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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Medicare Shared Savings Program ACO: Application Review
MLN Connects National Provider Call
Moderator: Amanda Barnes
June 10, 2014
2:30 p.m. ET

Contents

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

I will now turn the call over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Holley. Hello everyone. I'm Amanda Barnes from the Provider Communications Group here at CMS and I'll be your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on the Medicare Shared Savings Program ACO application process. MLN Connects Calls are part of the Medicare Learning Network.

During today's call, CMS subject matter experts will provide information on the Medicare Shared Savings Program application submission process. A question-and answer-session will follow the presentation.

Before we get started, I have a few announcements. The location of today's slide presentation was included in the reminder email. Unfortunately, the slide presentation has been revised. The current version was attached to an email sent to all registrants at about 1:15 p.m. eastern time today. The revision will also be posted to the CMS website by close of business today. We apologize for any inconvenience.

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

At this time I'd like to turn the call over to Laura Dash, Director of the Division of Application, Compliance and Outreach in the CMS Performance Based Policy Group, Laura.

Presentation

Laura Dash: Thanks Amanda. Hi everyone. As Amanda mentioned, my name is Laura Dash and today I'm speaking to everyone about our application process. And we'll give you tips on how to complete and submit an application for the 2015 cycle of the Medicare Shared Savings Program.

So as you can see on slide 4, today's agenda, we'll go over the Shared Savings Program application process, including some differences between prior applications and this year's application. We will also talk about our Application Reference Manual, which is a handy tool you should all be using, and required templates and other helpful hints to ensure you submit a successful application.

Slide 5 gives you the key dates for the Shared Savings Program application cycle for January 2015 performance year starters. 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, 2015, program start date was May 30th, 2014. If you did not submit an NOI by that date, we cannot, unfortunately, accept an application from you for January 1st, 2015, performance year start date, but we do invite you to consider an NOI next year so that you can apply for program year 2016.

The CMS User ID application deadline has also passed. It was yesterday, Monday, June 9th, 2014. If you haven't done so already, please submit an application for a CMS User ID immediately. A CMS User ID is necessary to access our online application submission system. Delays in obtaining your CMS User ID may cause delays in your ability to submit your application.

We will accept your application of the program from Tuesday, July 1st, through Thursday, July 31st, 2014, at 8 o'clock p.m. eastern time. We will send approval or denial notices in the fall of 2014. Please do not wait to submit your application until July 31st, 2014, and this will be a reoccurring theme in today's call. It is in your best interest to start your application submission as early as possible. It is important to note, if you cannot complete your application submission by July 31st, you will have to wait until the next application cycle to apply, which as I stated, in this case would be your January 2016 program start date.

Slide 6. I would like to take this opportunity to emphasize the importance of a timely application submission. Please do not wait for the last minute to apply. We will not process any applications received after July 31st, 2014, for the program year 20 January 1st, 2015, starters. If your application is submitted after 8 o'clock p.m. on that date, we will not review it.

Any number of things could cause a delay in your submission, for example, not having your ACO participant agreements in place, not having a CMS user ID, difficulty accessing HPMS. Therefore, it's very important for you to meet the deadline and plan ahead. You must build in time to account for delays that are out of your control. So we make every attempt to encourage you to submit early.

We will continue to update our website with information and key dates for subsequent Shared Savings Program cycles. For more information, please see our website that is provided on this slide. Any application or application process questions you have can be submitted to sspaco_applications@cms.hhs.gov. But please remember, it's important that you always include your ACO ID number, your ACO's legal name, and the topic of your question in the subject line of the email.

Slide 7. The only method to submit your application is electronically through CMS's Health Plan Management System, or HPMS, which you can access at the link provided in slide 6. All information you provided in your NOI is pre-populated in your application. If there is an error in any of the pre-populated information, you must contact us to request the change. You can send your change request to sspaco_applications@cms.hhs.gov, but

please remember, in the subject line of the email, include your ACO ID number, ACO legal business name, and the phrase "change request," and in the body of the email provide us with the incorrect information and the corrected information. We will make the change in HPMS and reply to your request, providing you with confirmation that the change was made in HPMS.

Now moving on to slide 8, which is step one, submitting an NOI, which is of course the first step in the application process. If you are on this call, you should have successfully submitted an NOI and, thus, are eligible to submit an application for the January 1st, 2015, start date.

