

**Centers for Medicare & Medicaid Services  
Medicare Shared Savings Program and  
Advance Payment Model Application Process  
National Provider Call  
Moderator: Leah Nguyen  
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Operator: At this time, I'd like to welcome everyone to the Medicare Shared Savings Program and Advance Payment Model Application Process 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. Thank you for your participation in today's call.

I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

## **Introduction**

Leah Nguyen: Thank you, Holley. I am 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 and Advance Payment Model Application Process.

On October 20th, 2011, the Centers for Medicare & Medicaid Services issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program along with a notice for the Advance Payment Model that will provide additional support to physician-led and rural Accountable Care Organizations participating in the Shared Savings Program. These two initiatives will help providers participate in ACOs to improve quality of care for Medicare patients. During this National Provider Call, CMS subject-matter experts will provide an overview and updates to the Shared Savings Program Application and Advance Payment Model Application Processes for the January 1st, 2013, Shared Savings Program start date. A question and answer session will follow the presentation.

Before we get started, I have a few announcements. The link to the slide presentation for today's call was e-mailed to all registrants earlier this afternoon. The presentation can also be downloaded from the CMS Fee-for-Service National Provider Calls Web page at [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 July 31st 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 CMS Fee-for-Service National Provider Calls Web page.

At this time, I would like to introduce Tricia Rodgers, Deputy Director of the Performance-Based Payment Policy Group here at CMS, who will cover the Medicare Shared Savings Program Application Process.

## **Presentation 1**

Tricia Rodgers: Thanks, Leah, and good afternoon and thank you all for joining us for the call. I will walk through the slide presentation that Leah just talked about, and you'll notice the numbers on the pages in the upper right-hand corner of each slide.

Slide 2 is just our disclaimer that everything you see in this presentation is true and accurate to the best of our knowledge as of today, July 31st.

I'm on slide 3 now. And this presentation is aimed at providers who are interested in participating in the Medicare Shared Savings Program Accountable Care Organizations. And today, we'll give you a brief background of Accountable Care Organizations, or ACOs, the various initiatives we have here at CMS, as well as specific information regarding the Shared Savings Program and the Advance Payment ACO Model Application Process and key dates.

We will go step-by-step with you through this process, and we'll provide information to help you fill out and submit your Medicare Shared Savings Program application. And we'll go over the acceptance and denial process. And lastly, you will have a review of the Advance Payment Model Application Process.

We're moving on to slide 5. Last year, we issued our final rule on the Medicare Shared Savings Program which adds to the menu of options for providers looking to better coordinate care for patients.

Anyone who has been involved in our healthcare system, whether as a provider, a patient, or a family member of a patient, knows that our healthcare system is fragmented. It has developed in pieces, and fragmentation of payment, especially Fee-for-Service payment, reinforces this fragmented care.

Accountable Care Organizations are a new approach to the delivery of healthcare, aimed at reducing fragmentation, improving population health, and lowering the overall growth in healthcare costs by promoting accountability for the care of Medicare Fee-for-Service beneficiaries, improving coordination of services provided under Medicare Parts A and B, and encouraging investment in infrastructure and redesigned care processes.

Moving to slide 6 now. While many providers are embracing these changes, it will take time. As a result, many Medicare provider organizations throughout the country are in various transitional phases. In order to facilitate a move toward participating in ACOs, CMS has developed several initiatives that meet providers at their level of readiness.

The initiatives on slide 7 show multiple pathways that encourage constant learning and improvement in the healthcare industry. CMS's ACO strategy is to create multiple pathways for organizations to participate.

There's the Shared Savings Program with two tracks available. There is also the Medicare Pioneer ACO model, which runs under the Innovation Center and is testing different ACO models to inform the program. And then there is the Advance Payment Model, which is also run under the Innovation Center and is for qualifying ACOs in the Medicare Shared Savings Program. You'll hear more about this in a bit.

I'm on slide 9 now. And the Medicare Shared Savings Program was enacted by Congress through Section 1899 of the Social Security Act as amended by Section 3022 of the Affordable Care Act. The final rule addressed over 1,300 comments and went on display at the Federal Register on October 20th, and was published on November 2nd in 2011.

Our final rule established the Medicare Shared Savings Program for Accountable Care Organizations. The Medicare Shared Savings Program is a voluntary program for healthcare providers that agree to become accountable for the quality, cost, and overall care of Medicare beneficiaries in the traditional Fee-for-Service program.

By focusing on the needs of patients and linking payment rewards to outcomes, the Medicare Shared Savings Program's goal is to improve the health of individuals and communities while lowering the growth in costs. ACOs may accomplish this by carefully coordinating patient care in order to eliminate duplication, medical errors, and mismanagement.

Ultimately, we believe that changes in infrastructure and redesigning care will increase our beneficiaries' quality of care while also reducing time and cost.

Slide 10 represents the key dates for the Medicare Shared Savings Program application cycle for the January 1st, 2013 program start date. I will walk through each section of the process in subsequent slides, but these are the deadlines for each step in the application process.

As you can see, the deadline to submit a Notice of Intent to Apply for the January 1st, 2013, program start date was June 29th. And we had extended the CMS User ID application deadline until Monday, July 9th. We are – we will begin accepting applications tomorrow, August 1st, through Thursday, September 6th. We will send approval or denial notices in the fall of 2012 for the January 1st, 2013, program start date.

It's important to note that if you cannot complete a requirement by a specific date, you must wait until the next cycle to apply. In this case, it would be for the January 2014 program start date.

I'm on slide 12 now. Although you already went through the Notice of Intent process to be considered for the January 1st start date, I'll briefly walk through the steps for future applicants. Submitting a Notice of Intent to Apply, or NOI, does not require you to submit an application. However, you must have an Accountable Care Organization ID, or ACO ID, which comes out of

the NOI process. And you have to have that prior to requesting a CMS User ID.

The CMS User ID is necessary to access the Health Plan Management System, or HPMS, to complete and submit your ACO application. You must also have a CMS User ID to access data if you're accepted into the Medicare Shared Savings Program.

I'm on slide 13 now. Once you are on the Shared Savings Program Web site to submit a Notice of Intent to Apply, you would – when it's active, the link will take you to a memo to apply through an online Web form at the Vovici Web site. This will be in effect for the 2014 NOI, process and we will have dates on our Web site letting you know when that is active for the 2014 application cycle.

You will fill out – once you are – once you have accessed this, you will fill out all of the questions and click “Submit survey” to complete your Notice of Intent to Apply, indicate – to indicate your interest in participating in the Shared Savings Program. You will receive an e-mail acknowledgment containing your ACO ID number and instructions on how to request a CMS User ID.

Slide 14 talks about after you receive your NOI acknowledgment letter via e-mail, the next step is to obtain a CMS User ID. We request that each ACO applicant submit up to three CMS User ID applications. And this should include two applications for IT, or information technology, contacts, and if the person who is entering the application – actually submitting the application – is different than one of the IT contacts, we ask that you also submit an application for the CMS User ID for this person as well.

