



# MLN Connects<sup>TM</sup>

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services  
Medicare Shared Savings Program Application Process:  
Question and Answer Session  
MLN Connects National Provider Call  
Moderator: Hazeline Roulac  
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1:00 p.m. ET**

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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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**Operator:** At this time, I would like to welcome everyone to today's 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 Ms. Roulac. You may begin.

## **Announcements and Introduction**

Hazeline Roulac: Thank you, Victoria. Good afternoon, and good morning to those joining us on the West Coast. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I will be your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Medicare Shared Savings Program application process. MLN Connects calls are part of the Medicare Learning Network.

On October the 20th, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program. This initiative will help providers participate in Accountable Care Organizations to improve quality of care for Medicare patients. During this call, CMS subject-matter experts will be available to answer questions about the Shared Savings Program and application process for the January 1, 2014, start date.

Before we get started, I have a couple of items to cover.

You should have received a link to the slide presentation for today's call in registration emails. If you have not already done so, please download the presentation from the following URL: [www.cms.gov/npc](http://www.cms.gov/npc). Again, that URL is [www.cms.gov/npc](http://www.cms.gov/npc). At the left side of the web page, select National Provider Calls and Events. Then, select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be released in the MLN Connects Provider eNews when these are available.

At this time, I would like to turn the call over to Laura Dash from the Performance-Based Payment Policy Group here at CMS. Laura?

## **Presentation**

Laura Dash: Thank you. Hello, and welcome to this question-and-answer session for the January 2014 application cycle of the Medicare Shared Savings Program. My name is Laura Dash, and I am the Division Director of the Division of Application, Compliance and Outreach in the Performance-Based Payment Policy Group at CMS.

I will start today on slide 4, the Agenda.

Today, we will provide you with useful suggestions and resources necessary in order to submit an application. In addition, we will furnish you with the links where you may find recordings from our previous calls. Finally, we will go over some frequently asked questions and give you the opportunity to ask our subject-matter experts questions pertaining to the current application.

## Resources

Slide 5, websites. This slide gives you the link to our Shared Savings Program website. We encourage you to continually monitor this site as we routinely update it with pertinent information regarding current and upcoming application cycles.

This site provides you with the information, including program news and announcements, various regulatory and guidance documents; Medicare data; the current application, toolkit, reference guide, and templates with instructions; as well as CMS contact information and frequently asked questions.

Please note that we have been updating documents on an ongoing basis when necessary. Recently, we updated the reference guide in the application toolkit in order to revise the naming conventions you may use if you choose to upload narratives and documents rather than use the text box option.

Remember that you – that you may choose to exercise this option if your narrative exceeds six sentences. You should indicate in the text box that you have chosen to submit the narrative as an upload by stating in the text box “See upload” and including the naming convention for the upload that corresponds to this question. This will alert the reviewer to look in the upload section of the application for the narrative associated with that question.

Failure to indicate in the text box that an upload is available will result in an error message in HPMS when you attempt to hit “Final Submit.” You will need to add this information in the text box before HPMS will allow you to hit the Final Submit button.

In addition, we restored the links associated with the electronic funds transfer, or Form CMS-588, and the agreement template instructions, as well as revised the participant list example that appears in the toolkit. All documents are complete and current as of today.

Now I’m moving on to slide 6, Resources for the Application Process.

I cannot emphasize enough the importance of a timely application submission. Please do not wait for the last minute to apply. The deadline for your application is Thursday, July 31st, 2013, at 8 p.m. Eastern Standard Time. We will not process any applications received after July 31st, 2013, at 8 p.m. Eastern Standard Time for the January 1st, 2014, start date.

If your application is submitted after this time, we will not review it. However, you will have the opportunity to apply for the next application cycle, which has a start date of January 1st, 2015.

In our attempt to help you complete a timely application submission, we are providing you with contacts you may need in the event that you require additional assistance. This slide gives you the phone numbers and email addresses for components that can help you. Please keep this reference with you as you submit your application.

As a reminder, contact HPMS when you are having trouble getting into the HPMS system. Contact the applications mailbox if you are experiencing problems inputting information in the application or unable to hit the Final Submit button. Contact the CMS IT service desk when you are having user ID issues, such as your user ID is locked out and it must be reset.

Moving to slide 7, Information from Previous Calls. We have had several calls that provided applicants with detailed information about how to submit their application. We encourage you to review these calls as often as necessary. All previously recorded calls are found on our Shared Savings website.

### **Frequently Asked Questions**

Slide 8, Frequently Asked Questions. At this time, I will go over some of the frequently asked questions that have been sent to us through the Shared Savings Application mailbox.

The first question: “Can I make a change to my NOI? If so, how do I do it?”

And the answer is, if you need to change any information from your Notice of Intent to Apply, have your ACO executive or your application contact send that request by email to [SSPACO\\_Applications@cms.hhs.gov](mailto:SSPACO_Applications@cms.hhs.gov). Again, [SSPACO\\_Applications@cms.hhs.gov](mailto:SSPACO_Applications@cms.hhs.gov). In the subject line of that email, include your ACO ID, the legal entity name, and the phrase “NOI change request.”

In the body of the email, include both the information that needs to be changed and the exact correction you would like to make to your NOI. Keep in mind that CMS is the only one able to make the change, and changes can only be made before the application due date. For this cycle, changes will be made in HPMS through July 30th, 2013.

The second question we’ve received is: “You have stated that the text boxes only accept 4,000 characters. Does this include spaces? What if my narrative is longer than 4,000 characters?”

The answer: CMS added text boxes for narrative submissions for the 2014 application cycle. The text boxes have a limit of 4,000 characters, including spaces. Certain characters, such as the greater than, less than, or semicolon signs, are not recognized. Therefore, please do not use these characters.

If your narrative will be longer than 4,000 characters, or approximately six sentences, you may choose to upload your narrative or supporting documentation. Please type in the corresponding text box, “See upload.” Also, include in the text box the naming convention that represents your narrative.

The next question: “I cannot locate the definition of a public contact in the MSSP toolkit resources. Can you assist me?”

The definition of a public contact is an individual – or this individual should be a person in your ACO’s organization who will handle inquiries about the general public about your ACO. Public inquiries could relate to things such as solicitations for information about your ACO or the ACO participant, requests to participate in research studies, requests to join your ACO, or advertisements from vendors.

The fourth question: “I have a specific question regarding the MSSP process. If we were to submit the application and get accepted, can we still decide to not participate?”

If an applicant is accepted into the Medicare Shared Savings Program, they may decide to not participate. Submitting an application does not bind the entity to participate if accepted.

The fifth question: “Are ACOs required to have at least one contracted hospital in their network and have them listed as an ACO participant?”

Our response: The final rule at 42 CFR Part 425 does not specify any requirements for the number, type, and location of the provider’s suppliers that are included as ACO participants.

Four more frequently asked questions for us to cover.