The CMS User ID

Moving along to slide 9, you all should've received an email acknowledging or, excuse me, an email acknowledgement containing your ACO ID number and instructions on how to request a CMS User ID. Submitting a notice of intent to apply does not require you to submit an application, but it does reserve your eligibility to submit an application.

On slide 10, the second step in the application process is to obtain a CMS User ID. As mentioned in the prior slide, you already received directions on how to apply for a CMS User ID in your NOI acknowledgement email. And again, that was sent to you already. And the deadline to do that was yesterday, June 9th. A CMS User ID, as I stated before, is very necessary to access HPMS. You can't get into HPMS without a user ID. And that is the system that you will use to complete and submit your ACO application to us.

You will also use your CMS User ID to access data if you're accepted into the Shared Savings Program. We will also give you guidance about obtaining CMS User IDs in the 2015 Application Reference Manual, which I'll talk a little bit about later on in the presentation.

Please note that CMS User ID numbers are issued to individual people and should never be shared with another person. If you already have a CMS User ID, you don't need to get another one. If you do not already have a CMS User ID, follow the specific instructions in your NOI acknowledgement letter that was sent to you already and the Application Reference Guide explaining how to fill out the CMS User ID application and submit to the address noted on this slide and the website direction.

At this time you should've already submitted your request for CMS User IDs. If you have not, we again urge you to immediately send the form CMS 20037. It takes about 3 to 4 weeks to process this form. Please do not call or email us for your status. This actually takes away time from processing the form and it's not necessary because we will notify you as soon as your CMS User ID has been approved.

If you have not received your user ID within 3 weeks from the date you submitted it to CMS, you can contact us at cmshpms_access@cms.hhs.gov. Also, if you are a consultant, you must include your consultant authorization letter from your ACO. Omission of this letter will delay your access request.

If you receive a phone call or email requesting additional information to complete your Form 20037, respond to that request immediately. Late responses to these inquiries will delay processing of your access request.

We are requesting that each ACO applicant submit four CMS User ID applications – two for your ACO's information technology or IT contact and two for people who enter the application into the system.

Occasionally, personnel terminations occur. If one of your contacts or anyone authorized to access your ACO's data is terminated or disassociated from the ACO, it is the responsibility of the ACO to notify CMS immediately so that the CMS User ID can be discontinued. To notify us, submit an email to the sspaco_applications mailbox, including, again, the ACO legal name, ACO ID number, and the user's full name and his or her CMS User ID when you terminate the relationship.

The Shared Savings Application

Moving on to slide 11, the third step in the application process is to complete the online application, and that's hopefully where most of us are going to benefit from today's conversation. While you're waiting for your CMS User ID, we strongly encourage you to visit our website and download the updated Shared Savings Application package, so the 2015 application package is now available. And you can begin working on it offline right away.

So, our application package includes the actual application; the application toolkit, which also includes the reference manual; the link to our CMS Form 588 electronic funds transfer form; and all the templates and instructions to complete the templates that you'll need to submit with your application. So those templates are the governing body templates, the ACO participant list template, the ACO participant agreement template, and so on.

Slide 12. We have developed the 2015 Application Reference Manual that gives you step-by-step guidance on how to complete and submit your application. You should have this document with you as a constant reference while preparing your application submission. This manual gives you directions to all of the various steps required to complete an application, as well as links to program rules, regulations, and guidance that is necessary in order to submit an accurate and complete application.

The 2015 Application Reference Manual also includes two important appendices. Appendix A gives the definitions of the ACO contacts that are required for the application. ACOs are required to submit, review, update, and maintain active ACO contacts for 17 ACO representatives listed in HPMS on an ongoing basis. Some contacts are required upon your application submission and the remaining will be required if your application is approved. Optional contacts are obviously not required but are recommended. And we encourage you to take advantage of the optional contact. We've

added them over time out of experience with ACOs needing secondary contact. So we strongly recommend you to take advantage of them.

Appendix B is the application reference table. This is a guide that walks you through each application question and will give you important application instructions and the naming conventions that you must use when uploading documents for submission. In addition, the application manual explains the request for information process when your application is in the review process.