If you have not received an e-mail confirmation about your CMS User ID by Friday, August 3<sup>rd</sup>, that's this Friday, please contact the HPMS access e-mail immediately at [hpms\\_access@cms.hhs.gov](mailto:hpms_access@cms.hhs.gov).

If you did not complete the CMS User ID application correctly, the HPMS access team will contact you. Please respond to their e-mail immediately so that you can receive your User ID as soon as possible.

Please note that it is the responsibility of the applicant to notify us if an employee with a CMS User ID is terminated. You must submit documentation including the ACO legal name, the ACO ID number, and the user's full name, and his or her User ID as soon as the relationship is terminated. We also want to be clear that the CMS User ID numbers are issued to individual people and should never be shared with another person.

By this time, your Notice of Intent to Apply is complete and you've received your ACO ID, so let's move on to slide 15 to walk through the application. An updated Medicare Shared Savings application package is available for viewing at the [cms.gov/sharedsavingsprogram](https://cms.gov/sharedsavingsprogram) applications Web page. The updated application package includes the application itself, a toolkit which includes reference table and template instructions for the governance body template, the ACO participant list template, the ACO participant agreement template, the executed agreement template, as well as a link to the CMS Form 588, which is the Electronic Fund Transfer Authorization Agreement form.

Slide 16 speaks to the application numbers that I'm referencing in this training. It represents the application version that appears on our Web site. It may look a bit different than the actual online applications that you will see in HPMS. However, the text and the numbering is the same.

We want to walk you through a few of the screenshots of your application to indicate what type of information you'll need to provide. Although you will need to answer all of the questions and provide all supporting documentation, the following slides are representative of the work ahead of you.

Slide 17 contains the screenshot of the 2013 application toolkit. We suggest that you use this toolkit as you walk your way through the application. We developed this as a guide to help you complete each section in the application. It references the regulation citations, the page on which the citation appears in the final rule, whether supporting documentation is required in the application,

and the naming convention of files – for files that will need to be uploaded. It is an adjunct to the application and a quick reference to the final rule for each pertinent section.

Slide 18 displays the sections of the application. I'm not going to read through this, but basically in the application, we ask that you provide us with information around different aspects of your organization. The list on the slide is the type of information we're looking for.

Now, as you make your way through the application questions, you will see in some cases, depending on your answer, that you may need to submit a narrative in addition to responding to the question.

For example, on slide 19, you see the screenshot of question 20 in the application. Here, you are asked about how you plan to use any Shared Savings Payments. You may refer to the reference guide in the toolkit for these elements that you must include in your narrative in order to meet the necessary requirements for this question. In this instance, number 20, section 8 of the reference guide gives you the regulation page of 67978 and section 425.204, subsection D, and it confirms that supporting documentation is required. It also gives the correct file-naming convention for this upload.

Slide 20 displays question 14 in the application. In section 5 of the application, we ask you to provide us with information about your governing body. You must show that your governing body has a fiduciary duty to the ACO. You must also indicate which governing body members are associated with which ACO participants.

Question 14 requires you to complete and submit the governance body template. Again, instructions for the template are found in the toolkit. By completing this template, you're providing us with information necessary to ensure that you're governing body meets the requirements for participation in the Shared Savings Program as set forth in our regulation. The template asks for information such as the name of the governing body, their corresponding titles or positions, the member's voting power, membership type, and the legal TIN name.

Slide 21 displays question 21 of the application. It asks for your ACO's banking information. In this section, we ask that you submit CMS Form 588, also known as the Electronic Funds Transfer, or EFT, Authorization Agreement. You will find instructions on how to complete this form in the toolkit. The signed CMS 588 is essential for you to get a Shared Savings Payment. Shared Savings will be deposited directly into your account. This form is due at the same time as your application, and applications are not considered complete until we receive this form. If you have questions about filling out this form, please follow the tutorial link on our Web site. It is next to the actual form link on the Web site.

We ask that you submit CMS Form 588 at the address noted in the application and also shown on this slide.

Moving on to slide 22. Question 22 in the application asks you to submit a list of participant tax identification numbers, or TINs, and CMS Certification Numbers, or CCNs. The toolkit contains the ACO participant list template and instructions for completing this requirement. You must submit one participant list for each ACO. We will not accept multiple participant lists. HPMS will validate the format of your ACO participant list when you submit it. You will need to correct any formatting errors if necessary and resubmit as part of your application. The formatting errors will be reported in a stepwise fashion. For instance, if you get through formatting steps 1 and 2 and have an error come up, you would fix those, resubmit, and then look to see if there are any issues with formatting steps 3 and 4, and so on.

Please note that the participant TINs may be listed in only one Medicare ACO. If a TIN or CCN are found in multiple ACO participant lists, we will notify you that they are not eligible for assignment in the Shared Savings Program ACO. This is done to avoid overlap and possible duplicate payments. Providers may function in other ACOs or other medical practices, but they can only provide and bill for services in one Medicare ACO.

It's important to understand that beneficiary assignment is based on primary care services rendered by ACO participants. Each ACO participant TIN that

bills Medicare for primary care services must be exclusive to a single Medicare Shared Savings Program ACO.

ACO participant TINs that do not bill Medicare for primary care services may apply for participation in more than one Medicare Shared Savings Program ACO. This also means that we view all practitioners billing through the participant TIN as part of the ACO.

Slide 23 displays questions 26 and 28 in the application. This asks you to complete the ACO participant agreement template and the executed ACO participant agreement template, respectively. The toolkit gives you instructions on how to complete these templates.

In summary, you must be sure that the agreement is between the provider or supplier of services and the ACO participant which is the billing entity. In addition, this agreement must be specifically for the Medicare Shared Savings Program and requires that the ACO participant and all associated ACO providers and suppliers bill through that ACO's TIN in order to comply with our regulations.

The agreements must also have a process in place to ensure that participants comply with the rules and how the ACO will deal with participants who are not compliant. By completing these templates, you are providing us with the information necessary to ensure your agreements meet the requirements for the participation in the Medicare Shared Savings Program as set forth in our regulation.

I'm on slide 24 now. And in section 12 of the application, you will be asked to attest that all of your statements made in the application are true, correct, and complete. It's imperative that you read and understand the program regulations before signing the application certifying that everything you have attested to is true and correct to the best of your knowledge.

In HPMS, you will select either the "I agree" button or the "I disagree" button and then click the "Submit" button. For a January 1st, 2013, program start

date, you must submit your application electronically through the automated HPMS system.