The next question is: “Are the agreements between the ACO and the ACO providers”—and the ACO providers are the NPIs—“required to be in place by application submission or just the start of the program?” So again, the question is “Are the agreements between the ACO and the ACO providers required to be in place by application submission or the start of the program?”

And the answer is: Signed agreements for ACO participants included on your ACO participant list are required at the time of your application submission.

The next question: “I know we need 5,000”—and this is a two-part question—“I know we need 5,000 beneficiaries for every ACO formed. I also know that CMS assigns the beneficiaries, but it seems that this assignment happens after the application is submitted. When do we receive notice of how many beneficiaries are assigned to the ACO? What happens if we do not reach the 5,000 threshold?”

The response is: Applications for the 2014 application cycle will receive a report in mid-August that includes the number of preliminarily assigned beneficiaries and results of screening. Applicants will have an opportunity to resubmit their ACO participant list if they did not meet the 5,000-minimum beneficiary threshold.

The second part to that question is: “If we submit our application but still have more PCPs that want to join after submission, how do we submit TINs for these PCPs? Are there specific cycle deadlines? As a corollary, how would beneficiaries assigned to these PCPs be added to the threshold—immediately, or again, on a cycle deadline?”

And the response is: After the resubmission of an ACO participant list, if necessary, ACOs must wait until they have been accepted into the program to add new TINs. At that time, the ACO must maintain, update, and annually give the list of ACO participants and the list of ACO provider/suppliers to CMS at the beginning of each performance year and at other times as specified by CMS. The ACO must certify the accuracy of these lists at the start of each performance year.

During the term of the participation agreement, an ACO may add or remove ACO participants or ACO provider/suppliers. An ACO must notify CMS within 30 days of such an addition or removal.

The next question is: “Can the same person serve in multiple contact roles on the ACO application? For example, can the secondary application contact also be the financial contact? Or do we need to set up 13 unique individuals to serve in each of the contact roles separate from the other?”

You may have one person in your ACO perform multiple functions and be the contact person for more than one designated position. The regulations do not prohibit one person from performing multiple job descriptions in the ACO.

And our last frequently asked question is: “I pulled up the application, but I’m – but am unable to enter the data. Can you help me on what to do to allow me to enter data?”

And our response is to please follow the instructions that I will highlight for the 2014 application. And if you require further assistance, call 410-786-8084.

And those instructions are to go to the website <https://gateway.cms.gov> and click on “HPMS,” using your CMS user ID and password from the EUA site to log in. Once you’re there, mouse over the words “ACO Management” in the blue bar on the left side of the screen. From the fly-out, select the ACO data.

Click “Select Agreement Number” from the blue bar on the left, enter your agreement number or select your agreement number from the box. Click “Next.” In the blue bar on the left, go through each of these sections: General Information, Contact Information, Online Application, and Documentation.

On to slide 9, Question-and-Answer Session. We will now open the lines to answer your questions.

## Keypad Polling and Special Announcement

Hazeline Roulac: Thank you, Laura.

Before we begin the question-and-answer portion of our call, we will conduct keypad polling and then give a special announcement. At this time, we will pause for a minute to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Victoria, we're ready to start keypad 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.

Again, if there – if there is only one 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.

Thank you. I would now like to turn the call back over to Ms. Roulac.

Hazeline Roulac: Thank you, Victoria.

And now the special announcement.

CMS will soon provide a new opportunity for Medicare-enrolled providers and suppliers to give us your feedback about your experience with your Medicare Administrative Contractor, or MAC, the contractor that processes your Medicare claims. This new assessment tool is called the Medicare Administrative Contractor Satisfaction Indicator, or MSI.

Your feedback will help CMS monitor MAC performance trends, improve oversight, and increase efficiency of the Medicare program. Each year, CMS will randomly select its MSI administration sample from a list of providers who register to become a participant. If you would like to register to become an MSI participant, or for more information, please visit the website listed on slide 10. Thank you.

## Question-and-Answer Session

Our subject-matter experts will now take your questions about the Medicare Shared Savings Program application process. 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 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 will address additional questions as time permits.

All right, Victoria, we are 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 into the conference.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Larry Cappel.

Larry Cappel: Yes. This is Larry Cappel from San Benito Medical Associates. The first question of a number of questions that we'll ask later: When we are looking at filling out the participant template – the NPI number goes into place—is there a place where we can verify that the names that we have for – the legal business name is, in fact, what Medicare has in their system?

Tricia Rodgers: Hi. This is...

Larry Cappel: How can we verify that a physician by the name of Frank Jones, PC, is the same that Medicare has on file for Frank Jones, PC?

Tricia Rodgers: Hi. This is Tricia. I'd be happy to try and help you with that.

So when you submit your participant list, there is more than just one piece of information that we will review, and we will match it to our records here. If they don't match up, we will let you know and give you the opportunity to make a correction.

Larry Cappel: OK.

Terri Postma: And this is Terri. If you want to make sure you get it right in advance, though, the providers that you're working with have access to the provider enrollment system, and they can go in and verify that it is the correct name.

Larry Cappel: That's the PECOS system?

Terri Postma: Yes.

Larry Cappel: OK. Thank you very much.

Terri Postma: Sure.

Hazeline Roulac: Thank you. Next question.

**Operator:** Your next question comes from the line of Linda Mack.

Linda Mack: Hi. Can you hear me? Hello?

Hazeline Roulac: Yes, we can.

Linda Mack: OK. Thank you. Just wanted to double-check.

Linda Mack from UMG ACO. I'm calling from Southern California. And Southern California has eight counties that is part – are a part of the CCI, the Coordinated Care Initiative for dual-eligibles. And yesterday I was part of a stakeholder call. And they had indicated that they were going to be sending letters out to all of the dual-eligibles effective the first 3 months of 2014, indicating that they were eligible to enroll into their – the CCI program.

And I had inquired if they would be touching the ACO participants that are going to be assigned to the ACO. And they said yes, they would because that's part of their State, that they're identified as dual. They're going to send it to them.

So, it struck me as – it struck me as dangerous, in a sense, that now, if we have our beneficiaries that are attached to our ACO and the State's starting to send out letters to these beneficiaries, these beneficiaries are going to be very, very confused and that we may have issues where there might be mass disenrollment due to misinformation.

Is CMS aware of this? That we could have this – run into this potential trouble that would affect the ACOs in our area?

Terri Postma: Hi, this is Terri. Yes, we are aware of this initiative. And just as a point of clarification, the beneficiaries that may ultimately be assigned to your ACO are fee-for-service beneficiaries that choose to frequent your ACO providers enough so that they receive a plurality of their primary care services from your ACO.

So, there's no – this isn't a managed – ACOs are not managed care, there's no enrollment, there's no requirement for you to reach out and connect with your preliminarily prospectively assigned list of beneficiaries. CMS provides that to you for your informational purposes so that you can start to think about how to redesign your

care processes to care for all the fee-for-service patients that your providers see. So, that's one thing.

