Centers for Medicare & Medicaid Services
Medicare Shared Savings Program Application Process National Provider Call
Tips on Completing a Successful Application
Moderator: Leah Nguyen
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Contents

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 Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I'm Leah Nguyen from the Provider Communications Group here at CMS, and I will serve as your moderator today. I would like to welcome you to this National Provider Call on the Medicare Shared Savings Program Application Process. Today's National Provider Call is brought to you by the Medicare Learning Network, your source for official information for health care professionals.

On October 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 National Provider Call, CMS subject-matter experts will cover tips on completing a successful application, including information on how to submit an acceptable ACO Participant List, Participation Agreement sample, executed participant agreement pages, and governing body template for the Shared Savings Program application. A question-and-answer session will follow the presentation.

Before we get started, I have a few announcements. Links to the slide presentation, additional guidance for Shared Savings Program ACO applicants, merger and acquisitions FAQ, and an agreement guidance document for today's call were e-mailed to all registrants earlier this afternoon. These materials can also be downloaded from the CMS MLN National Provider Calls Web page at www.cms.gov/NPC. Again, that URL is www.cms.gov/NPC. At the left side of the Web page, select National Provider Calls and Events, then select the April 23rd call from the list.

This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the MLN National Provider Calls Web page as soon as it's available.

Dr. Adamache was not able to join us today. His presentation on beneficiary assignment will be presented by Jenna Wright. At this time, I would like to turn the call over to Tricia Rodgers, Deputy Director of the Performance-Based Payment Policy Group here at CMS.

Presentation

Tricia Rodgers: Thanks, Leah. Welcome, everyone, to our second call for the 2014 applicants for the Medicare Shared Savings Program. My name is Tricia Rodgers.

Moving to slide 6, The Purpose of Today's Call: We will address three important and historically challenging issues related to your application. We believe that providing this

information now, you will have the tools necessary to develop a successful application. We strongly encourage you to begin working on these elements immediately.

We will begin our presentation today with Dr. Terri Postma, who will speak to you about ways to ensure that you have complete and accurate agreements between you and your providers and suppliers. Next, Jenna Wright will go over the details about your participant list. And Jenna will also go over in detail the logic we use to determine beneficiary assignment for each ACO. Then we'll leave time for you to ask questions at the end of the presentation.

So, we have an ambitious agenda today. Let's delve right into agreements on slide 9 with Dr. Postma. Terri?

ACO Participant Agreements

Terri Postma: Thanks. This is Terri Postma. Thanks, everybody, for joining us today. I'm a Medical Officer here at the Center for Medicare, and I've been privileged to spend the last 3 years or so working on the development and implementation of the Medicare Shared Savings Program. Thanks for joining us today.

I'm going to be focusing on the ACO participant agreements. These are the agreements that your ACO has with each ACO participant that is joined together to form the ACO and to participate in the program.

As Tricia mentioned, historically these have been a point of – something that can really hold up an application if they aren't correct. It can cause problems if you have to go back to the ACO participants and revise the agreement and get them re-signed. It can cause delays. So we want to do this presentation for you up front to give you some hints and tips on what we're looking for in the applications and in your agreements when you submit them, so that you can get it right the first time and not have to go back and redo them, sometimes with very short timeframes.

So I'm on slide 9. The first thing I want to do is just remind everyone, if you were on the call last time, we went over these definitions, but these definitions are also very important for today's call, and so I wanted to review them again.

An ACO participant is a individual or a group of Medicare-enrolled providers or suppliers, as identified by a Medicare-enrolled billing TIN that you include on the list of ACO participants. So it's important to understand that ACO participants are defined at the Medicare-enrolled billing level, whereas ACO providers and suppliers are either a provider or supplier that's enrolled in Medicare but that bills through the TIN of that ACO participant. So, for example, if there is a group practice that's joining with other group practices to form an ACO, the group practice, with its own Medicare-enrolled billing TIN, would be the ACO participant. Any practitioners—any physicians or NPs, PAs, clinical nurse specialists—that bill through the TIN of that group practice would be defined as ACO providers/suppliers.

So it's important to understand this, because what you're going to be doing is—as an ACO—is getting an agreement between the ACO legal entity and the ACO participant TIN. That is, it would be between the ACO and – from my former example, the group practice would be the one that you're making the agreement with.

Next slide, please, number 10: In the previous National Provider Call, we went over this slide as well. This is just to remind you of the typical ACO structure. This is not the only ACO structure, but the one that's very typical, where there's an ACO legal entity; there are multiple ACO participants that have joined together—each with their own Medicare-enrolled billing TIN—that have joined together to form the ACO; and underneath there, the ACO participants are the ACO providers/suppliers or the practitioners that are billing through the TIN of the ACO participant. And, again, what we're discussing here today are the agreements that the ACO must have between itself and the ACO participant.

Now, there also has to be agreements with each ACO provider/supplier that bills through the TIN of an ACO participant, but we're not going to be discussing those today. Those are things that you're going to have to have in place. We do not ask for those as part of the application. What we're asking for as part of the application are the agreements between the ACO legal entity and the ACO participant TINs.

Slide 11, please: I just want to mention a couple of things about the agreements themselves. In our guidance, in the final rule (and you see the references listed there on the slide), there are required – there are certain elements that are required to be in these agreements. The agreements must contain at least four elements, and these are the ones that are required.

It must have an – first, it must have an explicit requirement—*explicit* requirement—that the ACO participant or the ACO provider/supplier will comply with the requirements and conditions of the Medicare Shared Savings Program, including but not limited to those specified in the participation agreement with CMS—that is, the agreement that your ACO will be making with CMS once it's accepted to the program. So it must reference either the Medicare Shared Savings Program explicitly or – and/or 42 CFR Part 425 explicitly. The ACO participant must agree to participate in this program explicitly. That is part of the – and comply with the regulations. So that's the first one.

Second, the agreement between your ACO and the ACO participant must list the ACO participant's rights and obligations in, and representation by, the ACO.

Third, the agreement must contain information about how the opportunity to get shared savings or other financial relationships will encourage the ACO participant to follow the Quality Assurance and Improvement Program and the evidence-based guidelines that the – that the ACO is developing as part of the requirement to participate in the program.