On slide 25, it shows the information that you provided during your Notice of Intent to Apply through that submission process. It will be prepopulated on the application through HPMS. If you need to change any of the prepopulated information, you must request the change through the application e-mail box of SSPACO\_Applications@cms.hhs.gov. This would include updating the data formation that you submitted during your Notice of Intent to Apply. Please use the date of the TIN – the date the TIN of the legal entity was established, not the date that, perhaps, the hospital was established or, perhaps, a university was established, but rather the date that the TIN of the legal entity was established.

Moving on to slide 26. During our application review, we may request that you submit additional information because a portion or portions of the application are incomplete or require further clarification. You must upload the additional information or clarify through HPMS. If you do not submit the information in a timely manner, we will not accept the submission. Please note that while you can view the application online to prepare responses to the application questions – that is, on the Shared Savings Program Web site – you can only submit an application online through HPMS. We ask that you use the link that was in your CMS User ID notice to complete the application through HPMS.

I'm on slide 27 now. After we review your application and supporting documents, we will send you an e-mail either accepting or denying your application in the fall of 2012 for a January 1st, 2013, program start date. If you are approved, you will be asked to fill out and sign and return a number of documents. If your application is denied, you will receive an e-mail to this effect, and you will have the opportunity to request a reconsideration review.

If you choose to seek a reconsideration review, we must review your request within 15 days of the date of your denial e-mail. If you do not meet this deadline, you will not be reconsidered – you will not be considered for a

January 1st, 2013, start date. However, you may reapply for the next cycle, which in this case is the January 1st, 2014, program start date.

Slide 28 outlines how to withdraw an application. If you decide to withdraw your application at any time after you submit it, you must send an e-mail to us prior to the date in which we issue a final disposition. Your request must be in a PDF document on your organization's letterhead and signed by you – by an ACO executive or an authorized official. Please include the information listed on this slide in your request. These instructions are also available on our Web site.

We anticipate that you will have questions throughout this process so when those questions do arise, please contact us, as indicated, on slide 29 at [SSPACO\\_Applications@cms.hhs.gov](mailto:SSPACO_Applications@cms.hhs.gov). We would like to reiterate that it's critical to meet all deadlines in order for your application to be accepted. Any applications or supporting documents received after the scheduled times will not be considered for the current cycle.

We also encourage you to submit your application as early as possible to give yourself plenty of time to complete any requests for further information. I can't emphasize this enough: Please take the time to draft all answers to supporting documentation, review your responses carefully, then go in to HPMS to submit your application. The toolkit will help you get organized, but it's very important to submit your application so that there is time to clarify or correct any responses.

Slide 30 represents the lessons we have learned over the past two application cycles. And these have been – kind of, repeatedly caused challenges for ACO applicants. First, it's imperative that you have your participant agreement, processes, and structures in place prior to applying for participation in the Shared Savings Program. Applications that are not well-organized are more likely to get denied. The application period is not the time to get organized.

Second, it's in your best interest to pay particular attention to the regulations having to do with legal structure, governing body, and agreements between ACOs and their participants. If you do not meet the requirements set forth in

the regulations, you will encounter significant delays in the application process and increase the probability of denial.

Third, please be aware that beneficiaries on the board – the beneficiary on the board requirement does not mean that this person can also be a participant. This dual relationship constitutes a conflict of interest, and you will be required to name a non-ACO participant as the official beneficiary representative on your governance board as part of a request for additional information.

Fourth, your application must specifically address the remedial measures that will be taken against any of your participants or providers who are not compliant with the requirements of the ACO regulation.

Fifth, you must fully comply with the requirements that your ACO participants have at least 75 percent control of the ACO's governing body.

We would also like to point out question 1 in the application, entitled “Jointly Negotiated Contracts with Private Payors.” In the initial application that appeared on our Web site earlier this month, we indicated that if you answer “No” to this question, we would share your information with the Federal Trade Commission and the Antitrust Division of the Department of Justice. We have corrected this question to state that if you answer “Yes,” we will forward your information to the FTC and Department of Justice.

Finally, we encourage you to use the toolkit provided as a reference throughout your application process. In addition, if a problem arises in your ACO during the application review that could negatively affect your application or eligibility, please contact us at the [SSPACO\\_Applications@cms.hhs.gov](mailto:SSPACO_Applications@cms.hhs.gov) e-mail address. The sooner we know about the issue, the better we can work with you to resolve it.

Slide 31 shows the link to our Web site again and gives the application e-mail address and phone number in case you have questions.

We have two additional application training sessions scheduled. On August 7<sup>th</sup>, we will present specific information on using HPMS to submit an application. And the week of August 20<sup>th</sup>, we will have a question and answer session over the entire application. If you have questions when you begin submitting your application, we welcome your e-mail, but we also want to offer this time, the week of the 20<sup>th</sup>, to open up the phone lines for a Q&A session. We will have more information on the specific date of that question and answer session soon.

So this concludes the Medicare Shared Savings Program portion of the call. And when there's time remaining at the end of the next presentation, we will accept questions. But for now, I'll turn it back over to Leah.

## **Polling**

Leah Nguyen: Thank you, Tricia. At this time, we will pause for a few moments 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 result. Holley, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to this call together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

And this does conclude the polling session for today's call. I'll turn the call back over to Ms. Nguyen.

## **Presentation 2**

Leah Nguyen: Thank you, Holley. Our next presenter is Kerri Cornejo, Advance Payment Lead from the CMS Innovation Center, who will cover the Advance Payment Model.

Kerri Cornejo: Thank you, Leah. I'm going to start on slide 33 by providing you with some background on the Advance Payment Model. It is an initiative sponsored by the Center for Medicare & Medicaid Innovation. It is designed to provide physician-based ACOs and those with rural hospitals participating in the Shared Savings Program with advance payments. The request for public comment was released in May 2011, and the Federal Register Notice was posted in October 2011.

On slide 34, there are some program details. Participating ACOs will receive three types of payments. One is an upfront payment – upfront fixed payment of \$250,000. The other is an upfront variable payment equal to \$36 per preliminarily, prospectively assigned beneficiaries. And then a monthly payment of varying amount depending on the size of the ACO equal to \$8 per preliminarily, prospectively assigned beneficiaries through June 2014.

Now on slide 35 on eligibility requirements. The program is open only to participants in the Shared Savings Program who entered in April 2012, July 2012, or who are applying for January 2013. There are two types of organizations that are eligible. These are ACOs that do not include any inpatient facilities and have less than \$50 million in total annual revenue, and ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than \$80 million in total annual revenue.

Total revenue means all revenue expressed net of contractual allowances and bad debts but not charges of each ACO participant and of any organization that has an ownership stake of 5 percent or more in the ACO or any of its

participants. Total revenue includes all revenue sources, not just Medicare revenue.

Now on slide 36, the application process. Organizations must complete applications for both the Shared Savings Program and the Advance Payment Model. The Advance Payment Model will not require a separate Notice of Intent or a CMS User ID. For the January 2013 start date, we are accepting applications from Wednesday, August 1st through September 19th, 2012.