Second, in direct response to your question about the duals initiative, we've issued a number of facts on our website that you might want to review. It gives an overview of the duals initiative and talks about the different ways that some States are implementing their design for dually eligible beneficiaries.

In the State of California, fee-for-service beneficiaries may be passively enrolled in a – in a State dual-eligible demonstration. And because of that, those beneficiaries are not going to be available for assignment to the ACO because those beneficiaries would no longer be fee-for-service Medicare.

So, the only beneficiaries that retrospectively get assigned to the ACO for purposes of calculating your performance-year calculations will be those beneficiaries that had fee-for-service Parts A and B during the course of the year and are not passively enrolled in a managed care plan such as the duals initiative.

So, go to our website and look at those facts. And if you have questions beyond what those facts address, please feel free to email us.

Linda Mack: I apologize, but I still didn't quite get an answer to my question because we're applying for the ACO right now. The – if we get approved and the members are assigned to our ACO, that would become effective January 2014. Now, my – I guess, the basis of the question is that in 2014, the State will be sending out letters to these dual-eligibles letting them know about the enrollment and everything. So, are you telling me that these specific individuals that are in our – let's say they are in our ACO now for a January 1st effective date – are going to get taken out of the ACO and get passively enrolled into their dual – into the State's dual-eligible program?

Terri Postma: Correct. But, again, I just want to make sure that you understand that when CMS preliminarily prospectively assigns beneficiaries to your ACO, it's for informational purposes only. They don't belong to your ACO. They're fee-for-service patients that have freedom to choose their providers. And when there is overlap with other CMS initiatives, we handle that on a case-by-case basis with the – with the initiative. And that's clearly outlined in our facts and also in our regulation.

Linda Mack: I understand – I understand what you're saying. But it – to me, that already defeats some of our ACOs in terms of the application process and the approval, and then summarily come January or, you know – or February, March, all of a sudden that ACO that was approved no longer sees there are 5,000 memberships, and they're down – maybe down to 2,000 or something of that sort. And, by default, that ACO no longer – cannot exist.

Hazeline Roulac: OK. I think it would be helpful, maybe, for you to put your question in an email and send it to us, and we'll move on to the next question.

Linda Mack: Yes, please.

Terri Postma: And looking at the facts – please review the facts. And I think that answers a number of the questions that you’re posing here.

Linda Mack: OK. Great. Thank you.

Terri Postma: Maybe, I’m just not – I don’t have them in front of me. So maybe I’m just not explaining it right. But, I think the facts can help.

Linda Mack: All right. Thank you very much.

Hazeline Roulac: OK. Thank you. Next question.

**Operator:** Your next question comes from the line of Jordan McInerney.

Jordan McInerney: Hi. This is Jordan McInerney with Stryker Performance Solutions. I’m trying to understand or get clarification on the provider/supplier agreement. Specifically, does CMS require that an ACO have a signed agreement with each provider that is billing under an ACO participant TIN?

Terri Postma: Hi, this is Terri. So, the – one of things you might want to look at is our agreement guidance. And for purposes of the application – so, the agreement guidance goes through what agreements have to be in place. And the ACO must have an agreement between the ACO and the ACO participant. And the ACO must also ensure that each practitioner that bills through the TIN of that ACO participant has also agreed to participate and comply.

For purposes of the application, all we’re asking to see is the agreement between the ACO and the ACO participant. But that – but when you put that ACO participant on your list and you have that signed agreement that you submit as part of your application, the expectation is that you’re not putting an ACO participant on the list unless each practitioner that bills through the TIN of that ACO participant has agreed to participate and comply.

Does that help?

Jordan McInerney: An agreement can be verbal? It does not have to be in writing?

Terri Postma: No. It should be in writing, unless the – unless the practitioners are employed and, as a condition of their employment, they must agree to participate and comply. And, in that situation, the ACO participant can send a notification to each of them. Thank you.

Jordan McInerney: Then, you would have to submit the employment agreement with the application?

Terri Postma: If there is an employ – if there is a situation where the ACO is employing the ACO participant and all their practitioners, then you would submit an employment agreement. If the ACO, however, has contractual arrangements with each of the ACO participants, then the ACO has to – then, it's required that the ACO submit the ACO – the agreement that the ACO has with each of its ACO participants.

Jordan McInerney: OK. I understand participants, but, provider/supplier? It seems like you guys keep interchanging the two. And – but you define them differently.

Terri Postma: Yes. They're defined completely differently. The ACO participant is defined as its Medicare-enrolled TIN. And so the ACO will have an agreement with each of the ACO participants that it puts on its ACO participant list. That – the agreement guidance goes through what has to be in each of those agreements. And that's what you'll be submitting as part of the application.

The ACO also must ensure that each of the practitioners that bills through the TIN of each of the ACO participants has also agreed to participate and comply. You can do that directly or indirectly. The ACO can have a direct signed agreement from each of those practitioners, or the ACO can choose to do that indirectly through its agreement with the ACO participant, such that the ACO requires the ACO participant to ensure that each of the practitioners has agreed to participate and comply. And that's all explained in the agreement guidance on our website. So I encourage you to take a look at that.

Hazeline Roulac: OK. Thank you for your question.

Jordan McInerney: I have . . . .

Hazeline Roulac: I'm sorry. We need to move on to the next person. If you have another question, please feel free to get back in the queue. Thank you.

**Operator:** Your next question comes from the line of Jerusha Oleksiuk.

Jerusha Oleksiuk: Hello. My name is Jerusha Oleksiuk, and I'm with the Institute for Family Health. And we are an FQHC and have multiple sites and, as a result, we have one organizational NPI and individual site NPIs. Our providers are linked to both the organization NPI and the individual site NPI numbers. Claims are submitted with the site NPI. And we want to be sure that CMS attributes patients correctly. So which NPI number should be listed on our participant list?

Terri Postma: So, this is – this is Terri. So, what you'll put down on your ACO participant list is the TIN of the organization and the NPIs for each of those sites. And so, any sites that use that TIN have to agree to participate and comply. And so, the – so,

we'll be capturing all those – the billings of everyone that bills under that ACO participant TIN.

Jerusha Oleksiuk: OK. So it's the TIN. Not – so for the – so – sorry. So just so I'm clear. So, the NPI – should we – should we put the site NPI, then, for each (inaudible) or the organization NPI?

Terri Postma: The organizational NPI for FQHCs and RHCs that's associated with that TIN.

Jerusha Oleksiuk: OK.

Terri Postma: So you'd be writing your TIN down and then you'd be writing each of the organizational NPIs that's associated with it.

Jerusha Oleksiuk: So the – so the TIN and then the organizational NPIs.

Terri Postma: Yes.

Jerusha Oleksiuk: OK. OK, thank you.