And, finally, the agreement must contain remedial measures that will apply to the ACO participant for those who don't follow the requirements on the agreement with the ACO.

And largely, this is to protect the ACO from – so, for example, if CMS determines that the ACO has not been complying with certain rules and regulations of the program and – leading to the termination of the ACO, it may be that there's only one ACO participant that's being a problem in this area. So if the ACO – if the – if the ACO has the ability to terminate that ACO participant, it can result in only the termination of that ACO participant and not necessarily the termination of the entire ACO.

So this is really a good thing for you to have in your agreement, and make it clear that the ACO participants all need to agree to participate and comply, and that the ACO has some remedial measures in place by contract that they can take advantage of in case an ACO participant is not complying.

Also, the – let's move on to slide 12. Some other – some other key points to keep in mind is that the agreements must be between the ACO legal entity and the ACO participant legal entity. It can't be – they must be direct—that is, the agreement must show a direct agreement between the ACO and ACO participant TIN. They may not have a third-party intermediary. So, for example, the agreement may not be between the ACO and another legal entity such as an IPA or management company, who in turn then has an agreement with the ACO participants. The agreements have to be directly between the ACO legal entity and the ACO participant legal entity TIN.

ACOs may not include an ACO participant TIN on its list of ACO participants unless the ACO participant TIN has signed an ACO participant agreement. Do not put folks on your ACO Participant List in your application if you do not also have a signed agreement from that ACO participant TIN.

So ACO participant agreements should be signed by a person authorized to sign on behalf of the ACO participant TIN. So, for example, the owner of the group practice that I referenced earlier in the example, or the – or the president of the entity that's associated with the Medicare-enrolled TIN. That would be appropriate—a person who is authorized to sign on behalf of the ACO participant TIN and on behalf of all the ACO providers/suppliers that bill through the TIN of that ACO participant.

The ACO is responsible for ensuring, as I mentioned earlier, that all the NPIs—that is, all the ACO providers/suppliers that bill through the TIN of that ACO participant—have also agreed to participate and to follow program regulations. The ACO may ensure this by having direct agreements with each of the ACO providers and suppliers, or it may ensure this indirectly through its agreement with the ACO participant TIN—in which case, your contract should have very clear language obligating the ACO participant TIN to ensure that each practitioner that bills through it has also agreed to participate and comply.

If the ACO chooses to contract directly with the ACO providers and suppliers, the agreements must meet the same requirements as the agreements with the ACO participants—those four required things that I went through earlier. And then, remember that if an ACO chooses to contract directly with each of the ACO providers/suppliers, it

must still have the required agreement with the ACO participant TINs. So even if you have a direct contract with each of the practitioners that bill through the TIN of the ACO participant, you must still have the agreement with the ACO participant itself.

So I want to go through a couple of examples just so this is crystal clear for everybody. And these can be found on the – I believe we sent out some links to our guidance – and this can be found in the agreement guidance. And all these things can be, by the way. So if you need to refer to them, again, after this call, you can do so by looking at that guidance.

All right. So this is an example of a correct – correct contracting between the ACO and the ACO participant. Let's use that large group practice again that I referenced earlier. Let's say a large group practice decides to participate in an ACO. Its owner signs an agreement on behalf of the practice to participate in the program and to follow program regulations. Also, all the practitioners that have reassigned their billing to the TIN of the large group practice have also agreed to participate and to follow program regulations. In this case, the ACO may include this group practice TIN on its list of ACO participants. OK? So that's kind of the format; that's what we're looking for, and that's what's in the program regulations.

Examples that we've seen where things have created problems for applicants are the following: This example is an incorrect example. That is, let's say the large group practice decides to participate in an ACO. Its owner signs an agreement to participate in the program and follow program regulations. That's so far good. However, not all the practitioners that have reassigned their billing to the TIN of the large group practice have agreed to participate and follow program regulations. In this case, the ACO may not include this group practice TIN on its list of ACO participants because not all the practitioners billing through the TIN of the ACO participant have agreed to participate and comply.

Another example of something incorrect that we've seen in the past: Let's say several practitioners in this large group practice decide to participate in an ACO. However, the group practice as a whole has not agreed to participate, and not all the practitioners that bill through that TIN have agreed to participate. In this case, the ACO may not include this group practice TIN on its list of ACO participants.

All right. So, again, these points are referenced in our agreement guidance that can be found on our Web site and that were sent along in the link to you all for this webinar.

I want to give you a couple of tips and hints. Let's move on to slide 13. In general, it's in your best interest to use good contracting practices. We've seen a number of contracts that don't even meet the bare minimum for good contracting practices. And so, you know, if you have trouble with this or struggle with this, you might want to consider talking to a contracts lawyer to help you put together your contract between the ACO and the ACO participants.

But in general, some of the things that we've seen that make it very difficult for our reviewers to determine whether or not the ACO is meeting the requirements, and can cause a lot of back and forth and delay in processing your application, and can even sometimes result in not being able to approve the application, are some of the following. And I just want to give you some tips and hints for making sure that your contracts are clear and that the reviewer clearly can understand what a contract is and whether or not it's meeting our requirements:

So first, each agreement should clearly identify the parties entering into the agreement, the agreement date, and the length of the agreement. So this is pretty typical of contracts – is that there's an opening paragraph or opening sentence that says, for example, this participant agreement is by and between XYZ group practice, and lists the ACO participant TIN legal business name and the accountable care organization, and lists the accountable care organization legal business name, and it is effective as of X month/date/year. OK? So that's just good contracting practices. That makes it really clear to the reviewer who the agreement is between.

And, again, the agreement should be directly between the ACO legal entity and the ACO participant TIN. And make sure you understand those definitions so that you can get that right. And that you have used the correct legal business name for both the ACO and the ACO participant. You will be asked to re-execute the agreement if the legal entity names don't match what we have on record for the ACO legal entity or the ACO participants.

There's certain information that's generally included in a – in a good contract. Some of them are things that are required in the – that I went over, those four things, such as compliance with 42 CFR 425, the Medicare Shared Savings Program, the ACO obligations, the participant obligations. Oftentimes, ACOs will put in their contract how they intend to share or distribute shared savings or use shared savings. Termination is another section that you should strongly consider including. Often we've seen statements involving HIPAA compliance so that data sharing can occur between the ACO legal entity and the ACO participants. And the signature page.