Now on slide 37, you will see the Web site where you can go to access application information. Applications must be completed and submitted through an online application Web tool. The application template and required application worksheet are posted on the Advance Payment Model Web site at the address listed below. And to gain access to the online application, organizations should send an e-mail request to Advance – [advpayaco@cms.hhs.gov](mailto:advpayaco@cms.hhs.gov).

If you are looking for additional resources, you can visit the Web site for the Advance Payment Model or you can send questions to [advpayaco@cms.hhs.gov](mailto:advpayaco@cms.hhs.gov).

And that concludes the Advance Payment portion of the call.

## **Question and Answer Session**

Leah Nguyen: Thank you, Kerri. Our subject-matter experts will now take your questions about the Shared Savings Program and Advance Payment Model Application Processes. If you have other questions about the Shared Savings Program, please send them to [aco@cms.hhs.gov](mailto:aco@cms.hhs.gov). Questions about the application can be sent to [SSPACO\\_Applications@cms.hhs.gov](mailto:SSPACO_Applications@cms.hhs.gov). This e-mail address is also listed on slide 31 of today's presentation. Questions about the Advance Payment Model can be submitted to [advpayaco@cms.hhs.gov](mailto:advpayaco@cms.hhs.gov), which is listed on slide 38.

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.

Alright, Holley, 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. Please state your name and organization prior to asking a question, and pick up your handset before asking your question to ensure clarity. Please note your line will remain open during the time you are asking 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 Jeff Gross.

Jeff Gross: Hi, great presentation today. Thanks so much. A question about the governing body: We have an existing ACO that's working with commercial insurance companies right now. So as we've looked at the governing body requirements, it appears to us that we meet the requirements that MSSP has requested with the exception of the Medicare beneficiary.

So the question is: Can we add a Medicare beneficiary to the governing body? And if so, if that individual would be involved with all activity related to our Medicare ACO activity but they wouldn't be involved with the current book of business, which is on the commercial side – is that a problem or would that be acceptable?

Terri Postma: Hi, this is Terri Postma. The governing body requirements, as you know, are listed in the regulation. And the two that I want to highlight or emphasize here are the requirements that the governing body be at least under 75 percent control of the ACO participants, which are the Medicare-enrolled TINs that you submit on your ACO participant list. So that's one thing – that if you're using the same legal entity with that same governing body for commercial contracts, you want to be sure that it meets that requirement.

The second one, as you mentioned, is the beneficiary on the governing body. You can either add a beneficiary to your current governing body, but we've also included some flexibility for organizations to say that, no, they don't have the beneficiary in the governing body, but to tell us in narrative form and submit a narrative on how the ACO is going to include beneficiaries in governance. So take a look at that – those regulations and that exception. And that will be in the application. You'll see that.

Jeff Gross: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Marie Minton.

Marie Minton: Hi, this is Marie Minton from MV Healthcare Partners. I wanted to know for the review and approval process for the application, is CMS assigning the Medicare beneficiary during this review and approval process, and therefore, you need to meet the minimum 5,000 Medicare beneficiaries to fund your organization?

Tricia Rodgers: Yes, thank you for the question. This is Tricia Rodgers. We will be looking at the preliminarily, prospectively assigned beneficiaries, based off of the ACO participant list, that you submit to ensure that you meet the at least 5,000 beneficiary requirement during the application process. And you will be notified if you do not meet that requirement.

Marie Minton: Thank you.

Tricia Rodgers: Thanks.

Operator: Your next question comes from the line of Nicole DeVita.

Nicole DeVita: Hi, this is Nicole DeVita from Lahey Health Systems ACO. Our question is number 8, the legal entity organization structure. In the old – in the 2012 application, it actually asks the job descriptions to be submitted for your ACO key personnel. On the actual application, it just says an organizational chart showing the flow of responsibility. But then in the guide, it says that we

should include in the chart the names, titles, and responsibilities of your ACO key personnel. So can you help us understand – do you really want job descriptions or just some bullets of what their responsibilities will be on the organizational chart?

Tricia Rodgers: Thank you for that question. This is Tricia Rodgers. You're correct. We don't want job descriptions on the organization chart. We just would like bullets to be submitted with that information, please.

Nicole DeVita: OK, great. Thank you.

Tricia Rodgers: You're welcome. Thank you.

Operator: Your next question comes from the line of Toney Harville.

Toney Harville: Yes, I want to know when the contract is awarded, can you add a new supplier, or does the agreement have to be done before you apply?

Tricia Rodgers: Thanks for that question. This is Tricia. So in order to qualify, you have to at least have enough providers – participants and providers and suppliers – to meet the minimum 5,000 beneficiary rule requirement. However, after an organization is accepted, we will have a process in place to add participant TINs, providers and suppliers, to the ACO. And instructions will be forthcoming after we announce the accepted applicants.

Toney Harville: OK, thank you.

Operator: Your next question comes from the line of Stephanie Willis.

Stephanie Willis: Good afternoon and thank you for holding this call. I'm from Mintz Levin, and I'm helping multiple entities apply for MSSP. I have various questions about Section 9, question 26 which you've referenced on slide 23 or 24, I believe. So this application cycle, you're now requiring that the ACO submit the participation agreement template to identify the location of specific agreement provisions demonstrating the satisfaction of four criteria. How much – I understand that you are referring us to the toolkit, but the toolkit merely references the template. So how much detail is actually necessary?

Terri Postma: Hi, this is Terri Postma. Thanks for the question. This was one area that we found that there was, you know, folks – maybe, we had it in the regulation, it just wasn't compiled into one source. We've basically put out a guidance that kind of compiled these requirements into a more usable format for applicants. And this is one place that we have found that applicants have had some sticking points with the agreement that the ACO makes with the ACO participants, which again are the Medicare-enrolled TINs.

So we – our expectation is that there is a direct agreement, and that those agreements have these elements that are listed in the application. And so to assist applicants, we just put them right into the application, so that you can see exactly what we expect to see in those agreements, and a template for you to submit and show us where in the agreements those elements are.

So take a look at that. And let us know if the toolkit maybe isn't clear or if we can clarify some things in that.

Stephanie Willis: Thank you. I have – I mean, if I may, I have a followup question to that. So, one example, with regard to the second requirement, we're just not sure whether CMS wants applicants to provide – well, what type of – what type of documentation CMS wants us to use to evidence the “rights and obligations in representation by the ACO?” Is it just enough to, you know – do you want us to reference multiple sections within the agreement? And, you know, do you have specific ideas as to what you expect to see that will address the rights, obligations, and representation?

Terri Postma: OK, thanks. So in the – one of the things, just so folks on the phone know what we're referencing, one of the elements that we require being in the agreement between the ACO and the ACO participant is that the agreement have in it the ACO participants' and the ACO providers' and suppliers' rights and obligations in and representation by the ACO. So typically agreements have sections where they talk about the rights and responsibilities of the ACO, the rights and responsibilities of the participants, the providers and suppliers. So referencing that section when it's in your agreement would be sufficient.