So after you submitted it to us on July 31st and we're in the process of reviewing it, you may be required to provide us with additional information. The manual goes over in detail what you will need to do to revise your information and submit it to us. So again, I just stress the importance of looking at and being very familiar with the 2015 Application Reference Manual. It is a new tool that we put together to help assist applicants that is being posted with this new application cycle. We think it will be very helpful and is a compilation of former documents and some new ones to help aid your application process.

Slide 13 lists the 12 sections of our 2015 application. In Section 1, we ask you to provide us with your list of ACO contacts. Once you obtain access to HPMS, you may log in and update your ACO contact information. Whenever there is a change, it is your responsibility to notify us to terminate user access to your ACO if any of your contacts terminate or change so that we can make the necessary adjustments in our systems. Changing the contact information at HPMS does not remove a user's access to your data, so that's very important to remember. So you must send us a request to terminate a user's access when that occurs.

In Section 2, you'll give us some general information about your ACO. When you log into HPMS to submit your application, you will see that we have pre-populated this information from your notice of intent to apply. If you wish to change any of the information in Section 2, you must follow the instructions provided in Section 2 of the 2015 Application Manual titled, "How to Request Changes to Pre-Populated Information."

In Section 3, you indicated – or you need to indicate if you are considered newly formed. ACOs who have signed or jointly negotiated any contracts with private payers on or after March 23rd, 2010, must agree to permit us to share a copy of your Shared Savings Program application with the antitrust agencies. You can read the Federal Trade Commission and Department of Justice statement of antitrust enforcement policy regarding Accountable Care Organizations participating in the Medicare Shared Savings Program. That link can be found on our program website as well as in Appendix B of the Application Reference Manual.

In Section 4, you must provide narratives about your ACO's history and mission, as well as an organizational chart and other attestations regarding your ACO's legal entity type.

In Section 5, you must attest to various characteristics of your ACO's governing body, provide narratives where applicable, and upload a complete and accurate governing body template.

In Section 6, you will provide us with information regarding your ACO's management structure, compliance plan, and management and oversight.

In Section 7, you'll attest to and provide the names of any and all Medicare initiatives that involve shared savings in which you are a part of.

In Section 8, you provide us with a narrative of how your ACO plans to use your savings payments. We also provide in the section details about the information you must submit in order to have shared savings deposited into your ACO's checking account.

In Section 9, you provide us with information about your ACO's participant list, including a full and complete list of all ACO participants by their Tax Identification Numbers, or TINs, as well as employment agreements or participant agreements, which is dependent upon your organizational structure. Additional guidance for this section can also be found on our website. Go to the ACO Participant Agreement Guidance and ACO Participant List Guidance for Applications for more information about how to appropriately complete the section of the application.

In Section 10, you certify certain conditions of data sharing. So in order to protect the integrity of our beneficiaries and our data, we must be assured that due diligence is being done in terms of data protection issues.

Section 11 is commonly referred to as the four pillars section. In this section you must provide narratives explaining how your ACO provides quality assurance and improvement programs that promote evidence-based medicine, beneficiary engagement, reports internally on quality and cost metrics, and promotes care coordination for beneficiaries.

And finally, in Section 12, you certify that all of the information and application issues are complete and you must select "I Agree" where indicated in order for your application to be submitted in HPMS.

For slide 14, for the 2015 program year application cycle, we now require applicants to upload all narratives. So we are no longer providing textboxes as an option for the narrative sections. You must upload your narrative using the naming conventions we provide you in the 2015 Application Reference Manual found in Appendix B. Each of your narratives must be saved in a zip file and uploaded separately into HPMS. This process will save time when we're reviewing the applications and it will also be easier to locate the specific narrative and make changes to only the document or documents that are specified in any request for information we might send you.

Slide 15 provides information regarding question 22 in the application, which asks for your ACO's banking information. In this section we ask you to submit CMS Form 588, also known as the EFT authorization agreement. You will find instructions on how to complete this form in the application toolkit found on our website. Please submit the CMS Form 588 and the cover sheet required to the address noted in the application and found on this slide 15. The signed CMS 588 form is necessary for you to have shared savings deposited directly to your ACO's account. It is also due at the same time as your application. Applications are not considered complete until we receive this completed form from you.

For further guidance, see the links on this slide to the form, the cover sheet, our FAQs, and our banking form guidance found on our website.