I would just want to mention – before I get into the signature page, I just want to mention that there are certain amendments that we've also seen as part of the ACO participant agreements. Because the ACO is responsible for ensuring that all the ACO providers and suppliers that bill through the TIN of the ACO participant have also agreed to participate and follow program regulations, the ACO may ensure this by – may choose to ensure this by having direct agreements with each of the providers/suppliers, as I mentioned before, or indirectly through its agreement with the ACO participant TINs. If your ACO chooses to have direct agreements, then consider attaching an amendment to your ACO participant agreement with their – with their names. But if your ACO chooses to require the ACO participant to ensure that the ACO providers and suppliers all agree to participate, then consider including language that clearly requires the ACO participant to do this.

Now, finally the signature page: Each agreement must include a signature page that identifies the parties to this agreement. We strongly encourage you to include certain information to help the reviewer and to be clear that your agreements are meeting our requirements. The signature page must reflect information from both the ACO and the ACO participant and should be consistent with the legal business names listed on the first page of the agreement. Information other than the signature should be typed for easy reference and readability.

One example of things that should be included on the signature page: It's very helpful for the reviewers to have information for the ACO on one side, information for the ACO participant on the other side. So for the ACO, having the legal business name; the signature of the officer or agent who's signing on behalf of the ACO should have aligned; the name of that officer or agent who's authorized to sign on behalf of the ACO; and the title of that officer or agent is helpful. There should be the date and also the address and other information related to the ACO on that side.

On the other side, for the ACO participant, it's very helpful to include the legal business name of the ACO participant. And, again, you should make sure that that matches the actual legal business name of that ACO participant TIN, and that it matches the first page, showing who the agreement is between. It's often helpful to list the DBA of that ACO participant; that ACO participant's TIN so that it can be easily cross-referenced with the ACO participant TIN list; the signature, which is a signature of someone with the authority to sign on behalf of that ACO participant TIN as a whole, such as the owner of the ACO participant TIN or the president of that legal entity. The name of that authorized official should be written or typed, and the title of that officer or agent that's capable of signing on behalf of the ACO participant TIN. There should be a line for the date and also the address of the ACO participant TIN.

So I hope that that's been helpful. And, again, the guidance is listed on our Web site. Please use good contracting practices. Make sure it's very clear who the – who the agreement is between. And I'm going to turn it back over to Leah now. Thank you.

Keypad Polling

Leah Nguyen: Thank you, Dr. Postma. At this time, we will pause for a few minutes 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 polling.

Operator: CMS greatly appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office using only one 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 between 2 and 8. If there are nine or more you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

You may now – I would now like to turn the call back over to Ms. Leah Nguyen.

Presentation (continued)

ACO Participant List Issues

Leah Nguyen: Thank you, Victoria. Our final speaker is Jenna Wright from the Performance-Based Payment Policy Group. We'll be covering the ACO Participant List and beneficiary assignment.

Jenna Wright: Hi. I'm on slide 15. The ACO Participant List is required as part of your application. It includes information about the ACO participants and, in some cases, ACO providers/suppliers. I will discuss what information is required in a few slides.

Before you submit your application, you will determine what entities will be part of your ACO as ACO participants. As Terri mentioned, all ACO participants and providers/suppliers must agree to comply with the requirements and conditions of the program, as well as all laws, regulations set forth in 42 CFR Part 425. Before you submit your ACO Participant List, you must execute an ACO Participation Agreement with the entity that will be an ACO participant.

Start talking with potential ACO participants early and make sure they are aware of all program requirements before they sign an ACO Participation Agreement with you. We will use the ACO Participant List you submit with your application to determine your eligibility to become an ACO in the Shared Savings Program.

I'm on slide 16. The ACO Participant List is very important. Besides helping us determine if you're eligible to form an ACO, the ACO Participant List is the basis for allowing us to determine whether your ACO achieved shared savings. We will use the ACO Participant List to assign beneficiaries to your ACO. Stated another way, we will use the ACO Participant List to determine which fee-for-service beneficiaries your ACO will be held accountable for their health care quality and cost.

Beneficiary assignment is performed in order to establish the historical benchmark, perform financial reconciliation, and determine a sample of beneficiaries for quality reporting. The ACO Participant List also allows us to coordinate participation in the Physician Quality Reporting System under the Shared Savings Program, and allows us to monitor the ACO.

Although each ACO participant TIN is required to agree – to commit to a 3-year agreement with CMS to participate in the Shared Savings Program, we recognize there are – may be reasons why an ACO participant may leave or be added to an ACO during the course of the agreement period. When such changes occur, the ACO must notify CMS within 30 days of the change. Please review the guidance at this link in the slide to

learn more about how and when changes to ACO participants and ACO providers and suppliers will affect the program operations.

Slide 17, please: A merged or acquired taxpayer identification number, or TIN, is a TIN that was acquired by an ACO participant through purchase or merger. A merged or acquired TIN may be added to the ACO Participant List so that we can use the information for beneficiary assignment during the historical benchmark years. The merged or acquired TIN can be added to the ACO Participant List if the ACO participants subsumed the acquired TIN in its entirety, including all the ACO providers/suppliers that billed under that TIN. All the ACO providers/suppliers that billed through the acquired TIN must have reassigned their billings to the ACO participant TIN, and the acquired TIN must no longer be used.

It is not required that applicants include merged or acquired TINs on their ACO Participant List.

Slide 18, Merged or Acquired TINs, continued: It is important to note that merged and acquired TINs are not ACO participants. By virtue of the TIN being subsumed by another practice in its entirety, a merged or acquired TIN cannot execute a participant agreement with the ACO. Instead, the ACO applicant must submit other supporting documentation. See the application for more information about the supporting documentation that you will be required to submit.

OK, I'm on slide 19. On this screen, you will see the fields that are part of the ACO Participant List template you will fill out and submit with your application. In the first column, you will need to provide the taxpayer identification number, or TIN, that the ACO participant uses to bill Medicare for primary care services. You will also have to provide the TIN legal business name. We will search for the TIN in the Medicare enrollment system to ensure that the legal name you provided matches the legal name in its enrollment file. We do this to allow you to verify that the TIN you gave us is the correct TIN. You will have to indicate whether the TIN is Medicare enrolled and whether the TIN is not an ACO participant but is in fact a merged or acquired TIN.