Stephanie Willis: Great, thank you very much.

Terri Postma: Sure, thank you.

Operator: Your next question comes from the line of Read Pearson.

Read Pearson: Yes, thank you very much. Will CMS be – I’m sorry – I’m with Crossroads Hospices – will CMS be compiling a list of the approved ACOs as they are approved with the listing of the participating TIN or CCN providers with that?

Tricia Rodgers: Thanks for the question. This is Tricia. We will provide after announcing, after everyone has been made aware, and after the announcement at CMS of who has been accepted as an ACO, we provide a list of those. We’ve had one for the April 2012 start date, we have a list on our Web site for the July 2012 start date, and we expect to put one up for the January 1st, 2013, start date. And then we will also – each accepted and practicing ACO will also be providing, at some point in time – we have not had a date set certain – a list of the TINs and CCNs under each of the participating ACOs as set forth in our requirements.

Read Pearson: Thank you very much.

Tricia Rodgers: Thank you.

Operator: Your next question comes from the line Amy Fehn.

Amy Fehn: So I just have a question about the – on slide 25, you said you wanted the date that the TIN legal entity was established. Were you just saying that because you meant the ACO TIN, you want the date that, you know, that the operating – or the articles of organizations or whatever were approved? Or do you actually want the date that the TIN was received?

Tricia Rodgers: I believe the former, the date the articles of incorporation were set forth of that TIN.

Amy Fehn: OK. That’s all you – OK.

Tricia Rodgers: Yes. And that this was – mostly you’ve already completed that during your Notice of Intent to Apply process, but if we need you to change anything, you

would need to submit that information on letterhead in writing to us in – because it is prepopulated in the application, we can then go in and make that change for you. That was just one example that I gave.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Joleen Huneke.

Joleen Huneke: Hi, thank you for taking my call. I'm from Nebraska. A question on the participation agreements, number 26 again: when you talk about the TIN of an ACO participant and that they have to reassign their billings to the TIN of an ACO, does that mean, like, all of the Fee-for-Service billings that the different clinics do or the different participants do comes to the ACO now? Or is it just the, you know, the other Shared Savings?

Terri Postma: Hi, this is Terri. Just let me clarify. So the section I think you're referring to, the question that says, "All ACOs," – let's see – "submitted an example of the agreements you're currently using between the ACO and the ACO participants," which are the TINs.

Joleen Huneke: Right.

Terri Postma: "ACO providers and suppliers and other individuals or entities, et cetera, all ACO providers and suppliers" – that is, NPIs – that have "reassigned their billings to the TIN of an ACO participant must also agree to participate, et cetera." So basically, what we're saying here is that they are provided – the ACO participant, the definition of that is a Medicare-enrolled TIN that bills Medicare directly for services. So typically, that's a group practice – it could be a solo practice – you know, those are examples of what an ACO participant TIN might be.

Underneath that then there are providers and suppliers that have reassigned their billings to the TIN of that ACO participant. So we're not saying that the entities need to reassign their billings now to the ACO which may be different than the TINs of the ACO participant when they are multiple ACO participant TINs.

- Joleen Huneke: So if they have a Fee-for-Service – I just need clarification: if they are billing Medicare Fee-for-Service, that money still goes back to, let's say, that TIN at that clinic. Is that – that is correct, right?
- Terri Postma: Correct. There shouldn't be any changes. This shouldn't necessitate any changes in the current billing practices.
- Joleen Huneke: All right, thank you.
- Leah Nguyen: Thank you.
- Operator: Your next question comes from the line of Aaron Delarito.
- Aaron Delarito: Hi. For TINs that have applied to Comprehensive Primary Care Initiative, can we include them on our application and later remove them if they're accepted in CPPI?
- Tricia Rodgers: Thanks. This is Tricia. No, you would not include those. We can't have any competing programs. It would be – it would be considered an overlap, and you would need to remove them for consideration of your application.
- Aaron Delarito: OK, thank you.
- Tricia Rodgers: Thank you.
- Operator: Your next question comes from the line of Daniel Willis.
- Daniel Willis: Yes, good afternoon. Three – I guess, a question kind of in three parts. Does – as I understand it, there is the application available now on the CMS Web site, but there will be a partially prepopulated application available on HPMS. So is that true? And two, is it on HPMS now? And then three, how do we access it from HPMS?
- Tricia Rodgers: Thanks for your question. This is Tricia. So the application for you to view is available online on the Shared Savings Program Web site. And beginning tomorrow, you will be able to access the application – the proper application that you actually submit information through on HPMS. And that is what will

be prepopulated with the questions you submitted for the Notice of Intent to Apply. But it will be open beginning tomorrow, August 1<sup>st</sup>, through September 6th.

Daniel Willis: And is it just available only on the home page, or do you have to navigate through HPMS to access it?

Tricia Rodgers: You need to navigate through HPMS to access it. It should – the link that was in your CMS User ID e-mail or notification is what has the HPMS Web site in it.

Daniel Willis: Wonderful. So at some point tomorrow it will be available?

Tricia Rodgers: Yes.

Daniel Willis: OK, thank you.

Tricia Rodgers: You're welcome.

Operator: Your next question comes from the line of Nancy Sachetti.

Nancy Sachetti: Hi. Yes, this is Nancy Sachetti. I'm with the Highland Healthcare Associates IPA. And I just had a quick clarifying question that came up on – for me on slide 22. I represent a multispecialty primary care physicians in many specialty areas IPA. At one point, you had indicated that TINs could not participate in multiple ACOs. But then you indicated shortly after that PCPs must be exclusive. So I guess I have a two-part question. One is can our specialists be included in the application? And if so, do they have to be exclusive?

Terri Postma: Hi, this is Terri Postma. Thanks for bringing that question up. Exclusivity is a concept that means different things to different people. And the way that we've used it in our program – as you know, we're going to be assigning Fee-for-Service beneficiaries based on where they chose to receive a plurality of care in the last 12 months and based on the billings of the ACO participant TINs.

So what we've said in our rule is that those ACO participant TINs that you put on your list for the ACO have to be exclusive to a single Medicare Shared Savings Program ACO if that TIN bills for primary care services as we defined it in the rule. So we did not make a distinction between – exclusivity does not apply to individual practitioners. It applies to the Medicare-enrolled billing TIN that is the ACO participant. So you'd have to talk with the billing people at that ACO participant TIN to see whether or not its bills for primary care services as we defined those in the rule. So that's one thing.

The second thing is that there are also cannot be any overlap between the TINs that are listed on the participant lists regardless of whether or not they bill for primary care services with any of the list that CMS maintains for any other Medicare program that involves Shared Savings. So that's a statutory requirement. We expanded it in a rule – we defined it in the rule to be a Medicare rule TIN again. And so we'll be checking to make sure that there's no overlap there.

