

# Medicare Shared Savings Program Application Process: Agreements, Participant List & Assignment

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# Introduction

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# Agenda

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- This presentation will cover:
  - ACO Participant Agreements
  - ACO Participant List Issues
  - Beneficiary Assignment



# Purpose of Today's Call

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- Explain and clarify these critical elements in the Medicare Shared Savings Program (Shared Savings Program) application:
  - Agreements between your ACO and ACO Participants
  - ACO Participant List
  - Beneficiary Assignment



# Shared Savings Program: Background

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- [Shared Savings Program](#) web site
- Mandated by Section 3022 of the Affordable Care Act
- Establishes a Shared Savings Program using Accountable Care Organizations (ACOs)
- Must be established by January 1, 2012
- Notice of proposed rulemaking issued March 31, 2011
- CMS sought and received over 1,300 comments on the proposal
- Issued Final Rule November 2011



# ACO Participant Agreements

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# Shared Savings Program: Definitions

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## **ACO Participant:**

Individual or group of ACO provider(s)/supplier(s) that is identified by a Medicare-enrolled taxpayer identification number (TIN), that alone or together with one or more other ACO participants comprise(s) and ACO.

E.g. Acute Care Hospital, Group Practice, Individual Practice, Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Critical Access Hospital (CAH), Pharmacy, Long-term Care Hospital (LTCH), Skilled Nursing Facility (SNF), Emergency Room (ER), etc.

## **ACO Provider/Supplier:**

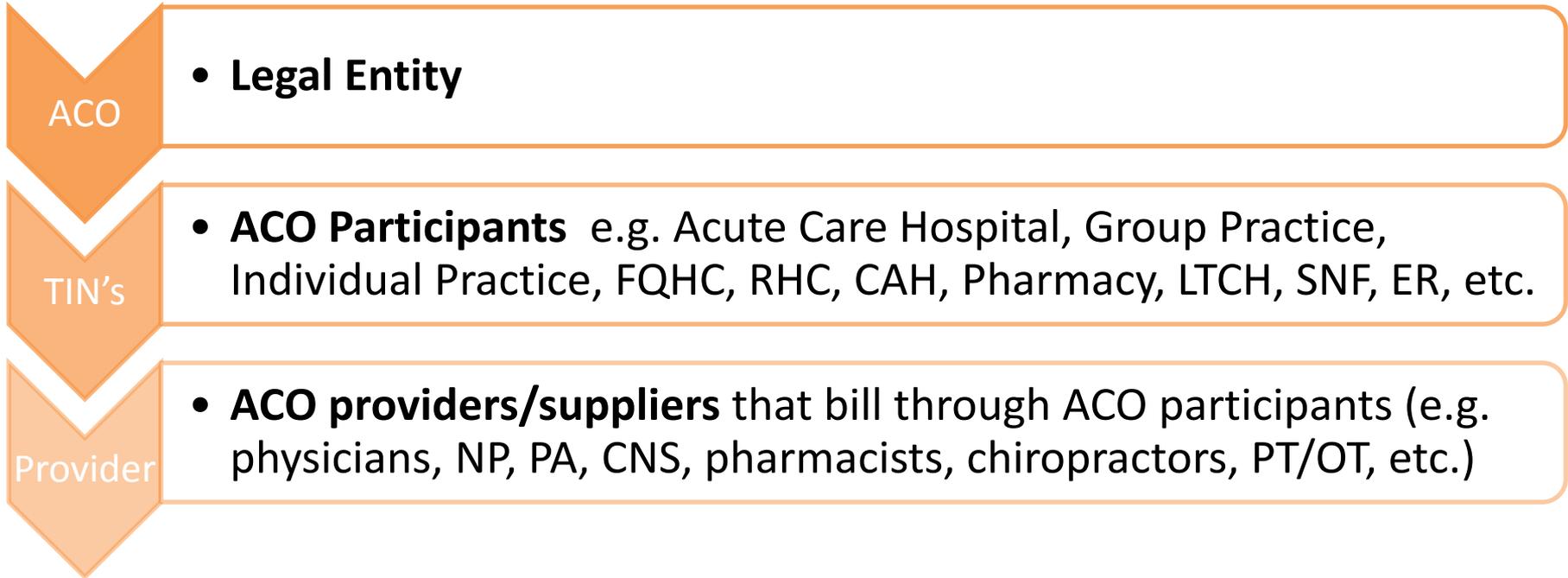
- (1) A provider (as defined in §400.202) , or a supplier (as defined at §400.202)
- (2) Enrolled in Medicare
- (3) Bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant.