Finally, you will need to provide the name of the individual who is authorized to sign the ACO participant agreement on behalf of the TIN. We will ensure the name you provide matches the signatory on the executed participant agreement for the TIN that Terri was referring to earlier.

I mentioned earlier that you will have to provide information about ACO providers and suppliers on the ACO Participant List in some cases. These fields are only required in some cases. For example, if the ACO participant is a Federally Qualified Health Center or a Rural Health Center, you will need to provide us the CMS certification number, or CCN, the facility uses for billing Medicare, as well as the National Provider Indicator, or NPI, of physicians who directly provide primary care to patients at that facility. By including an NPI on the ACO Participant List, you are attesting that the physician directly provides primary care. You should not include other types of providers, such as

nurse practitioners, certified nurse specialists, or physician assistants on the list. Although those types of practitioners are part of the ACO as ACO providers/suppliers, we do not want those numbers – those NPI numbers on the ACO Participant List itself.

If the ACO participant is a Critical Access Hospital billing under method II or is an Electing Teaching Amendment Hospital, you will only need to provide the CCN and the information that goes along with the CCN. If you have multiple CCNs or NPIs affiliated with one of the ACO participant TINs, then you will need to provide multiple rows of data where the TIN information repeats on every row. Think of the ACO Participant List like a dataset, and the computer will read every row of data separately.

I'm on slide 20 now, Evaluation. We will use the ACO Participant List submitted with the application to preliminarily assign beneficiaries to your ACO for the benchmark years, which are the 3 years prior to the start of the agreement period, and we will screen the ACO participants and ACO providers/suppliers that have assigned their Medicare billings to ACO participants.

Later, we will discuss beneficiary assignment in more detail. But in summary, CMS will use the ACO participants' identifiers—such as the TINs, the CCNs, or the NPIs you submitted on the ACO Participant List—to look up beneficiary claims. We will use those claims to assign beneficiaries to your ACO.

It is important to note that we will exclude claims from any ACO participants that are participating in another Medicare initiative involving shared savings, as well as any participants that bill Medicare for primary care services that were submitted with multiple Shared Savings Program applications. Those types of overlaps are not allowed, and during the application review period we will identify if there are overlaps like that, and we will exclude those claims when preliminarily assigning beneficiaries to your ACO to determine if your ACO reaches the 5,000 assigned beneficiary minimum. That's why it is in very – it is very important that ACO participants understand that they must be exclusive to one ACO if they bill Medicare for primary care services.

You can review Frequently Asked Questions on the CMS Web site for more information about ACO participant exclusivity and the Medicare Shared Savings Program, and make sure that your ACO participants fully understand this exclusivity requirement when they agree to participate with your ACO.

We will also use the ACO participant identifiers you submitted on the ACO Participant List to make sure that each of your participants meet the definition of an ACO participant and match information for that participant in the Medicare enrollment system. We will use the ACO participant identifiers you submitted on the participant list to review the ACO participant or any ACO providers/suppliers with regard to their program integrity history, including any history of Medicare program exclusions or other sanctions, and affiliations with individuals or entities that have a history of program integrity issues.

I'm on slide 21. Applicants will receive a report that includes the number of preliminarily assigned beneficiaries and results of screening. We will send this to your application contacts in an e-mail with an encrypted zip file attachment. In the past, a few applicants have experienced issues with receiving this e-mail because of their firewall, and it has blocked the incoming e-mail with the encrypted attachment. You will know if this happens to you because you will receive a followup e-mail from CMS with a password in it referencing the report we just sent, and you may not have received the previous e-mail with the report actually in it. If that happens, contact us right away so that you have plenty of time to review the information in that report. You should also work with your IT staff now to see if they can adjust your system to avoid this problem from occurring in the first place.

All applicants will receive this report at the same time and will have a window to make any changes necessary and resubmit their ACO Participant List. If you review the report and decide that you do not have changes to make to your ACO Participant List, you do not need to resubmit it.

On slide 22, I am going to wrap up by briefly going over how to submit the ACO Participant List with your application. You must successfully upload an ACO Participant List before the application system will allow you to hit "Final Submit" on your entire application. By "successfully upload," I mean that you have uploaded an ACO Participant List that meets basic formatting requirements. Again, the ACO Participant List is a dataset, and computers read the information in that file, not humans.

For example, a taxpayer identification number must be nine digits and does not include any spaces, dashes, or other special characters. Another example of a basic formatting requirement is that if you have indicated to us that the ACO participant is a Federally Qualified Health Center, you must provide CCN and NPI information. If the application system detects that you did not provide data in the correct format or missed required data, then it will give you an error report that describes the errors, and you will have to correct them and re-upload your file. We strongly encourage you to upload your ACO Participant List before the application due date to give yourself enough time to correct formatting errors if they occur.

Beneficiary Assignment

I'm now going to move on to beneficiary assignment. I'm on slide 24. Preliminary – so the ACO – the Shared Savings Program will perform preliminary prospective assignment with final retrospective beneficiary assignment during the performance years. When we run your preliminary prospective assignment during the application period, an ACO needs to have at least 5,000 preliminarily assigned beneficiaries in each of the 3 benchmark years preceding the start of the agreement period.

A beneficiary assigned in one year of the program may or may not be assigned to the same ACO in the following or preceding years. So this means that when we are assigning a beneficiary to a given year, we are looking at the claims in that year and not at claims in prior years to determine if that beneficiary received a plurality of their primary care at

your ACO. So a beneficiary may have come to see a provider in your ACO in one year but then did not see that same provider in your ACO the next year, and that beneficiary may not be assigned in the next year for that reason.

CMS uses claims submitted to Medicare for primary care services in the assignment process, as I mentioned before. And we will use the information you provided to us on the ACO Participant List to determine which claims to attribute to your ACO.

On slide 25, I'm going to just begin discussing some definitions, and the next few slides will cover some definitions that are important for you to understand for the – to understand the assignment algorithm.

Taxpayer identification numbers, or TINs, are used to identify qualifying physician practice claims. And we know of – we have two different types of TINs: There are employer identification numbers and Social Security numbers. We see physician group practices use EINs on their claims, but sometimes for solo practices CMS needs the – needs the Social Security number because the physician has decided to bill Medicare with their Social Security number instead of a different type of employer identification number. So it's very important for you to know what taxpayer identification number the ACO participant has decided to bill Medicare for, historically during the benchmark period and going forward during the performance years.