Hazeline Roulac: Thank you. Next question.

**Operator:** Your next question is from Maura Hoxsie.

Donna Hoxsie: Donna Hoxsie. Hello?

Hazeline Roulac: Yes. Go ahead with your question, Donna. Thank you.

Donna Hoxsie: Well, we're a specialist, so I don't know if we even need to participate in this. And that's what my question is—is this only for general practitioners?

Terri Postma: Hi, this is Terri. Thanks for your question.

We have a good overview of the program on our website if you want to listen to that presentation. Just as a high-level snapshot, this is a voluntary program. This is designed for Medicare-enrolled providers and suppliers to join together to form an Accountable Care Organization.

And I stress voluntary. And there's a place – so any Medicare-enrolled provider or supplier can – that's enrolled in Medicare is welcome to join and participate.

Donna Hoxsie: OK.

Terri Postma: But it is voluntary, and the ACO organization has to meet certain criteria, which are outlined in that overview – in that overview presentation on our website.

Donna Hoxsie: And your website?

Terri Postma: Yes. So – which is [www.cms.gov/sharedsavingsprogram/](http://www.cms.gov/sharedsavingsprogram/).

Donna Hoxsie: Thank you.

Terri Postma: You're welcome.

Hazeline Roulac: Thank you. Next question, please.

**Operator:** Your next question comes from the line of Peter Brawer.

Peter Brawer: Hello, this is Peter Brawer from SSM Health Care in St. Louis, Missouri. And not to repeat the questions posed by the individual from Stryker, but if we could get some further clarification—in the frequently asked questions that you reviewed before the call, or in the beginning of the call, one of the questions began with the comment about providers, and it was answered with the question about participants in the process.

So let me give you a real-life example. In SSM, we have three physician groups who are participating within the ACO application. Do we need the signed participant agreement from the three groups or from the 150 individuals within those groups? And they are all employed individuals. If you could give clarification on the provider versus participant, that would be really a benefit.

Terri Postma: Hi. OK. So, this is Terri. Let me try again.

So, the requirement is that everybody down the line has agreed to participate and comply. However, for purposes of the application, all we need to see is the agreement that the ACO has with each of the ACO participant TINs. OK? So . . . .

Peter Brawer: Would that . . . .

Terri Postma: Does that make sense?

Peter Brawer: It does. And it's – in the frequently asked questions, I think some of the confusion came because it asked “provider” and the answer was “with participant.” And that clear answer is really of benefit to us.

Terri Postma: OK. Got it. Thank you. We appreciate that; we'll try to clean that up.

Peter Brawer: Thank you. Sure.

Hazeline Roulac: Thank you. Next question, please.

**Operator:** Your next question comes from the line of Diane Dykstra.

Marie Hooper: Hello. This is Marie Hooper from NPO. And my question is around the start of a performance year. So, understanding the – in some of the clarification you've given us today, if we – after submission of our application and we have sufficient number of Medicare beneficiaries—5,000 or more—and we have additional providers who want to sign on, is the start of a performance year – would that actually be January 1 of 2014? Or would we have to wait until January 1 of 2015 to add those additional providers if they wish to participate?

Terri Postma: Hi, this is Terri. So, during the application period, you're given one opportunity – right? Two – sorry – two opportunities to add ACO participants to your list. And after that, the next opportunity that you would have if you're accepted into the program would be to add for the second performance year.

So the list that you're doing during the application period, you have those two opportunities to modify it. After that, that list is closed and we're accepting you on the basis of that list for the first performance year. And then during the first performance year you'll have opportunities to add, but then it would be for the certified list for the second performance year.

Does that make sense?

Marie Hooper: Yes, it does. Thank you for clarifying that.

Terri Postma: Sure.

Hazeline Roulac: Thank you. Next question, please.

**Operator:** Your next question comes from the line of Paul Meyer.

Paul Meyer: Hi. Thank you. Paul Meyer at the South End Clinic. Question as it relates to CMS Form 588 relative to the banking information on the application. It requires an NPI number to be filled in on that form.

We are a single-group practice. Our provider list will consist – or our participant list is our group practice. Are we to use the NPI number of our group practice? Or are we to apply for a new NPI number under the ACO?

Terri Postma: Hi, this is Terri. I believe the toolkit instructions ask you to ignore that field. ACOs are not required to submit an NPI . . .

Paul Meyer: OK. Thank you.

Terri Postma: . . . right? On the 588 form. Right.

Paul Meyer: Thank you.

Terri Postma: Yes.

Hazeline Roulac: Thank you. Next question, please.

**Operator:** Your next question comes from the line of Jordan Gay.

Jordan Gay: Yes, hi. This is Jordan Gay with Covenant Health Partners. My question is in regards to when you submit the application attaching narratives for questions 21 and 33 in regards to shared savings and data security. There's no naming convention listed on the toolkit.

And I was just wondering if the expectation is that those particular narratives are supposed to be under 4,000 characters so that they may be entered into the text box, or if you guys are actually going to allow us to attach those as well. And if so, what would the naming convention be for those narratives?

Terri Postma: Hi, this is Terri. Thanks for the question.

And we have recently updated the toolkit on the website to include those naming conventions. So, if you wouldn't mind going to the – to our website and looking at the updated toolkit, you should find them there.

Jordan Gay: OK. So, that is – so that has been changed. OK.

Terri Postma: Yes. It's under the reference table in the toolkit.

Jordan Gay: OK. I thought I was looking at the most current version. I didn't see it on there. But I'll check again.

One quick followup to that. Can you tell me the – you know – the naming convention specifies a month, a day, and a year. But what is – what are that date supposed to be? Can you – can you give some clarification on that?

Karmin Jones: The date should be the date you uploaded into HPMS. And we (inaudible).

Jordan Gay: OK.

Karmin Jones: (Inaudible) that version in case you have to revise that document later on. Then you will give us a new date for that.

Jordan Gay: OK. Got you. OK, thank you very much.

Hazeline Roulac: Thank you so much. Next question, please.

**Operator:** Your next question comes from Robin Wallace.

Robin Wallace: Hello, everyone. Can you hear me?

Hazeline Roulac: Hi. Go ahead.

Robin Wallace: I have a question. One, I need clarification about – Terri, what you said – I think you said there were two opportunities to add names to the application once it's submitted. I know that once the beneficiaries are assigned and the – you get it back to confirm it, that you – if there – if you're deficient, you have an opportunity. And – but I wanted to clarify whether or not if, in fact, you're not deficient, would you have an opportunity to add additional names to that list?

And also, I wanted to know how CMS will be handling the participants that – for those companies that have announced that they will be falling out of the Pioneer program, and if those participants that were formerly part of the Pioneer programs want to be a participant in the MSSP, how in – how would they be addressed on the participant list that they were submitted for the ACO?

Terri Postma: Hi. Yes. Thanks for – thanks for bring that up.