E.g. Physicians, Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialists (CNS), pharmacists, chiropractors, Physical Therapy/Occupational Therapy (PT/OT), etc.



# Shared Savings Program: ACO Structure

## ACO Structure



# ACO Participant Agreements

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- [Agreement Guidance](#)
- Required Elements:
  - Reference: [Final Rule](#) 42 CFR 425.204, 425.210
  - Required elements in the agreement:
    - Explicit requirement to comply with 42 CFR 425
    - ACO participant rights/obligations
    - How sharing in savings will encourage compliance with Quality Assessment and Performance Improvement (QAPI) and evidence-based medicine (EBM) guidelines
    - Remedial measures



# Key Points

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- Must be between the ACO legal entity and ACO participant legal entity
- Must be **direct**
- May not include ACO participant without a signed agreement
- ACO ensures all ACO provider/suppliers have also agreed to participate
- [Examples of correct and incorrect agreements](#)



# Use Good Contracting Practices

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- Opening – clearly identify parties to the contract
- Include required elements
- Signature page – suggested elements:
  - Date
  - Signature of person with authority
  - ACO participant legal entity name
  - ACO participant TIN



# ACO Participant List

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# ACO Participant List

- Includes information about the ACO participants and, in some cases, ACO providers/suppliers
- Used to determine an applicant's eligibility to become an ACO in the Shared Savings Program
- Once approved, CMS uses the ACO Participant List to:
  - Assign beneficiaries to the ACO
  - Establish the historical benchmark
  - Perform financial reconciliation
  - Determine a sample of beneficiaries for quality reporting
  - Coordinate participation in the Physician Quality Reporting System under the Shared Savings Program
  - Monitor the ACO for program integrity issues



# ACO Participant List

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- Once accepted into the Shared Savings Program, ACOs must tell CMS within 30 days of a change to their ACO participants or ACO providers/suppliers
- Changes to ACO participants after the start of the agreement period affect some program operations (Refer to the [Changes in ACO participants and ACO providers/suppliers during the Agreement Period](#) web page)



## Merged or Acquired TIN

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- TIN that was acquired by an ACO participant through purchase or merger
  - The ACO participant must have 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 reassign their billing to the ACO participant TIN
  - The acquired TIN must no longer be used
- Not required on the ACO Participant List, but applicant may choose to include for retrospective beneficiary assignment and benchmarking purposes



## Merged or Acquired TIN

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



# ACO Participant List Template

TIN	TIN Legal Business Name	Medicare Enrolled TIN	Merged or Acquired TIN	First Name of Person Authorized to Sign ACO Participant (TIN) Agreement	Last Name of Person Authorized to Sign ACO Participant (TIN) Agreement

CCN	CCN Legal Name	CCN Identification Code	Organizational NPI	Organizational NPI Name	Individual NPI	Individual NPI First Name	Individual NPI Last Name

Additional information required if the ACO participant is a:

- FQHC: CMS Certification Number (CCN) and National Provider Identifiers (NPIs)
- RHC: CCN and NPIs
- CAH billing under method II: CCN only
- Electing teaching amendment hospital: CCN only