Other types of entities on slide 26 that we had discussed earlier were Rural Health Centers Federally Qualified Health Centers, Critical Access Hospitals, billing under method II, and Electing Teaching Amendment Hospitals. These types of entities actually bill Medicare using their CMS certification numbers, or CCNs, and that's why we need those numbers on the ACO Participant List in order to identify the claims.

RHCs and FQHCs also must submit attestation lists of the physicians providing direct primary care. And that's – I mentioned that earlier when we were discussing what elements were required on the ACO Participant List.

On slide 27, these four types of physician specialties are what we consider primary care physicians: internal medicine, family practice, general practice, geriatric medicine. There are other types of physicians which we are only considering are the M.D.s and the D.O.s. And then ACO professionals include all of the primary care physicians, all types of physicians, in fact, and as well as nurse practitioners, certified nurse specialists, and physician assistants.

On slide 28, we provide a definition – our definition of primary care services, which are defined by groups of evaluation and management services, wellness visits, and clinic visits at FRHCs and FQHCs, or by their providers in selected settings.

On slide 29: Here I'm going to start discussing the assignment logic that we will use to assign beneficiaries to your ACO. So the first step we do is to decide if a given beneficiary is eligible to be assigned to your ACO. So a beneficiary must have a record of

Medicare enrollment. A beneficiary must have at least 1 month of Part A and Part B enrollment and cannot have had any months of Part A-only or Part B-only enrollment. A beneficiary may not have had Medicare Advantage at any point during the look-back period for that year. And the beneficiary must reside in the United States, which would include Puerto Rico and territories. Finally, and this is very important, a beneficiary must have had a primary care service with a physician at the ACO in that year.

So on slide 30, we're going to start talking about, in detail, the assignment logic that we use. We use a two-step process. If the beneficiary meets the eligibility criteria I just went over, then we will look to see if a beneficiary has had at least one primary care service furnished by a primary care physician at the ACO or outside the ACO. So if the beneficiary has received the primary care service from a primary care physician in that year, then we will determine if the ACO provided the plurality of primary care services by primary care physicians, or if an outside entity provided the plurality of primary care services by primary care physicians. And remember that primary care physicians were defined a couple slides ago and include those four specialty types that I mentioned.

On slide 31, Assignment Policy Step 2 says that if a beneficiary has not actually received any primary care services from primary care physicians at the ACO or outside the ACO, then we can consider the types – other types of primary care services from the other types of ACO professionals. So we will look at the claims from the nurse practitioners, the certified nurse specialists, the physician assistants, and the specialty – specialist physicians that are in the ACO – that are outside the ACO to determine if the ACO provided the plurality of that individual's primary care in that year. And plurality, I should mention, is measured by Medicare allowed charges.

On slide 32, we're going to start going over some kind of detailed examples about a given beneficiary, where they received their care, and where that beneficiary would ultimately be assigned. So slide 32 covers some information about the following examples. What we're calling organizational ID is the A number for each ACO. Every ACO applicant will receive an A number, and that's how we're denoting that it's an ACO. A TIN or a CCN are listed in the examples following, and those would denote that it's outside the ACO—it's a TIN outside the ACO. And for each beneficiary assignment example to follow, the top row indicates the ACO or non-ACO provider to which the beneficiary was assigned.

So on slide 33, Example 1, Beneficiary A1 is assigned to ACO 9999 because that ACO had the highest allowed charges for primary care services provided by primary care physicians, even though two other non-ACO practices had higher allowed charges provided by ACO professionals. So if you look at the first column under PCP, then you see that there – that this beneficiary did receive primary care services from primary care physicians in the year, which means that we are looking only at primary care services from primary care physicians to determine where that beneficiary should be assigned. And that beneficiary will be assigned to the ACO or non-ACO individual or group TIN that provided the plurality of their primary care measured by allowed charges.

In Example number 2 on slide 34, the beneficiary is going to be assigned to a taxpayer identification number outside of an ACO, because that taxpayer identification number, again, provided the plurality of primary care services by primary care physicians. And we're only looking at column 1 under PCP again, because there are charges under that column, which means we only look at that column when determining which entity provided the plurality of primary care.

On slide 35, this is an example of when the beneficiary did not receive any primary care services from primary care physicians in the year, either inside or outside the ACO. Therefore, we have to look at the primary care services provided by other ACO professionals, which are specialist physicians or nurse practitioners, clinical nurse specialists, or physician assistants. And, again, don't forget that there is a requirement that beneficiaries must have received at least one primary care service from a *physician* in the ACO in order to be eligible to be assigned to the ACO.

So in this case, Beneficiary A3 is assigned is to ACO A9999 because the ACO professionals in the ACO provided the plurality of primary care to that beneficiary. However, we know that this beneficiary did receive a primary care service from a specialist physician in this ACO in order to have been assigned there.

On slide 36, we're going to go over a few, kind of, examples of what a typical ACO might look like from some ACOs that we've seen in the past. So in the first row, we are showing the number of beneficiaries provided at least one primary care service by a physician in the ACO. So that's any type of physician—it could be a primary care physician or a specialist physician. But these are – this is the number of beneficiaries that ACO as a whole has seen in that year by primary care – by any type of physician. So ACO 1, we're almost at 12,000 beneficiaries; ACO 2 is at 28,000; ACO 3 is at 24,000 beneficiaries. And this is probably a closer number to what you might consider your number of Medicare patients, and this is a larger number than what you will ultimately see assigned to your ACO.

So if you go to row 2, you'll see what – how many beneficiaries were ultimately assigned to these ACOs. And on average, we're seeing about 60 percent – 50 to 75 percent of those – of row 1 being assigned, but that is not inclusive. So the range could be much lower than 50 percent or much higher, depending on your ACO's specific circumstances—what type of market your ACO is in, and what type of providers are actually in your ACO. So we excluded, in this first ACO, 4,000 beneficiaries for various – for the various exclusion reasons.