So it's kind of two separate concepts, and I just want to make sure that everybody understands that.

Nancy Sachetti: Thank you.

Terri Postma: Thank you.

Operator: Your next question comes from the line of Jane Kuesel.

Jane Kuesel: Hi. I'm Jane Kuesel from Epstein and Becker. I just have a followup question on the participation agreement template. In box number two, I think, the question was already asked, but there isn't an obligation to add to the participation agreement anything that explicitly addresses how the participants or providers will be handled under the operating agreement. The question goes more to how the participation agreement is structured, correct?

Terri Postma: This is Terri again. So, the – let's be cleared about this. The ACO is going to be entering into an agreement with CMS. The ACO must also have agreements with the ACO participant TINs where the ACO participants agree

– are joining together and agree to participate and to comply with the program regulations that the ACO is – you know, the ACO is going to be signing this agreement on their behalf with CMS. And the agreement, as you’ll probably note, has been up on the Web site and available for your review to see what’s in that agreement. It’s fairly simple. Generally speaking, it states that the ACO is going to be participating and agrees to comply with the Medicare Shared Savings Program regulations.

Our regulations have in them several requirements for what the ACO participants and ACO providers and suppliers have to comply with and agree with. So as part of that participation agreement, we anticipate seeing something that obligates the ACO participants, the providers and suppliers, to agree to participate in the program and to comply with the regulations. It also should enumerate their rights and obligations again, and the fact that the ACO is going to be representing them to CMS. This third goal is how the opportunity to share in savings or other financial arrangements encourage them to adhere to the quality assurance and improvement program and evidence-based clinical guidelines which, again, are a part of our program rules and are further asked about in the application. And finally the remedial measures, the processes that will apply to the ACO participants and ACO providers/suppliers in the event of their noncompliance.

So the bullets here are things that we explicitly require as part of our regulations to have in those agreements. And then that’s what the template is set up to do is for you to point out where in those agreements we can find those things. Does that answer your question?

Jane Kuesel: Yes, I think so.

Terri Postma: OK.

Jane Kuesel: Thanks.

Operator: Your next question comes from the line of Raquel Sevilla.

Raquel Sevilla: Hello.

Female: Hello.

Raquel Sevilla: Hi, this is Raquel Sevilla from Basic Home Infusion. I have a question.

Tricia Rodgers: Yes, go ahead.

Raquel Sevilla: My question is – I just wanted to know – when we're using a TIN number for an application for the agreement to be executed, does the – does one of the physicians have to file the application, or can the CEO of the facility sign the application?

Tricia Rodgers: Hi, this is Tricia. An executive that is authorized to bind the ACO can sign the application. It doesn't necessarily have to be the physician.

Raquel Sevilla: OK, thank you.

Tricia Rodgers: You're welcome.

Operator: Your next question comes from the line of Bruce McDonald. Bruce, your line is open.

Bruce McDonald: Hi, sorry, had you on mute. Just to follow up on the recent question on exclusivity. If I have a specialist – a urologist or a neurologist – who sees a lot of beneficiaries in their office and so he is generating E&M codes – if I have that neurologist or urologist on my participant TIN list, could he then have Medicare beneficiaries assigned to him and therefore he's exclusive to my ACO?

Terri Postma: Yes, this is Terri again. Thanks for that question. So exclusivity, like we said, doesn't apply to individual practitioners. So let's take the example of a multispecialty group practice where, let's say, there are 10 practitioners, each with different specialties, that bill through the TIN of that multispecialty group practice. And so, you know, some of them are cardiologists, some of them are neurologists, some of them are internal medicine, and some are family practice – they're all billing for those primary care service codes, as we've defined them, which are largely E&M based, are CPT office-based

codes, some G codes – you know, that sort of thing. But the ones that you would expect that would be billed through an office setting.

So the TIN of that multispecialty group practice decides it wants to join with some other TINs to form an ACO. That TIN would be included on the ACO participant list, that TIN bills for primary care services regardless of whether those primary care services were assigned to it from the cardiologist or the family practice doc. And so we're going to be using that TIN and its billings to assign patients to the ACO as a whole. We can sort of collectively take all the TINs together so beneficiaries aren't assigned to a single doc or even to a single TIN of an ACO participant. It's sort of a – it's a collection of all those. But what we said is that, if that TIN does bill for primary care services as we defined them in the rule, that TIN has to be exclusive to a single Medicare Share Savings Program ACO.

Bruce McDonald: Thank you very much.

Terri Postma: Thank you.

Operator: Your next question comes from the line of Helen Kotilainer.

Nellie Colone: Yes, hello. This is Nellie Colone. I work with Helen. Are you there?

Tricia Rodgers: Yes, go ahead, please.

Nellie Colone: Oh, OK, great. So would you clarify your definition of an ACO provider/supplier for the purpose of agreements? So an ACO provider will sign a participating agreement to be a part of the ACO. Is an ACO supplier a separate thing, and would they have to sign a separate agreement?

Terri Postma: Hi, this is Terri. So I sort of think of it as a kind of a flowchart where you have the ACO that's a legal entity. That's the one that signs the agreement with CMS to participate for three years. And then the ACO participants are those Medicare-enrolled billing TINs that have joined together to form the ACO. So they kind of are under the ACO. You have all these different practice TINs, for example, or the CCN of a hospital, you know, things to that nature. So those are the ACO participants. And those are defined as – and this,

by the way, is in the rule, and we have some good Q&As and factsheets on this on our Web site.

But an ACO participant is defined as a Medicare-enrolled entity that bills Medicare directly for services. So that could be a group practice, it could be a solo practice, it could be a hospital, you know, that sort of thing. Those are examples. Underneath those ACO participants are the – are what's defined as the ACO providers and suppliers. And the rule defines an ACO provider/supplier as an entity that has reassigned its billings to the TIN of an ACO participant. So for example, the one I gave earlier of a group practice – the group practice would be the ACO participant. It's Medicare-enrolled, it bills Medicare directly for services. And the ACO providers/suppliers would be those TIN docs that have reassigned their billings to that TIN of the ACO participant, the group practice.

Does that help?

Nellie Colone: Oh, OK, thank you. I just wasn't sure of the supplier. So providers/suppliers can be one and the same – is what you're saying? It's not a vendor?

Terri Postma: No, it's just a term that is use to define any provider or supplier that has reassigned its billing through the TIN of an ACO participant.

Nellie Colone: Wonderful, thank you.

Terri Postma: Thank you.

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

Jeff Gross: Oh, hi. Thanks for bringing me back. I have a question for Terri on Advance Payment. If a – I know the Advance Payment is just for a physician-only groups of a certain size. Does that prohibit them from partnering with their local hospital to achieve quality and cost goals?