Yes, there will be two opportunities to either add or delete ACO participants during the course of your application review. I'm sorry . . . .

Tricia Rodgers: Even for those that are not deficient. You may also add during that time.

Terri Postma: Yes. For everyone. Yes. For everyone will have that opportunity. So, it doesn't matter if you had deficiencies or not. You'll be seeing that and get that opportunity – get those two opportunities.

As far as ACO participants that might want to join your ACO, that's something that the ACO will work out with ACO participants regardless of whether they're a Pioneer that's transitioning in or other entities that are participating in other initiatives. So, that's something that would be worked out between the ACO and the ACO participants.

Robin Wallace: The concern was – because I know that there were issues before with overlap in terms of the (inaudible). And I know that the application does address – or has – it has a component that addresses whether or not they are currently participating in some kind of Medicare shared initiative.

Terri Postma: Yes. That's right.

Robin Wallace: But for those CMS – those Pioneer program that were – that have announced that they are no longer – that they are transitioning out of those – out of the CMS program, and for those participants who were participants of the Pioneer program, the question was, could we add them to this application that's being submitted for

July 31st, knowing that they would be transitioning out and not being clear on what that date would be?

Terri Postma: So, any of – any ACO participants that are on an ACO applicant's list, we will be checking them for overlap against our shared systems. We have a shared system where all the ACO participants – or all Medicare-enrolled TINs are – we log them for whatever initiatives they are for their end date. And that's why that series of questions is so important in our application, because there may be a TIN that's participating in an initiative currently but it's expected to end as of the end of this year, that is, before the expected start date of 1/1/2014 for the ACO.

So – and then when we check our shared systems, we check against those start and end dates. So, if that TIN is participating in another initiative and they want to end their participation before the end of the year, they need to notify that initiative at CMS and make sure that other initiative, whatever it is, updates the shared systems to reflect that end date. And then when we check against it during the application, it won't be flagged as an overlap.

Does that help?

Robin Wallace: It helps.

Terri Postma: OK. Great. OK.

Robin Wallace: The timing – I don't know will be – will work. But, it helps. Thank you.

Hazeline Roulac: Thanks for your question. Next question, please.

**Operator:** Your next question comes from the line of Rahil Hann.

Hazeline Roulac: Hello. Is anyone there?

Can we go to the next question?

**Operator:** Yes. Your next question comes from the line of Jeanine Moran.

Jeanine Moran: Hi, good afternoon. How are you doing? My question is, with respect to an ACO participant, must every NPI that bills under that ACO participant agree to participate and be a participant of the program? Or can we exclude them from the NPI list?

Terri Postma: Hi. This is – this is Terri. So, you're a little bit hard to hear but I think the question was, does every practitioner that bills through the – bills through the TIN of an ACO participant need to agree to participate and comply?

And the answer is yes. Any Medicare-enrolled practitioner that is billing through the TIN of the – of the ACO participant must agree to participate and comply. If there are practitioners that are not Medicare enrolled, you don't have to get them Medicare enrolled; they're not seeing patients, they don't need to agree to participate in a Medicare program if they're not Medicare enrolled.

But, if they're Medicare-enrolled practitioner – every Medicare-enrolled practitioner that is billing through the TIN of that ACO participant must agree to participate and comply.

Jeanine Moran: OK. So, the effect, then, is if you've got one physician out of 100 that doesn't want to participate in the MSSP, then the group cannot participate.

Terri Postma: Correct.

Jeanine Moran: OK. Thank you very much.

Hazeline Roulac: Thank you. Next question, please.

**Operator:** Your next question comes from the line of Edward Duke.

Edward Duke: Here I am. Hi, I think my question was answered previously as it relates to switching from – a doctor switching from one ACO to another. However, there is a piece of it that I wasn't sure.

The questions 18, 19, and 20 all seem to relate to someone who was voluntary – you know, involuntarily terminated, and it doesn't really address the voluntary termination. I just wanted to be very sure that they can voluntarily terminate from one. And, if so, which, if any, of the boxes under question 19 should be checked?

Terri Postma: OK. So, the past participation relates to past participation in the Medicare Shared Savings Program. So that just asks if any of the – if any of – have your ACO, ACO participants, or any of the ACO provider/suppliers ever been voluntary or involuntarily terminated from the Shared Savings Program? And so, that's separate than participation in other initiatives involving shared savings, such as Pioneer or CPCI or, you know, the Physician Group Practice Demonstration, or any of those.

Edward Duke: OK. This is – this would be a simple transition from one existing ACO to another new ACO.

Terri Postma: Oh, I see. So, they're voluntarily terminating their participation in one Shared Savings Program ACO and coming in and joining another Shared Savings Program ACO. I think that we're – I think we're interested more in whether that termination had to occur from the CMS standpoint, not transitions that occur sort of underneath the – you know, they weren't that – it wasn't a provider that CMS said, you know, you need to leave the Shared Savings Program, and you can't be a part of the Shared Savings Program.

Edward Duke: Right. These are – this would be an administrative decision by one practice that they wished to join, for whatever administrative reasons or business reasons, a different ACO.

Terri Postma: Yes. So – yes. So, in that case, I think you would answer “no” to that question [background noise]. Sorry.

Tricia Rodgers: You would answer “yes” to question 18, that you’ve participated in Shared Savings Program. And then you would provide a narrative identifying your reasons for voluntarily terminating. And then you would answer – you could answer either “yes” or “no,” depending on your current situation.

But if you are only – if you are only a participant in the Shared Savings Program, you would – and you terminated, you would answer “no” to question 19, because you are no longer currently participating in a – in the Medicare initiative involving a shared savings arrangement.

Edward Duke: OK. Thank you very much.

Tricia Rodgers: You’re welcome.

Terri Postma: Thanks, Tricia.

Hazeline Roulac: Next question.

**Operator:** Your next question comes from the line of Susan Harrington.

Susan Harrington: Yes, hello. Just as clarification before I ask my question on the application—wherever there is a star, you can’t write in to say that you’re uploading the answer. Is that correct? It’s just expected . . . .

Karmin Jones: Hi, this is Karmin. And you’re referencing in HPMS where there is a star next to every question where it is possible that an upload – it could be submitted.

Susan Harrington: Correct.

Karmin Jones: You’re correct in that you can’t write anything there. It’s just a friendly reminder that you may, based upon your response, be required to submit something. You would simply go to the appropriate upload section to upload that information.

Susan Harrington: OK. And my question is, if there is only one participant in the ACO, then the ACO agreement between the ACO and the participant would be an agreement between the participant as an ACO and itself?

Terri Postma: So, if the ACO legal entity has a TIN that's different than the TIN of the full ACO participant, you would have to upload an agreement between the ACO legal entity and the ACO participant. But if the ACO legal entity TIN is exactly the same as the sole ACO participant, then no – then no ACO-to-ACO participant agreement is required, and you would be answering these questions on the agreement part a little bit differently.

