonomies are excluded at the non-physician level. Thank you.

Kari Vandegrift: Ramandeep or Walter, do you want to take this?

Walter Adamache: Okay. I will. The short answer to your question is, no, we don't use the taxonomy code at all during assignment. We use the specialty code that appears on claims. And that's that traditional two-digit code that CMS has been using for about 40 years.

Erin DeLoreto: Thank you.

Operator: And our next question comes from the line of Jennifer Gasperini.

Jennifer, your line is open. And her question has been withdrawn.

The next question is a followup from Vanessa Schatzberg.

Vanessa Schatzberg: Hi. I'm – my question is about switching ACOs. If you're – if you need to be exclusive to an ACO but you would like to end your performance year and join a different ACO, how does that impact the ACO Participant List? Are going to be seen by CMS as in two different ACOs?

Leah Nguyen: One moment, please.

Sarah Fogler: So – this is Sarah Fogler with the Shared Savings Program. So, participants with ACOs obviously have the choice of which ACO they want to participate in, which I

think is like the first flavor of your question. So at any point you want to terminate your agreement with your ACO, you have the ability to kind of do that from CMS's perspective. But we mechanically have an annual process that we go through in the Shared Savings Program – I'm not sure if you are interested in switching Shared Savings Program ACOs or if you're contemplating switching across Medicare ACO initiatives. Regardless, for the Shared Savings Program, there's an annual process where ACOs make revisions, modifications, additions, deletions to their Participant List for any given performance year that's coming.

So in 2017, you'd be revising your 2018 Participant List as an ACO. So as long as the Shared Savings Program within its defined windows understands that a specific participant TIN will no longer be continuing in that ACO in the 2018 performance year, we kind of process that through on an annual basis. So, as long as you're working with your ACO to kind of terminate your agreement and the ACO informs us of that termination, you'd essentially be discontinued from participation on December 31, 2017, for the coming 2018 performance year.

Vanessa Schatzberg: But if I am going to then be on a new or different ACO's – Medicare Shared Savings ACO's Participant List when their application gets submitted in July, isn't that a double...

Sarah Fogler: Right. It's a good question. And – yes, it's a good question. And we have kind of gates in effect over here that allow us to review a 2018 Participant List despite 2017 participation. So, we're all looking ahead to 2018 participation. So we're not kind of looking at your 2017 participation during our review cycle for the 2018 performance year.

Vanessa Schatzberg: Got it. And what is – what period of time is that annual review process for 2018 for those ACOs that already existed in 2017?

Sarah Fogler: It's the same defined window, I think, that's aligned with our application cycle. So, it runs from the submission of the application through really kind of December when ACOs are going through our official document signing. But the bulk of Participant List activity probably happens between September and November.

Vanessa Schatzberg: Okay. So, if I want to change ACOs, I can notify my current ACO in November, let's say, of this year. But I can still join the new ACO for their Participant List for July.

Sarah Fogler: No. Yes. You want to get ahead of that. We'd encourage you to have these conversations more in the summer timeframe. We're at a review cycle at CMS from September through December. So we're giving ACOs feedback on their Participant Lists.

But, really, as a participant TIN, you want to get ahead of all of that. So, I'd say in the summer is when you want to be having those participation conversations.

Vanessa Schatzberg: Is there a hard deadline?

Sarah Fogler: There is.

Vanessa Schatzberg: What is it?

Jonathan Blanar: So, there – I don't know off the top of my head. But, the – you can have – you can terminate your agreement with your current ACO at any time and make sure that they put in a delete request to delete your from their Participant List for 2018. And then whoever you want to start with with a new ACO, they'll have to add you to their Participant List. The last time to add ACO participants is with RFI 1, which I think is early September.

Vanessa Schatzberg: August 30?

Sarah Fogler: August 30.

Jonathan Blanar: August 30. Thank you. Yes. That's the last time that the other ACO will be able to add you to their Participant List for 2018.

Vanessa Schatzberg: Okay. But they shouldn't penalize me for saying I don't want to be in that ACO in 2018. I can continue to be part of the ACO for 2017, right?

Jonathan Blanar: That's correct. It will be effective at the end of the – 12/31/17.

Vanessa Schatzberg: Okay. Great.

Leah Nguyen: Thank you.

Vanessa Schatzberg: Thank you. I apologize for the complexity.

Operator: And our next question will come from the line of Jennifer Gasperini.

Jennifer, your line is open. And again ...

Jennifer Gasperini: For the attes...

Operator: Go ahead.

Jennifer Gasperini: For the Attestation List for FQHCs and RHCs, is it only physicians that you're listing or attesting to there or are those also non-physician practitioners?

Sarah Fogler: You are attesting to physicians on the Attestation List for FQHCs and RHCs. You are attesting that they provide direct primary care services.

Jennifer Gasperini: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Ois Yu.

Ois Yu: Hi. I just wanted to know if the 2018 target quality metrics have been published and, if so, where we can find them. Are those any different from 2017?

Sarah Fogler: So we're – for folks that are familiar with our Medicare Shared Savings Program, we explore kind of our quality measurement approach for any given year through the Physician Fee Schedule Rule, and we're in the process of rulemaking right now so we can't speak toward the 2018 quality measure set.

Terri Postma: And this is Terri Postma. One thing that we finalized in last year's Physician Fee Schedule rule for the Shared Savings Program was that we were going to align with whatever QPP finalizes for the performance year for purposes of the Web Interface measures. So, Sarah's correct. Keep your eye on the 2018 Physician Fee Schedule rule for measure change proposals related – unrelated to the Web Interface but that are present in the Shared Savings Program measure set. And keep your eye on

the QPP proposed rule that's going to be coming out soon for any proposed Web Interface measures changes.

Ois Yu: Thank you.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Sheree Love.

Sheree Love: Yes. I just had a question regarding participants that are in a Track 3 ACO. If they decide to get out of the Track 3 ACO, can they join a Track 1 or a CPC Plus program?

Sarah Fogler: Yes. There's – CMS does not dictate the kind of participant like structure for ACO, for any ACOs.

Terri Postma: It's also worth noting that CPC Plus is not a shared savings initiative, so there isn't a problem with dual participation there.

Sheree Love: Oh, so in other words, they – a person – if a practice is a part of the Track 3 or Track 1 because it doesn't matter, they could also be a part of CPC Plus?

Sarah Fogler: That's right. Just be cognizant of the – you know, the – we're not the experts on their program rules, but there are some kind of different track arrangements in CPC that you'll just want to make sure you're clear on given that we allow for overlap between their program and our program.

Sheree Love: Okay. So ...

Terri Postma: This is Terri. There is a CPC Plus and Shared Savings Program overlap webinar being held, I believe, tomorrow afternoon. That should be posted on the CMS website. So if you're interested in hearing about how that – more about how that interaction works, you should plan to listen in to that.

Sheree Love: Okay. Thank you very much.

Leah Nguyen: Thank you.

Operator: And our final question for the day will come from the line of Vanessa Schatzberg.

Vanessa Schatzberg: Hi. One clarifying question. If we are setting up a new ACO Track 1+ Model, did I hear that we have to also complete a Track 1 application in addition to a Track 1+ application?

Jonathan Blanar: Correct. If you're coming into the program initially, you will need to fill out the initial Shared Savings Program application as well as a Track 1+ Model application.

Vanessa Schatzberg: Okay. Thank you.

Jonathan Blanar: Sure.

Leah Nguyen: Thank you.

Additional Information

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. On slide 68 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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