On slide 37, we are showing what types of – generally, what types of ACO professionals and how many of them are in each of these ACOs. So it's interesting to note that ACO 1 had less primary care physicians than specialist physicians. They still received a relatively large proportion of row 1 number of beneficiaries as assigned beneficiaries. However, in ACO 2, you see less primary care physicians than specialist physicians, and that ACO has not achieved a plurality for less than 50 – for more than 50 percent of row 1.

So it just goes to show that it's difficult to predict what assignment will happen. You have to understand your market in terms of: Where are my Medicare patients actually going to seek care outside my ACO as well? Are they seeing other primary care physicians outside my ACO? Do I know whether that's happening? And this is – all these factors play a role in whether we will determine, when looking at all the claims, whether your ACO provided the plurality of primary care to beneficiaries.

On slide 38, these are some examples of ACOs that did not achieve the 5,000 beneficiary threshold. And these – in row 1, again, you see the number of beneficiaries that the ACO provided at least one primary care service by any type of physician in the year. And you see some of them are well over 5,000 in this first row. However, when we actually ran the assignment algorithm and assigned beneficiaries to these ACOs, they did not reach the 5,000 beneficiary minimum.

On slide 39, we also give the types of ACO professionals affiliated with these three ACOs.

I'm going to turn it back over to Tricia Rodgers at this point. Thank you.

Application Reminders and Resources

Tricia Rodgers: Thanks, Jenna. We hope that these presentations have helped you to begin preparing your application.

We went – we went over the key dates on slide 41 on our last call. And as a reminder, we're required to start each new cycle on January 1st. So we must meet these deadlines to be in compliance with the law. We will accept a notice of intent to apply, or NOI, from May 1st to May 30th of this year. And you will need to submit CMS User ID forms for all individuals who will submit an application for those who may utilize CMS data if your ACO is approved. And you must submit these forms by June 10th, 2013.

Because it takes 3 to 4 weeks for us to process user ID requests, we stress the importance of completing this step as soon as possible. It's due no later than June 10th, but we ask that you complete that step as quickly as possible.

We will accept applications from July 1st through July 31st of this year. And we will issue application dispositions later this fall. Please note that if you've previously submitted an application for the Medicare Shared Savings Program, and your application was either denied or you withdrew it, you must complete the process again from the beginning. This means that you need to submit a 2014 NOI and receive a new ACO ID. After you complete that, you must submit a new 2014 Medicare Shared Savings Program application. We will not evaluate any previous submissions.

Slide 42 outlines upcoming application calls. So please mark your calendars for these future calls. On June 20th, we will provide a 2014 application overview. On July 9th, we'll go over how to submit an application through our Health Plan Management System, and

on July 18th, we will hold an open question-and-answer session to go over your questions during the middle of the application submission period.

I'm on slide 43 now, and we ask that you continually monitor our Medicare Shared Savings Program Web site for updates. If you have any questions regarding the application throughout the process, you may contact us via e-mail at SSPACO_Applications@cms.hhs.gov, or leave us a voicemail message at 410-786-8084.

This wraps up our prepared portion of the Medicare Shared Savings Program application call, so I'll turn it back over to Leah Nguyen for the question-and-answer portion of our call.

Question-and-Answer Session

Leah Nguyen: Thank you, Tricia. Our subject-matter experts will now take your questions about the Shared Savings Program application process. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask more than one question or ask a followup question, you may press star 1 to get back into the queue, and we'll address these additional questions as time permits.

All right, Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Please note: Your line will remain open during that time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Bob Cawley.

Bob Cawley: Hello. I was just wondering, when you were talking about the assignment, could you confirm for me – it did not look like residence, other than being a U.S. or Puerto Rican resident, was factored into the assignment. So, for instance, if somebody had a residence in Florida but they received a majority of those services in New York, they could still be assigned in New York. And this is Bob Cawley from Adirondack Health Institute.

Tricia Rodgers: So we can assign a beneficiary to an ACO wherever the ACO is, but the beneficiary must have received services at the ACO's providers. So if the ACO is a snowbird, and is a resident in Florida for half the year and a resident in New York for half the year, then we can still assign the beneficiary to the ACO wherever the beneficiary received the plurality of their primary care during that year.

Bob Cawley: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Natasha Anderson.

Natasha Anderson: Yes, good afternoon. This is Natasha from Larkin Hospital. Our question is: If we become a participant for an ACO, are we still able to submit an application to become our own ACO?

Terri Postma: This is Terri. No. If you're an ACO participant, then you would not be able to form your ACO in addition.

Natasha Anderson: If there's a clause on the contract that you are able to go out and we do cancel, we can still apply?

Terri Postma: I'm sorry. Re-state that question, please?

Natasha Anderson: If we became a participant for another ACO, and we decide to remove ourselves from there, and there's, let's say, a 30- or a 60-day termination clause, are we able to submit our application?

Terri Postma: That would be within whatever you're able to do within your contract with the ACO. But if your ACO is – if you're an ACO participant on the ACO Participant List that's accepted in the program, then, for example, you'd have to disassociate yourself from that ACO if you wanted to apply as your own ACO. Does that make sense?

Natasha Anderson: It sure does. Thank you so much.

Operator: Your next question comes from the line of Angela Hacker.

Angela Hacker: Hi, I'm calling from McKenzie Medical Center in McKenzie, Tennessee. We are close to the edge of the State. Can we join with a group outside of our State, outside our demographic area, to get enough numbers to be part of the ACO?

Terri Postma: This is Terri. Yes. The ACO program isn't – there's no – there are no limitations in terms of geography. So it's reasonable that if you have a, you know, a lot of beneficiaries seeing practitioners in different States, you know, especially if there are border States, there's a lot of that back and forth, so there are – there aren't any geographic restrictions.

Angela Hacker: Thank you.

Operator: Your next question comes from the line of Robert Johnson.

Ricardo Johnson: Hello. I think – it's Ricardo Johnson. I just had a question. When you say that the ACO participant will be excluded if they are part of any other shared savings program, will they – will the ACO participant also be excluded if they are part of a – of any other, sort of, the Innovation Challenge grants, or any other, sort of, CMS project that has – you know, that sort of is dealing with coordinated care like that ACO?