So, you would have to answer the employment question to tell us whether or not the practitioners that bill through the TIN of the ACO participant are employed or not. And if they are, then you would just submit your employment agreement.

Susan Harrington: But they're employed by the participant. And the participant's the only participant in the whole ACO. So, doesn't it mean that the providers who are in that ACO will need to just sign that agreement?

Terri Postma: So, first, tell me, is your ACO legal entity, the TIN, the same or different than the . . . ?

Susan Harrington: The same.

Terri Postma: The same. OK. So, in that case, when you're answering question . . .

Susan Harrington: Twenty-six.

Terri Postma: Right. But go back to 4, 5, and 6. You're answering – 4: Is the ACO formed among multiple otherwise independent ACO participants? You would say, "No."

Susan Harrington: No.

Terri Postma: And then 5 is – you answered "no," so you select "NA" to question 5. And then – if you answered "no" to question 4, OK. And then you would answer "no" to question 6. Correct?

Susan Harrington: Correct.

Terri Postma: No, NA, no. OK. So then, going over to the participant agreement, if you answered "no" to both questions 4 and 6, which you did, then you would answer the question 26, the employment agreement. Right?

Susan Harrington: That's "no"—"Are your ACO providers employed by the ACO?" They're not employed by the ACO. They're employed by the participant.

Terri Postma: Well, but you just told me they were one and the same.

Susan Harrington: Correct. So that would have to be a "yes"?

Terri Postma: Yes. They're – so, they're employed by the ACO.

Susan Harrington: OK. And so, then we would have to include an employment agreement?

Terri Postma: Correct.

Susan Harrington: Which we would have to make up. OK.

Terri Postma: Well, I assume if they're employed, they – you have an employment agreement. Right?

Susan Harrington: Correct.

Terri Postma: OK. So, that's what we would need to see.

Susan Harrington: OK. Thank you very much.

Terri Postma: Great. Thank you.

Hazeline Roulac: Thank you for your question. Next question, please.

**Operator:** Your next question comes from Bobbi Presser.

Bobbi Presser: Hi, this is Bobbi Presser from Scottsdale Health Partners. I just – I know you've said it at least two or three times, but I want to get clarification on adding providers. So, you submit your application; in mid-August, I believe, you said you find out how many participants you've been attributed. And then at that point, you have the opportunity to add more, either to get over 5,000 or just to add.

Do you know approximately how much time lapses between when you've been notified and when you have to submit that first pass of additional providers? And then, the second part of that question is, you said there were two opportunities. So, after you've submitted that first pass to get to, let's say, greater than 5,000 if you haven't met that, you can add providers just to make sure they're in the ACO starting 2014. And can you tell me approximately when that deadline is?

Tricia Rodgers: Hi, this is Tricia. So, you're correct. We have two opportunities during this application cycle to add participants to your application. And we will provide information to each applicant when – for the timing of those additions, deletions, or modifications. And you will have a very short amount of time to get your agreements together and submit those once you've been notified that it's time for you to make those modifications or additions or deletions—talking days, not weeks. So please be prepared to make that a quick turnaround.

And then if – you will be notified again of the second opportunity to add, delete, or modify participant TINs for the 2014 application cycle. Now, if you make – if you want

to add TINs – participants during the actual performance year, you can do that. We’ll – there’s guidance on our website for ACOs that are currently operating on how they need – on the timing and how they can do that. And you’re able to go and look on our website and see that.

We’re accepting them and looking at those on a quarterly basis. But those, again, would not – those TINs that were added after our screening process and everything that we go through to look at the proposed participants to add, those would not become active for assignment purposes until the 2015 performance year.

Bobbi Presser: OK. So, let me just clarify. So, mid-August, you’re going to have 5, 7 days or so to submit the additional participants that you’ve gotten to sign up in the meantime that you didn’t have when you first applied. The second opportunity does not help you get over 5,000 but is just an opportunity to add these participants before your year starts. Is that correct?

Tricia Rodgers: No, if I could just clarify—so, the opportunity to add TINs is not to take that opportunity to get the agreements together. You need to have your agreements together when you submit your participant list during the initial application before July 31.

Bobbi Presser: Correct.

Tricia Rodgers: You will be given the opportunity to add TINs if you fall below 5,000 assigned preliminarily prospectively assigned beneficiaries, or if you are – have – now have signed agreements and you add that TIN – that participant TIN – to your application.

Bobbi Presser: Correct.

Tricia Rodgers: The second round of the application – during the application cycle is for the same purpose. You can – it would be used for the beginning of the 2014 participate – or – sorry, performance period if you add them during the application cycle.

Bobbi Presser: So, if you – let’s assume you got up to 4,000 after the second round. Does that third round allow you to exceed the 5,000?

Tricia Rodgers: No. There are only two rounds to add. And if you’re below 5,000 after that second opportunity to add TINs, you will not be permitted – your application will not be approved.

Bobbi Presser: The second opportunity is the mid-August or the time after that?

Tricia Rodgers: No, the time after that. You have your initial application cycle . . . .

Bobbi Presser: OK. So there really are the initial, the mid-August, and sometime after that to get to your 5,000?

Tricia Rodgers: Correct. You have only two opportunities to add additional participant TINs.

Bobbi Presser: OK. And approximately – we’re talking mid-August for the first. Do you have any idea, approximately, when that second would be?

Tricia Rodgers: It depends on our application review. So, it’s – it’ll – it’ll be short – a short time after that mid-August. But, honestly, you need to have your participant TINs and agreements in line before July 31 because there is very little time to make any changes.

Bobbi Presser: OK. Thank you.

Hazeline Roulac: OK, thank you for your question.

Tricia Rodgers: Thanks.

Hazeline Roulac: Next question, please.

**Operator:** Your next question comes from Benjamin Levine.

Benjamin Levine: Hello. An FQHC applicant with multiple sites and multiple NPIs for those practice sites—how many participant agreements need to be executed?

Terri Postma: Hi, this is Terri. So again, the ACO participants are defined by the Medicare-enrolled TIN. And so, there may be different NPIs and practice sites that fall underneath that TIN. But the ACO is required to submit an agreement between the ACO and the ACO participant TIN.

So whatever legal entity – so, it’s just one. So, there might be multiple practice sites under the TIN, just like there might be multiple practitioners under a TIN. But all we need for the application is the agreement between the ACO and the ACO participant TIN.

Benjamin Levine: On the participant list, though, we will list the TIN and that organizational NPI number. Do we need to list all of the practice NPI numbers as well?

Terri Postma: Yes. Any practice NPI numbers that are associated with that TIN should go on the list.

Benjamin Levine: And on those initial attributions that are done in August and thereafter, if we’re over 5,000, will we get that number that’s over 5,000? Or we only get the number if we’re below?

Terri Postma: Oh, you'll get – you'll see your numbers. Everybody will see their numbers.