# Evaluation

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



# Opportunity to Resubmit

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- Applicants will receive a report that includes the number of preliminarily assigned beneficiaries and results of screening
  - Sent by email with an encrypted zip file attachment
  - Many applicants' firewalls block emails with encrypted attachments
    - **Take steps now to make sure this does not happen to you!**
- Applicants can resubmit their ACO Participant List if needed



# Submitting the ACO Participant List

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- Upload required before finalizing the application through the Health Plan Management System (HPMS)
- Must meet basic formatting requirements
  - See instructions for the ACO Participant List in the Application Toolkit
- If there are formatting errors, the HPMS will not accept the upload and require you to correct the errors



# Beneficiary Assignment

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RTI International



# ACO Beneficiary Assignment

- Preliminary prospective assignment with final retrospective beneficiary assignment
  - An ACO needs to have at least 5,000 preliminarily assigned beneficiaries in order to be in the Shared Savings Program in each of the three years preceding the start of the agreement period (2011, 2012, 2013)
  - 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
- CMS uses claims submitted to Medicare for primary care services in the assignment process
- CMS uses information you provide to us on the ACO Participant List to determine which claims to attribute to your ACO



# TINs

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- TINs are used to identify qualifying physician practice claims
- There are two types of TINs:
  - Employer Identification Number (EIN)
  - Social Security Number (SSN)
- Physician group practices use EINs on their claims
- For solo-physician practices, CMS needs the TIN submitted on the claims
  - Some of these practices use SSNs while others (professional corporations) use EINs



# Other Participating Entities

- These include:
  - RHCs
  - FQHCs
  - Method II CAHs
  - Electing Teaching Amendment (ETA) hospitals
- CMS CCNs are needed to identify the above entities in claims
- RHCs and FQHCs also must submit attestation lists of the physicians providing primary care



# ACO Assignment: Individual Provider Types

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- Primary Care Physicians (PCP)
  - Internal Medicine
  - Family Practice
  - General Practice
  - Geriatric Medicine
- Other physicians (M.D., D.O.)
- ACO Professionals include both of the above types of physicians plus:
  - NP
  - CNS
  - PA



# ACO Assignment: Definition of Primary Care Services

- Evaluation & Management Services provided at:
  - Office or Other Outpatient settings (CPT 99201 – 99215)
  - Nursing Facility Care settings (CPT 99304 - 99318)
  - Domiciliary, Rest Home, or Custodial Care settings (CPT 99324 - 99340)
  - Home Services (CPT 99341-99350)
- Wellness Visits (HCPCS G0402, G0438, G0439)
- Clinic visits at RHC/FQHCs or by their providers in selected settings (UB revenue center codes 0521, 0522, 0524, 0525)



# ACO Assignment: Beneficiary Eligibility

- A beneficiary is eligible to be assigned to an ACO if the following criteria are satisfied during the assignment period:
  - Beneficiary must have a record of Medicare enrollment
  - Beneficiary must have at least one month of Part A and Part B enrollment, and cannot have any months of only Part A or Part B
  - Beneficiary cannot have any months of Medicare group (private) health plan enrollment
  - Beneficiary must reside in the United States including Puerto Rico & Territories
  - Beneficiary must have a primary care service with a physician at the ACO



# Assignment of a Beneficiary to an ACO

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If a beneficiary meets the eligibility criteria, the beneficiary is assigned to an ACO using a two-step process:

## Assignment Policy Step 1

CMS will assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care physician at the participating ACO, and more primary care services (measured by Medicare allowed charges) furnished by primary care physicians at the participating ACO than from primary care physicians at any other Shared Savings Program ACO or non-ACO individual or group TIN.



# Assignment of a Beneficiary to an ACO

## Assignment Policy Step 2

This step applies only for beneficiaries who haven't gotten any primary care services from a primary care physician. CMS will assign the beneficiary to the participating ACO in this step if the beneficiary got at least 1 primary care service from a physician at the participating ACO, and more primary care services (measured by Medicare allowed charges) from ACO professionals (physician regardless of specialty, NP, PA, or CNS) at a participating ACO than from any other ACO or non-ACO individual or group TIN.