Slide 16, the governing body template. In Section 5 of the application we'll ask you to provide us with information about your governing body. Slide 16 provides you with specific details about the governing body template that you will fill out and submit. You must include each member of the governing body, indicating the member's voting power, and what the ACO participant that member represents on the governing body.

Let me say that again. You must include each member of the governing body. You'll need to indicate the member's voting power and you'll also need to tell us what ACO participant that member represents on the governing body. Both the template and instructions for completing the template are found in the application toolkit. By completing this template, you are providing us with the information necessary to ensure that your governing body meets the requirement for participation in the Shared Savings Program as set forth in our regulations.

Moving on to slide 17, the ACO participant list is very important, so you must submit it correctly. 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. And additionally, the ACO participant list is the basis for allowing us to determine whether your ACO achieves shared savings.

We also use the ACO participant list to assign beneficiaries to your ACO. Beneficiary assignment is performed in order to establish your historical benchmark, perform financial reconciliation, and determine a sample of beneficiaries for quality reporting. So please pay close attention to this slide. It's a very important step in the application process.

The ACO participant list also allows us to coordinate participation in the Physician Quality Reporting System, also known as PQRS, under the Shared Savings Program. Follow the ACO participant list template instructions to submit your ACO participant list accurately and completely.

On the ACO participant list template, you need to provide the Tax Identification Number, or TIN, that the ACO participant uses to bill Medicare. You will also have to provide the

TIN legal business name. We actually 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 verify that the TIN you gave us is the correct TIN. So please be certain that you're giving us correct information that matches what's in our Medicare enrollment system.

Also, you will need to provide the name of the individual who's 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. So please don't tell us that person A is authorized to sign the participant agreement but submit a participant agreement for that TIN where person B has signed. That will be problematic. So little details like this are very important to pay attention to before you submit your application.

An important note about sole practitioners that I just want to mention: If you have an ACO participant that is a sole practitioner, they may have both an enrollment TIN with Medicare, which is usually their Social Security number, and they might have a billing TIN with Medicare, which is usually an EIN. In such instances, ACOs should include both the SSN and the EIN on its ACO participant list or said a little differently, you should include both the billing TIN and the enrollment TIN on your ACO participant list for a sole practitioner with two Medicare identifiers. It is the ACO's responsibility to provide both of this information to us. You will not receive a separate report or notification for sole practitioners.

It's very important, because in the event the ACO submits only one identifier for a sole practitioner, the participant TIN may either not be found to have a valid Medicare enrollment in our enrollment system or it may not have any primary care service billings, which could affect beneficiary assignment. So it's very important that you make sure that you're including both of those for sole practitioners.

And under certain circumstances, you will be asked to provide information about ACO providers and suppliers that are associated with the ACO participant. So for example, if the ACO participant is an FQHC or an RHC, you will need to provide us the CMS certification number, or CCN, that the facility is using to bill Medicare and the National Provider Identifier, or NPI, of physicians who directly provide primary care to patients at that facility. By including the NPI on the ACO participant list, you're attesting that the physician directly provides primary care services.

You should not include other types of providers such as nurse practitioners, certified nurse specialist, or physician assistants on the list. We capture all the billings associated with each ACO participant TIN, but the claims used by FQHCs and RHCs are a little different than claim forms used by most Part B providers. And so it requires us to request the NPIs of physicians that provide direct patient care in those settings in order to comply with our statutes.

Also, if the ACO participant is a critical access hospital that is billing under a Method 2 or is an electing teaching amendment hospital, you will only need to provide the CCN. If

you have multiple CCNs or NPIs affiliated with the ACO participant TIN, then you will need to provide multiple rows of data where the TIN information repeats on every row. So think of the ACO participant list like a dataset and the computer will read every row of data separately.

And finally, it's not required, but you may choose to include the TINs of practices that have been merged or acquired by other ACO participants in your organization. A merged or acquired TIN is a TIN that was acquired by an ACO participant through purchase or merger. A merger 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 participant subsumed the acquired TIN in its entirety, including all of the ACO providers and suppliers that billed under the TIN. All the ACO providers/suppliers that billed through the acquired TIN must have reassigned their billing to the ACO participant TIN, and the acquired TIN must no longer be used. You will need to indicate whether the TIN you are submitting is a merged or acquired TIN.