Benjamin Levine: And on the org chart that we submit, do we need to list names on those org charts' positions?

Terri Postma: Yes. I believe the question asks you to submit the key leadership on each of the committees. And you should also, by the way, include the medical director on that flowchart.

Benjamin Levine: OK. Thank you.

Hazeline Roulac: OK. Thank you for your question. Next question, please.

**Operator:** Your next question comes from the line of Bruce Wiggins.

Hazeline Roulac: Hello, sir? Are you there?

Bruce Wiggins: Yes, I am. This is Bruce Wiggins.

Hazeline Roulac: Yes. You may go ahead with your question.

Bruce Wiggins: I just had a quick question. One of the founders of our ACO in Arizona is a physician. But he is also — a retired physician — but he is also a Medicare participant – excuse me, a Medicare beneficiary. Can he, in fact, be on the governing board as the Medicare beneficiary?

Terri Postma: This is Terri. So, if I understand this correctly, this is a retired practitioner. But, if he still has some involvement with your ACO, we believe that represents a conflict of interest. So just to – you know, look and see what the relationship is. I mean, the Medicare beneficiary that's on the governing body should be representing Medicare beneficiaries, not, you know, the – not practitioners in the ACO or practices in the ACO.

Does that make sense?

Bruce Wiggins: Great. Then we will – we will act accordingly. Thank you.

Terri Postma: You're welcome.

Hazeline Roulac: Great question. Thank you. Next question, please.

**Operator:** Your next question comes from Steve Barry.

Hazeline Roulac: Hi, Steve. Are you there?

Operator, can we move on to the next question, please?

**Operator:** Your next question comes from Lynn LeVecque.

Lynn LeVecque: Hello? My question is around file formats on some of the uploaded files. So in your application reference table on the participants list, it says it should be an Excel file. But in some of the previous presentations from your other calls, I think it said text. Do you know which it should be?

Karmin Jones: Hi, this is Karmin. Yes. Your participant list is the only one that we specifically define that you have to save it as a .txt file. And those instructions are on the participant list instruction. You must zip that file up as .txt. Otherwise, you will receive error codes when you try to upload it in HPMS. Do not save it as an Excel file.

Lynn LeVecque: OK. But that's not clear in your reference table that you just posted. So, you might want to check that.

Karmin Jones: OK. Make sure that you review the participant list instructions. Those are clear. And we will take another look at the reference guide just to make sure.

Lynn LeVecque: OK. Yes. That's a – there was a conflict. That's what I didn't understand. So do all uploaded files have to be zipped or just this one?

Karmin Jones: All files – there are two different ways. We put – there's two different upload sections in HPMS. The participant list upload is the only one that will include one file. And that will be your participant list file saved as a .txt file. And it must be zipped.

The other one is the application upload, which you would provide all of your supporting documentation in the application using the file-naming convention in your – in the reference table. And the – most of those documents can be saved as a PDF. I believe the organizational – the governing body template is an Excel file. But the majority of those documents, including if you choose to use your narrative, should be saved as a PDF. And then that entire file should be zipped.

So do not zip each individual document. Instead, take all of your documents, PDFs, and Excel files using the file-naming convention and zip that folder up and put that in the application upload section. Thank you.

Lynn LeVecque: OK. And just one clarification. When you're saying – the PDFs. Are those OK if they're scanned documents? Or do you mean it's got to be created from the Adobe program?

Karmin Jones: They can be scanned.

Lynn LeVecque: OK. Thank you.

Karmin Jones: You're welcome.

Hazeline Roulac: Thanks for your question and comment. Next question, please.

**Operator:** Your next question comes from Sherri Fisher.

Sherri Fisher: Hi, Sherri Fisher from GGC ACO. I'm wondering, once we've sent our application in, how and when will we be notified if the application was accepted?

Karmin Jones: Hi, this is Karmin. As soon as you hit "Final Submit," you will receive a very – a notice, a email – by email to your email address for the application contacts. That would be the primary and the secondary contacts. And it will notify you that your application was submitted.

Additionally, on the HPMS screen, it will show you that – a confirmation page that says "Your application is submitted" and then will give you a reference number. And you can click on that hyperlink reference number and it'll basically say the same thing and show you the email that we sent to you.

Sherri Fisher: OK. So . . . .

Tricia Rodgers: As far as your acceptance into the program, we go through quite a bit of review of your application, naturally. And we will be issuing our decisions later this fall.

Sherri Fisher: OK. And will that decision come in the form of a letter?

Tricia Rodgers: It will. In an email.

Sherri Fisher: A letter and an email, or in email?

Tricia Rodgers: A letter in an email. Sorry.

Sherri Fisher: A letter in an email. OK. So then, after we have submitted the application, the next thing that we can expect to hear would be sometime in mid-August about the number of beneficiaries?

Tricia Rodgers: That's correct.

Sherri Fisher: OK. And then we'll hear through an email – I'm sorry, you said late fall?

Tricia Rodgers: Yes. We expect to have our decisions in late fall.

Sherri Fisher: OK. And then, is there any – is there a website to go to to check the status of the application, or no?

Tricia Rodgers: No. But you will be receiving information via email about – if there – if there are deficiencies that we found after our review, either for the beneficiaries, or if we

have questions on some of your narratives, or we need clarification or – there will be communication back and forth, and you will be able to respond to our questions that way.

Sherri Fisher: OK. And that will go to the email of the contact person that was put on the application?

Tricia Rodgers: And the application contact. That's correct.

Sherri Fisher: OK. OK, thank you.

Tricia Rodgers: You're welcome.

Hazeline Roulac: Thanks for your questions. Next question, please.

**Operator:** Your next question is from Eric Bouchard.

Eric Bouchard: Yes, hello. This is Dr. Eric Bouchard. I'm in a medical group, multispecialty, that got subsumed into a physician partner group. And I understand everyone in the TIN has to agree. And since we've been – since our group TIN has been subsumed into the physician partner TIN, it just is not going to happen that I can convince a – an exec to be a participant list, especially when it could probably hurt the revenues going through their hospital or what not – whatever – secondary gain, I don't know.

Anyway, my question is, if the group were to leave and take back their old TIN, which they used 2 years ago, or to join another TIN, how long would they have to have transactions through a new TIN before they could be assigned beneficiaries and such and be able to participate in a ACO where they would be able to make a difference?

Terri Postma: So – this is Terri. Let me maybe walk through some of our operations and that'll help answer the question. When we get an ACO participant TIN list, we go back 3 years. So we look – we pull claims for each of the 3 years before the – before the agreement period begins.

So, for folks applying for the – for the January 1st, 2014, agreement period, we would go back to 2011, 2012, and 2013, pull all the claims associated with the TINs that are submitted, and develop a benchmark based on those claims and those – the assigned beneficiaries in each of those 3 years.