Maria Alexander: Hi, this is Maria Alexander. I'm with Innovation Center.

Jeff Gross: Hi, Maria.

Maria Alexander: There would be no specific rule against you partnering with any kind of organization in your community, but if that hospital is actually a part of your ACO – and the way we defined it is the same way the Shared Savings Program does – so if that hospital or any inpatient facility other than the approved ones is included on the participant list, the TIN list that you submit to Shared Savings Program, they are considered part of your ACO for the purposes of the Advance Payment Model as well.

Jeff Gross: Great. Thank you. That helps.

Maria Alexander: Thank you.

Operator: Your next question comes from the line of Natalie Kehm.

Natalie Kehm: Hi, I'm Natalie Kehm with Solis Women's Health. And my question is – we're mammography provider, and we provide other breast imaging services – and we provide those services to an ACO. How do we fit into this? It sounds like we're not a supplier because we have not reassigned our billings to the ACO Tax ID number.

Terri Postma: So does your – does the TIN of your organization, is that – does that bill Medicare for services for the imaging?

Natalie Kehm: Yes, it does.

Terri Postma: OK. So you could be defined then as an ACO participant because your Medicare-enrolled and you bill Medicare directly for those imaging services.

Natalie Kehm: OK, so we would be a participant.

Terri Postma: Yes, you can join with other – obviously, you're not – well, I don't know, but from your description it doesn't sound like you render primary care services as we define them in the rules. So what you would have to do would be to join with other ACO participants that do bill for primary care services so you will meet the eligibility – so your ACO could meet the eligibility requirement of having at least 5,000 beneficiaries assigned.

Natalie Kehm: OK, thank you.

Terri Postma: You're welcome.

Operator: Your next question comes from the line of Nicole DeVita.

Nicole DeVita: Hi. Our question is in Section 4, number 8, which has been somewhat revised from the 2012 application. We're wondering about the committees that report through the board of directors. It doesn't seem to ask in question 8 about names, and yet in your Frequently Asked Questions, it specifically addresses the names of the committees and says you must submit names for all committee members. But the templates no longer offer a place to do that, and the questions in the application don't seem to offer a place to do that. Can you talk to that?

Female: Can you hold on for a moment?

Nicole DeVita: Yes.

Female: Hold on for one moment, we're looking up your answer for you.

Nicole DeVita: OK.

Tricia Rodgers: So thanks so much for that question. It looks like we need to take a look at the difference between the 2012 and 2013 application. And we will submit – we will get an answer back to all participants on this call so that all of you can hear the response as well. Thanks very much.

Nicole DeVita: OK. So just to be clear, it's a mix between the Frequently Asked Questions, the new application Section 4, number 8, and the old application section C14.

Tricia Rodgers: Thank you.

Nicole DeVita: Thanks.

Operator: Your next question comes from the line of Stephanie Willis.

Stephanie Willis: Hello again. Thank you for taking my call. So I have another question about number 26 in Section 9. So it seems that from the responses you've given to other questions during this call, that the level of detail that you're seeking in the agreements with respect to some of those four criteria is just a reference.

So, for instance, would it be sufficient for the participant agreement to state that, you know, to meet the requirements that CMS wants – to meet the requirement about how the opportunity to get Shared Savings or other financial arrangements will encourage ACO participants and ACO providers/suppliers to adhere to the quality assurance and improvement program and evidence-based guidelines? Do you think it would be sufficient for the agreement to just say that participant acknowledges and agrees that its providers/suppliers will have an opportunity to receive Shared Savings or other financial arrangements as a result of adherence to the quality assurance, et cetera?

Terri Postma: Hi, this is Terri. As long as your agreement is meeting the requirements as set forth in the rule – and I'll refer you to the guidance that we issued regarding this – and, by the way, you might look through the regulations because there are other – you know, every organization is going to be a little bit different – and you might look through the regulations and see what other specific issues the ACO participants will be held accountable for. So, you know, I think that there's a lot of different ways that these things can be accomplished in those contracts. We don't want to be too prescriptive, but we do want to make sure that all these elements are clearly addressed.

Stephanie Willis: So – that's helpful. So if, for instance, the participant agreement refers to another document such as a compliance plan or a, you know, a policy and procedure that would address one of the four criteria, would you need to see that document that is referenced in the agreement? Because the application says that – to provide sample agreements, so I wasn't sure if you needed other types of documentation as well.

Terri Postma: Yes, we do ask for a sample agreement. And, you know, it would be helpful to see the entire agreement, or if there are appendices that are referenced by the agreement. That's always helpful to send in.

Stephanie Willis: OK. And how about operating policies and procedures or other nonparticipant agreement-related documents?

Terri Postma: Generally, no. Those tend to be fairly lengthy. And you know that's not something – we're really looking at the agreements and not assessing those other documents.

Stephanie Willis: All right. Thank you so much.

Terri Postma: Thank you.

Operator: Your next question comes from the line of Aaron Delarito.

Brandon: Hi, this is Brandon from QualCare. I believe this was touched on early but I just looking to clarify a little. Could you explain what “rights and obligations” mean on the participating agreement template a little further?

Terri Postma: Hi, this is Terri. So the rights and obligations of the – again, this is going to vary from agreement to agreement and situation to situation. There is you know, ACOs – groups of providers are joining together in all sorts of different ways. And there's sort of not a formula for these agreements to sort of what they'll all agree to between the ACO and the ACO participants. So generally speaking, agreements have, you know – agreements just in general, generally outline what the rights and obligations of each party are. And then in particular, the ACO participants have to be aware that the ACO is going to be representing them with their agreement with CMS. And so, you know, there's nothing – there may be all sorts of different rights and obligations that the ACO and the ACO participants are agreeing to. And that's going to be – that may be a variable, but the point is that these things are outlined in those agreements.

Brandon: OK, thank you.

Terri Postma: Thank you.

Operator: Your next question comes from the line of David Levenstein.

David Levenstein: Hi, I'm with Bay State Health. In the toolkit – can you hear me?

Tricia Rodgers: Yes, go ahead.

David Levenstein: In the toolkit section 11, number 34, which I believe is a new narrative that was introduced, and section 11, number 37. Both of those sections have the same file-naming convention. And I was wondering whether that was intentional or perhaps a mistake. And if they're intentional, was it – can you explain whether that section – the number 34 should be a part of the narrative on internal reporting on quality and cost metrics?

Tricia Rodgers: Thank you for telling us about that. We will take a look and get that information back to you as well as the previous caller's question. The naming convention should not be the same for different uploads, so – documentation – so we will – we'll take a look and let you know.

(David Levenstein): Thank you very much.

Tricia Rodgers: Thank you.

Operator: Your next question comes from the line of Debra Baverman.