Terri Postma: This is Terri. So we've tried to do our best to update the application to include all Medicare – all initiatives that involve shared savings, to the best of our knowledge. Now, if innovation – if there is an Innovations Challenge that involves Medicare shared savings, we will list it on the application. I'm not aware of any at this time, but if we do become aware of one, then, yes, we would be screening against that overlap.

Ricardo Johnson: Thank you.

Terri Postma: But we think we have them all listed right now in the application.

Ricardo Johnson: OK, thank you.

Operator: Your next question comes from the line of Larry Preston.

Larry Preston: Yes, good morning. Out here on the west coast. The question really centers around a group—if you've got – according to your examples, if you have 15 doctors in one group and one decides not to participate, does that mean the other 14 cannot, or they just have their individual NPI that we put through?

Terri Postma: This is Terri. No, the first one that you stated was correct, that all 15 NPIs – all 15 practitioners would have to agree to participate and comply in order for that ACO participant TIN to be listed on the list.

Larry Preston: OK. So it's all or nothing, whether it's a small group or a large group?

Terri Postma: You got it.

Larry Preston: Wow. OK, thank you.

Operator: Your next question comes from the line of Cynthia Gross.

Cynthia Gross: Hi. My question is: Where an ACO wishes to obtain support services such as operations or IT support from a company, may the ACO offer a share of ownership in its legal entity to those companies, even though those companies are not part of a Medicaid provider – Medicare provider?

Terri Postma: Hey, this is Terri. So the Medicare Shared Savings Program doesn't address that question directly, or actually either indirectly. We don't make any statements about ownership, and that's not part of our program rules. So all we're looking at is the

control, for example, over the ACO governing body. So you should make sure that the ACO participants—that is, the ones listed on that list of ACO participants that are Medicare enrolled—have 75-percent control over the decisions of the ACO governing body. But we don't – we don't have any rules or regulations around ownership of the ACO. So that's something you would have to work out as part of your contracts.

Cynthia Gross: Right, thank you.

Operator: Your next question comes from the line of (Fred Simmons).

(Fred Simmons): Hello, I'm having some trouble understanding the definition of primary care physician. Can a specialist like a cardiologist who provides a plurality of the E&M services—can they be considered a primary care physician?

Jenna Wright: Yes, this is Jenna. They – we can consider they are primary care services that they have furnished to an – a beneficiary, but when we are looking at the first step of assignment, we are only looking at primary care services furnished by primary care physicians, one of the four that we mentioned in slide 27. So they must be internal medicine, family practice, general practice, or geriatric medicine.

So that is our way of enabling a beneficiary to be assigned where their primary care physician is. Now, we recognize that beneficiaries do not all have primary care physicians. Maybe they use a specialist physician for their primary care, and in that case, we would be able to assign the beneficiary to the – using the – looking at the services that were provided by the specialist physician.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Shawn Franklin.

Shawn Franklin: Hi, good afternoon. I'm Shawn Franklin with Holy Cross Physician Partners. We found, based upon some of the guidance today, that it may be necessary to amend some of the agreements that we already have in place. Our amendment provision in our agreement really just allows for a right to dispute the amendment over 30 days and does not require, you know, a signature or a positive affirmation from the – from the contracted physician. So in terms of what you're looking for in the application and the, you know, explicit affirmation of some of the requirements, I wondered if that was going to be permissible, or if you were going to require a signature.

Terri Postma: Yes, this is Terri. We will be requiring a signature. The instance where we would not—the one that I can – the one example that I can think of right now is, for example, if there's a – let's say an ACO participant TIN is a group practice, and the group practice employs all their physicians. They don't have a – they don't have, you know, contracts with their physicians as employment arrangements, in which case, the ACO participant, if as a – if as part of those employment contracts, the practitioners must engage in the program, participate, and comply as part of their – as a condition of their

employment, then – then they would only have to be notified that the – that the ACO participant TIN has agreed to participate and comply, and that the expectation is that they do, as well. That's in the – that's if it is a condition of their employment.

If, though, the group practice has contracts with the practitioners, then they each need to have a – have an agreement. Now, if the ACO – so that's a little nuance, and you can read about that in the application, because there's a little more information on that. But now, to get to your question specifically—yes, the contracts have to have that explicit agreement in them, between the ACO and the ACO participants, to agree to comply and participate in the Shared Savings Program specifically. There has to be a signature, and we – and our reviewers will be looking for that closely.

Shawn Franklin: If I may follow up, I mean, we do have signed agreements with all of our physicians. But if we would choose to have to amend certain provisions within the agreements, certain language to perhaps be more specific with regard to the requirements, that amendment at present does not require their signature. It only requires that they respond within 30 days to their objection of that. So I'm just trying to clarify whether or not this previously agreed-to agreement with an existing amendment provision would allow for those necessary language changes.

Terri Postma: Yes. My sense is that if the previous agreement didn't have the requirements in them, those requirements have to be specifically agreed to. Though I think that, you know, you probably should get an affirmative signature on those requirements specifically.

Shawn Franklin: OK, thank you.

Terri Postma: Thanks.

Operator: Your next question comes from the line of (Kuh Putiera).

(Kuh Putiera): Yes, my question is: Under the presentation slide 10, it mentions pharmacy. Some pharmacies have DME services, as well, under the waivers. Will that service be allowed, both pharmacy/DME?

Terri Postma: I'm not sure I understand the question, but let me address what the pharmacy and pharmacists listed there, by way of example, are—on slide 10. Some pharmacies bill Medicare directly for services. They're Medicare-enrolled entities; they have a Medicare-enrolled TIN. And if that's the case, then they could be considered an ACO participant and be on the list of ACO participants. But I felt like there was a more specific question in there, so could you please rephrase that?

(Kuh Putiera): Yes. On the waivers, it indicates that ACOs cannot do contracts with either pharmacy, DME, or home health, but those pharmacies that also have DME services and bill Medicare under DME services, can they be included as an ACO participant when they combine both pharmacy and DME?

Terri Postma: If you could e-mail that question over the box—we don't have any folks here that are experts in the waiver. And so I hesitate to even try to approach an answer to that.

Female on Kuh Putiera's Line: Will do, thank you.

Terri Postma: Thank you.

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

Jordan McInerney: Sorry. Hello, this is Jordan McInerney with Stryker Performance Solutions. My question is: As far as non-physician providers—since they're not added to the participant list, do they still need individual participant agreements to be executed?