# ACO Assignment: Notes for Following Examples

- Organizational ID
  - Is the A# for each ACO—all TINs and CCNs on an ACO's Participant List are associated with the ACO's A#
  - TIN or CCN for non-ACO practices and providers
- For each beneficiary assignment example, the top row indicates the ACO or non-ACO provider to which the beneficiary was assigned



## ACO Assignment: Example 1

### Allowed Charges for Primary Care Services

<u>Beneficiary</u>	<u>Organization ID</u>	<u>PCP</u>	<u>ACO Professional</u>
A1	A9999	\$454	\$654
A1	555555555	\$300	\$1,900
A1	456565656	\$250	\$2,500

Beneficiary A1 is assigned to ACO A9999 because A9999 had the highest allowed charges for primary care services provided by a primary care physician (\$454) even though two other non-ACO practices had higher allowed charges provided by ACO professionals



## ACO Assignment: Example 2

### Allowed Charges for Primary Care Services

<u>Beneficiary</u>	<u>Organization ID</u>	<u>PCP</u>	ACO <u>Professional</u>
B3	333333333	\$1,200	\$1,250
B4	A5656	\$800	\$800
B5	A9999	\$600	\$700

Beneficiary B3 is assigned to a non-ACO provider (333333333) because it had the highest allowed charges for primary care services provided by a primary care physician (\$1,200)



## ACO Assignment: Example 3

### Allowed Charges for Primary Care Services

<u>Beneficiary</u>	<u>Organization ID</u>	<u>PCP</u>	<u>ACO Professional</u>
A3	A9999	\$0	\$300
A3	555555555	\$0	\$250
A3	333333333	\$0	\$200

Beneficiary A3 did not receive any primary care services from a primary care physician. So A3 is assigned to ACO A9999 on the basis of the highest allowed charges for primary care services provided by ACO professionals (\$300)



## Assigned Beneficiaries for Three Typical ACOs

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

## ACO Professionals Affiliated with the Three Typical ACOs

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



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

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

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

Type of ACO Professional	ACO 1	ACO 2	ACO 3
Primary care physicians	26	33	33
Other specialist physicians (e.g., cardiologists)	16	3	43
PAs, NPs, Clinical Nurse Specialists	8	4	4



# Application Reminders

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# Application Cycle: Key Dates

Start Date	January 1, 2014
2014 applications posted on CMS Web site	June 2013
Notice of Intent to Apply (NOI) forms accepted	May 1, 2013 – May 30, 2013
CMS User ID forms accepted	May 1, 2013 – June 10, 2013
2014 applications accepted	July 1, 2013 – July 31, 2013
2014 application disposition	Fall 2013

# Upcoming Application Calls

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- Save the date:
  - June 20: 2014 Application Overview National Provider Call
  - July 9: HPMS Submission
  - July 18: Application Process Q&A National Provider Call



# Who to Contact for Assistance

- [Shared Savings Program Application](#) web page
- Questions related to your NOI submission or application process  
[SSPACO\\_Applications@cms.hhs.gov](mailto:SSPACO_Applications@cms.hhs.gov) or Call: (410) 786-8084
- Questions related to your access to HPMS, Form CMS-20037, and/or CMS User ID (e.g. new access to HPMS, trouble finding the HPMS Web link)  
[HPMS\\_Access@cms.hhs.gov](mailto:HPMS_Access@cms.hhs.gov) or (800) 220-2028
- Questions related to HPMS Log-In assistance (e.g., trouble logging into HPMS, password reset)  
[CMS\\_IT\\_Service\\_Desk@cms.hhs.gov](mailto:CMS_IT_Service_Desk@cms.hhs.gov) or 1-800-562-1963



# Questions?

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