The same thing go – is going forward. So, at the end of the first performance year, we look at all the – we pull all the claims associated with the ACO participant TINs on the certified list and make an assignment and calculate the per capita cost and then compare that to the benchmark. So, if a particular ACO participant TIN doesn't have any claims for a particular time period, we wouldn't be – I mean, there just wouldn't be anything for us to look at or to use in terms of our operations. So, keep that in mind as you're making these decisions.

Eric Bouchard: So, what would be the minimum time period?

Terri Postma: The minimum for?

Eric Bouchard: Having a beneficiary assigned to you.

Terri Postma: Well, beneficiaries get assigned at the ACO level, not at the ACO participant TIN level. So, like I said, we look at the entire list of ACO participant TINs and pull the claims associated with those.

So, there might be a list of 10 TINs and one of them doesn't have any claims for that year. We're going to be looking at the claims associated with the other nine TINs. Some of those beneficiaries might have seen practitioners in the other – in the 10th TIN that doesn't have any claims for that year, although I don't know how they would, because that TIN wasn't billing for them. But, in those other years, maybe, they see those practitioners.

So, I'm not quite sure how to answer your question. But it – let's say an ACO is only a single ACO participant. If – like a large multigroup specialty group practice or something and that's the only participant in the ACO, if that participant doesn't have claims for a certain year, then they're going to get an assignment of zero and not be eligible to participate.

Eric Bouchard: Right. So what I'm trying to find out is how long would it take to get an assignment? A year?

Terri Postma: Well, the ACO is going to have an assignment if they have TINs that have any billings. Right?

Eric Bouchard: Correct. So let's say this — the ACO goes through, gets approved. One of its participant list — say it's a new doctor that just started out of residency. And he just opened up his practice and signs up.

Terri Postma: Yes.

Eric Bouchard: So, will he generate any revenue for the first year? So he signs up July 31st. He starts seeing patients under his TIN August, September. And then the performance year July 2014 through December 2014, does he – would he receive any savings from that?

Terri Postma: So that – I think that's a different question. The – like I said, at the end of each year, we're going to look at the list of certified ACO participants and pull all the claims associated with them for that year. So – in order to generate the assignment for that year and to calculate per capita cost.

So, if there was a TIN that was on the certified list but for whatever reason – you know, at the beginning of the year but, for whatever reason, they didn't bill until three-quarters of the way through the year, we'd be picking up their claims along with all the other ACO participant claims. And that would go into the calculation for that year. But that assumes that they were part of the certified list of ACO participants at the beginning of that performance year.

Eric Bouchard: OK.

Hazeline Roulac: OK. Thank you ...

Terri Postma: There – oh, I might also mention that we had a presentation a while back that's on our website where we discuss assignment in detail. So if you want to – if you want to review that, that might be helpful to you.

Eric Bouchard: OK.

Hazeline Roulac: Thanks for your question. Next question, please.

**Operator:** Your next question is from Gail Fournier.

Gail Fournier: Hi, this is Gail Fournier. I just have a – from Holyoke Medical Center. I had a question on the governing body template. On the ACO participant TIN legal name column, is that just for physicians? Or do you want all ACO board members to list either – I would imagine, if they don't have a TIN, their Social Security?

Terri Postma: No. This is Terri. So, what the governing body template asks you to list is the member names of each of the folks that are on your governing body. And then the ACO participant TIN legal name is the legal name of the ACO participant that that particular person is representing on your governing body.

So, for example, if you have, you know, XYZ Clinic as an ACO participant, and Dr. Jones is from that clinic and he's on the ACO governing body representing that clinic, then you would put XYZ Clinic in column G for the ACO participant TIN legal name.

Gail Fournier: OK. So, if we have the president of the hospital – say, for example, is also on the ACO board, we would just put the hospital TIN number. Correct?

Terri Postma: You – it's better if you put the name of the – of the – the legal name of that hospital TIN, not the TIN number.

Gail Fournier: OK. I see what you're saying.

Terri Postma: Yes.

Gail Fournier: Thank you.

Terri Postma: Yes. You're welcome.

Hazeline Roulac: Thank you. Next question.

**Operator:** Your next question is from Mike Melnyk.

Mike Melnyk: Yes. My question's related to the ACO participant template and, specifically, page 4 of the How to Complete the ACO Participant List Template. You outlined if you're an FQHC what the format should look like within this template. But, rows 3 and 4, identified as FQHC, are a little bit confusing.

So, if we have an FQHC, we're to list every PCP, essentially, and their NPI and their name under that FQHC. But we are entering multiple entries on this for that?

Terri Postma: So, this is Terri. So we identified a couple of errors on this particular template that we've updated.

Mike Melnyk: OK.

Terri Postma: Or it should be updated this afternoon. Sorry about that. So – on the website. But, yes, in essence, what you're doing for each FQHC is you are required to list the name of each physician that's directly providing primary care services in each of those – in each of those sites of care.

Mike Melnyk: And nurse practitioners?

Terri Postma: Physicians.

Mike Melnyk: Just physicians. OK.

Terri Postma: Just physicians. And this is because we have to comply with the law which says that we can only make an assignment based on – based on primary care services rendered by physicians. It's a – it's a quirk of the – of the way that FQHCs and RHCs bill that we have to ask you for that additional information.

Mike Melnyk: OK.

Hazeline Roulac: OK. Thanks for your question. Victoria, we have time for one more question, please.

**Operator:** Your last question comes from the line of Justine Procter.

Justine Procter: Hi. This is Justine Procter from Pershing Yoakley and Associates. We had a question with respect to question number 8, where it's asking us to submit our ACO's organizational chart. We were just kind of wondering what the format of this

This document has been edited for spelling and punctuation errors.

answer needs to look like. Are we restricted to just basically submitting an organizational diagram itself? Or can we include additional language or a narrative describing the chart in greater depth?

Terri Postma: Yes, this is Terri. So, basically what we're expecting to see is just a standard organizational chart showing the flow of responsibility from the ACO's governing body to the various committees and key leadership personnel. If you want to include additional narrative information about those key leadership personnel or other information you feel would be useful for us to understand that flow of responsibility, that – it would be helpful. You can – you can do that. But, at minimum, what we need to see is just a basic organization chart.

Justine Procter: Thanks.

Hazeline Roulac: OK. Thanks so much for the question.

## Additional Information

Unfortunately, that is all the time we have for questions today. If we did not get to your question, you may email your question to one of the addresses listed on slide number 6.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website at [www.cms.gov/npc](http://www.cms.gov/npc) under the National Provider Calls and Events section. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 11 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience. We look forward to getting your feedback.

My name is Hazeline Roulac. I'd like to thank our presenters, Laura Dash, Terri Postma, Tricia Rodgers. And I would also like to thank everyone for participating on today's MLN Connects Call on the Medicare Shared Savings Program application process.

Have a great day, everyone.

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

**-END-**