Terri Postma: Yes, this is Terri. Yes, they do need – they need – do need to – they do need agreements. They need – do need to affirmatively agree to participate and comply, and the agreements have to contain those four required elements. They're – I'm going to turn it over to Jenna to address how we get the certified list of those NPIs.

Jenna Wright: Go ahead.

Terri Postma: Yes. The providers that are billing through the TIN of the ACO participant are ACO providers and suppliers, and we do need a certified list of those. But Jenna, how do we get that?

Jenna Wright: Yes. Once your application is approved and you become an approved ACO, we will use the Medicare enrollment system to identify all of the ACO providers/suppliers that have reassigned their Medicare billings to ACO participant TINs. We will provide that list to you so that you know what's currently in the Medicare enrollment system, and you can make updates to that and have your ACO providers/suppliers make updates to their enrollment files if need be at that time.

Jordan McInerney: OK, great. Thank you.

Operator: Your next question comes from the line of Jenny Kovich.

Jenny Kovich: Hi, this is Jenny Kovich calling with UroPartners. And I have a question; it's kind of a followup to an earlier question. When that second step of the assignment process is used to assign a beneficiary based on a specialty physician: If that beneficiary gets assigned to an ACO based on a specialist, does that specialist then get locked into that ACO as a primary care provider, or do they still have the ability to participate in multiple ACOs?

Terri Postma: This is Terri, and I just want to mention that we have some QAs online about our TIN exclusivity principle, which is . . .

Jenny Kovich: OK.

Terri Postma: . . . that if an ACO participant TIN bills Medicare for primary care services, that ACO participant TIN must be exclusive to a single Medicare Shared Savings Program ACO list.

So it's not whether or not a beneficiary ends up ultimately getting assigned. It's really whether that ACO participant's TIN bills for primary care services as they are defined in the rule. All assignments are done retrospectively, so we can't predict when a patient is going to be assigned or not. So that's why it's any TIN upon which assignment is based, which would be any TIN that bills for those primary care services.

Jenny Kovich: So just to clarify: We're a specialty group but we do provide a number of E&M codes. So that means that we're not technically considered specialists in the way that we would be able to participate in multiple ACOs. We will be locked in, because we do provide primary care services?

Terri Postma: Yes. Let's say there's a multispecialty group practice—there's some primary care and some not, or even a specialist group practice that bills for those primary care services. If that TIN is listed on the ACO participant's list and it does bill for those primary care service codes, then it will have to be exclusive to a single list.

Jenny Kovich: OK, thank you.

Terri Postma: You're welcome.

Operator: Your next question comes from the line of (John Williams).

(John Williams): Yes. I had a question. Our – is for sure the Advance Payment program not going to be run in 2014?

Tricia Rodgers: Hi, this is Tricia. And we don't have anyone on the line from the Center for Medicare and Medicaid Innovations, but it is our understanding that they are not offering that advance payment application at all for anything beyond 2013, which has already started, so—nothing for 2014 and beyond.

(John Williams): OK, thank you.

Tricia Rodgers: Thank you.

Operator: And your final question comes from the line of Larry Preston.

Larry Preston: Yes, thank you. Since we have bordering counties between Nevada and California, the question comes up is, when you have a rural facility, is there any exclusion if there's only one doctor group, or several doctors in that group, that they can

all – or is there an exclusion if only one of those can be participating in an ACO because it's in a rural community?

Leah Nguyen: Could you hold on for a moment?

Terri Postma: Hi, this is Terri. So I think – if I understand your question correctly, you're saying is there an exception for ACO participant TINs in which – so we've said that all the practitioners that bill through the TIN of an ACO participant have to agree to participate and comply, and you're asking is there an exception for those ACO participant TINs that happen to be in rural places, because their practitioners are spread out? The answer would be no. There is no exception. So I think I got – I think – I hope I got your questions.

Larry Preston: No, it was – we had saw an alert that came out – not an alert, but just a bulletin that came from one of the attorney firms, saying that if there's two doctors, and they only have one TIN—and they're in, you know, Nevada rural, rural California, something like that—that they cannot be part of an ACO because that would be exclusive. You would have – you would have that community locked up with that ACO. And we're not – we can't find anything in the rules that state that. But this just came out from one of the attorney firms that were sending out an alert—if you're working with a rural community, you only can have one doctor in that community that can be on your ACO, and the other doctors possibly could not be on it. But I can't find any regulations that support that.

Terri Postma: Oh, OK, thank you. So that helped. So what I said before still applies as far as the Shared Savings Program goes. Both of the docs would have to agree to participate and comply. What that legal firm might be referencing is the – is the PSA shares, but that would be for the ACO as a whole, is my understanding. That's something that has to do with the antitrust policy statements. So we do have a link to that on our Web site, and if you want to take a look at that antitrust policy statement and run the numbers on your PSA shares, that should answer the question about whether or not that TIN, that practice TIN, could be a part of an ACO or not.

Larry Preston: OK. So even if that – in this particular case, it was a sole doctor – sole community, he could still be part of the ACO as long as it's in conjunction with the larger part of the ACO, or how that fits into the whole ACO – the ACO as a whole.

Terri Postma: As far as the program rules go, there's nothing in the program rules that would prevent that ACO participant TIN from being a part of an ACO. But what you'd have to do is look at the – calculate the PSA shares, and look at the antitrust policy statement, and see if there's any antitrust reasons that would prevent it.

Larry Preston: OK.

Terri Postma: Thanks.

Larry Preston: Thank you.

Leah Nguyen: Thank you.

Additional Information

Leah Nguyen: I would like to thank everyone for participating in this Medicare Shared Savings Program Application Process National Provider Call. On slide 45 of the presentation, you will find information and a URL to evaluate your experience with today's call. The evaluations are anonymous and strictly confidential. I should also point out that all participants for today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box within 2 business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. Please note: Evaluations will be available for completion for 5 business days from the date of today's call. We appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to the CMS MLN National Provider Calls Web page.

Again, my name is Leah Nguyen. And it's been my pleasure serving as your moderator today. I would also like to thank our presenters, Tricia Rodgers, Dr. Terri Postma, and Jenna Wright.

Have a great day, everyone.

Operator: Thank you for your participation in today's conference. This concludes today's conference call. Presenters, please hold.

END