Debra Baverman: Hi, Debra Baverman from Collaborative Health Solutions. I have a question in regards to Section 9, question 24, merger-acquired TINs. Could you describe a little bit the type of supporting documentation you would be expecting that demonstrates that the TIN was acquired through a sale or merger?

Terri Postma: Hi, this is Terri. So, we developed a process for accepting merger-acquired TINs as part of the application from a request from some stakeholders. Basically, it – so, I want to give you a little bit of background so you understand why it's important and why we're doing it. We've previously requested the ACO participant TINs, and when we get those in, we calculate things like the, you know, we use that list to calculate the benchmark, to make sure that they are an adequate number of beneficiaries assigned – you know, that sort of thing. And because of that, if those TINs did not have billings for 2009, '10, or '11, or if those TINs had acquired other practices through a merger or sale, that were no longer you know Medicare-enrolled TINs, the

billing practices – those TINs that were merger acquired wouldn't – you know, they're not ACO participants because they don't – you know, they're not existing anymore, so they wouldn't appear on the participant list. And so because of that, we wouldn't completely capture any assignment that would be part of them, or their billings as part of the assignment or benchmarking calculations.

So because of that, stakeholders said to us, “Well, you should develop a process,” so that, you know, if we had – let's say, we're applying as, you know – we have 5 participant TINs that are applying, they're going to be our ACO participants on our list, but we've acquired or merged with five others in the past year, but we'd really like to have a benchmark that's truly reflective of our organization, so: “Can you come up with a process for doing this?” So this is our response to that request. We suggest, in fact, we can take those into account under limited circumstances and with certain information provided. So the question as outlined there talks about, you know, the criteria. It has to be all ACO providers and suppliers – that is, those entities that bill through the acquired TINs. They have to have reassigned their billings to the TIN of an ACO participant, that's going to be moving forward in the program. And the acquired TIN must no longer be used for billing – that is, it's completely – that TIN is done, it's not being used anymore.

And then if those things are true, then there's instructions on how to submit documentation around that. There's an attestation that's required telling us which ACO participant merged with or acquired which TIN, so we have those both and understand who those entities are. And that the ACO providers and suppliers that previously billed under the acquired TIN have now reassigned their billings to the TIN of an ACO participant that's identified on the list. And also a certification that the acquired TIN is no longer in use and then supporting documentation demonstrating that the TIN was acquired through sale or merger. So for example, the portion of the merger document that shows that that TIN was acquired.

So – and then instructions how to include those TINs on the participant list. Now, those wouldn't be ACO participants going forward but they would be

used in the calculation to determine if the ACO is meeting the minimum necessary assigned beneficiaries and then also to set the benchmark.

Debra Baverman: Thanks. That's very helpful. Just as a followup to that: This three-year benchmark – the three years for benchmark for the January applications would be '09, '10, and '11, or '10, '11, and '12.

Terri Postma: Yes, sorry, I'm still functioning on 2012 time. So for you all, for the starters for January 1st, 2013, the benchmark period would be the three previous years, which would be '10, '11, '12.

Debra Baverman: Thank you very much.

Terri Postma: Thank you.

Operator: Your next question comes from the line of Harry Purcell.

Harry Purcell: Oh, yes. Thank you very much. I work with a number of radiologists, and several of our groups in multiple states have recently received notification from hospitals where they work that they have 30 days to join their ACO. One: I guess my question is, would that hospital establishing that ACO not have to disclose those radiologists as participating as part of their application? And have you heard of this in particular as a specialty from other providers?

Terri Postma: Thanks for the question. This is Terri. That's one of the reasons why we're being very careful to make sure that you all understand that when you submit an application for the Shared Savings Program that those agreements already be in place. So if those radiologists bill through the TIN of a Medicare-enrolled entity – bill Medicare for services through the TIN of a – that would be the ACO participant – if that ACO participant has agreed to participate with the hospital and has signed a participation agreement, then, you know, that's fine, and the ACO participant would be included on one of the lists of the applicants. But if those agreements are not in place, they could not be included. So it's really up to the billing TIN, the ACO participant to, you know, to talk with those – I don't know what the billing situation is with the docs that you're referring to. But there has to be an agreement in place.

Harry Purcell: Just a followup, if – I’m deducing this from what you said. So if a hospital was in a process of applying for an ACO and accumulating the list of providers that would be part of that ACO, let’s assume they send this notice out to them asking for the radiologists as this particular specialty to participate, it wouldn’t be reasonable to ask for that disclosure or copy that application as a specialist? Further, I understand they’re also supposed to talk about, as part of their application, governance and distribution of Shared Savings. Would that outline that specifically – say, for the radiologist specialists, say, they can’t, you know, 1.2 percent or – is that how that disclosure would occur?

Terri Postma: The ACO participants, who are the Medicare-enrolled entities billing Medicare for those services, those ACO participants are the ones that joined together to form the ACO. So there should be an ACO-to-ACO participant agreement, and that’s what we asked for in the application, but there should also be an agreement between the ACO and the ACO providers/suppliers who are the, you know, the docs that would be billing through the ACO participant TIN, either directly or indirectly through the ACO participant. So there need to be agreements – you know, very clear agreements all the way down the line that everybody has agreed to participate and to comply with the program regulations.

As part of those participation agreements, it would – I would think that, you know, if I were an ACO participant or if I were a doc billing through an ACO participant, I would think that I would want to negotiate and make agreements about what the Shared Savings distribution was going to look like. And so that’s fair game as part of the agreement.

Harry Purcell: Thank you so much.

Tricia Rodgers: Thank you. Holley, it looks like we have time for one final question.

Operator: OK. Your final question comes from the line of Jamie Rolston.

Garren Durulan: Hi, this is actually Garren Durulan with Yavupai Accountable Care. And I was wondering: Do you have example templates, or formats, or sample submission narratives that you could potentially share with us?

Tricia Rodgers: Thanks for that question. This is Tricia. We are actually looking for the uniqueness of each ACO applicant to submit, you know, what it is that you believe will help coordinate care and will show us different ways. So we are prescriptive in that manner at all, but thank you very much for your question.

Leah Nguyen: Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can e-mail it to the addresses listed on slides 31 and 38. And I just wanted to mention again that we will be sending an e-mail to all call participants with the answers to the two questions that needed further research.

I would like to thank everyone for participating in the Medicare Shared Savings Program and Advance Payment Model Application Process National Provider Call. On slide 40 of the presentation, you'll find information and a URL to evaluate your experience in today's call. Evaluations are anonymous and strictly confidential.

I should also point out that all registrants of today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box within two 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 five 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 on the CMS Fee-for-Service National Provider Call's Web page.

Again, my name is Leah Nguyen, and it has been my pleasure serving as your moderator today. I would also like to thank our presenters Tricia Rodgers, Kerri Cornejo, and Terri Postma. Have a great day, everyone.

Operator: Thank you for participation on today's conference. You may now disconnect.

END