And if you indicate a merged or acquired TIN on your ACO participant list, you must mark "Yes" to question 25 and upload your merged or acquired TIN attestation and supporting documentation. Please also keep in mind that merged or acquired TINs are not considered ACO participants, but as I just mentioned, can be added for purposes of assignment for the historical benchmark years. You can see the Application Reference Guide for further guidance on question 25.

HPMS will validate the format of your ACO participant list upon submission. So it's important that you submit the ACO participant list early to allow you to correct any formatting errors. I can tell you that this is one thing that a lot of ACOs don't do and we see it be problematic each application cycle. So please do not wait until the last minute to upload your ACO participant list. So that way if you do have formatting errors, you've allowed yourself a time to correct the formatting errors and upload the list timely.

The HPMS help desk is available for technical assistance. You must successfully submit your ACO participant list through HPMS to submit your application. We will not accept it from you any other way.

Please also note that the ACO participant TINs that bill Medicare for primary care services may be listed in only one Medicare ACO. Once you've successfully submitted your application, if TINs or CCNs are found on multiple ACO participant lists, we will notify you that they are not eligible to participate in your Shared Savings Program ACO. This is done to ensure each ACO has a unique patient population assigned in each year of the program. ACO participant TINs that do not bill Medicare for primary care services may appear on ACO participant list of more than one Shared Savings Program ACO.

Completing the ACO Participant Agreement

So I know that was a lot. Let's move to slide 18, which relates to question 27B and question 29, which asks you to complete the ACO participant agreement. And I just want to make sure that everyone is still paying attention because slides 17 and 18 really touch on a lot of the concerns that we see be raised during the application process. So please bear with us as we go through these two really important slides.

So again, slide 18. The application toolkit gives you instructions on how to complete these, as well as information from the ACO participant agreement guidance and ACO participant list guidance for applicants, which is the third link on this slide. I would very strongly encourage you to read this guidance now. It includes several hints and tips that will help ensure your agreements are successful and you aren't required to make last-minute changes during a request for information that might leave you scrambling to get corrected agreements re-signed.

This is also something that we're offering new for this application year. We've included some information on our enrollment system, which is PECOS—the Provider Enrollment, Chain based Ownership System. So some very, very helpful information in this guidance titled ACO Participant Agreement Guidance and ACO Participant List Guidance for Applicants. I cannot emphasize enough that you should be reading this guidance now and making sure that you're setting up your agreements correctly so that they're successful.

In summary, you'll be asked to send in a sample agreement that your ACO uses when your ACO participant joins the ACO or when contracting with other individuals or entities that perform functions or services related to ACO activities. The agreements your ACO makes with each ACO participant and other entities must contain certain elements. You will use this template to tell us where each of those elements is present in your sample agreement that you submit.

For example, your agreement with an ACO participant must contain an explicit statement that the ACO participant will agree to participate in the Shared Savings Program and comply with program rules. So you will use this template to indicate where that explicit requirement can be found in your sample agreement.

I'm on slide 19 now. In Section 12 of the application you will be asked to attest that all statements made in the application are true, correct, and complete. It's imperative that you read and understand the program regulations before selecting "I Agree." And by selecting "I Agree," you are certifying that everything you have attested to is true and clear to the best of your knowledge. After selecting "I Agree," you will hit the "Submit" button to complete your application submission.

Moving to slide 20. During our application review, we may request that you submit additional information because a portion or portions of your application are incomplete or require clarification. So I know I mentioned this a little bit earlier, RFI process. You must correct your attestation and/or upload the additional information into HPMS. If you do not submit the information in a timely manner, we may not accept the submission. And

subsequently, we may deny your application. So it's very important to keep an eye out for those notices and to make sure you're responding before the deadline.

Requests for information, also known as RFIs, will be sent via email to the ACO executive and primary and secondary application contacts. Each applicant will get an RFI early in the process to provide information about things like application reviewer name and contact information, count of beneficiaries, and if you've selected a Tract 2, the repayment mechanism estimated amount. It is very important to make sure that all contact information in your application is correct at all times so that you do not miss any of these important communications about your application.

I'm now on slide 21. After we review your application and supporting documentation, we will send you an email either approving or denying your application in the fall of 2014 for our January 1st, 2015, program year start date. If you are approved, you will receive additional instructions regarding the Electronic Signature Management, or ESM as we call it. ESM is the mechanism through which ACO officials effectuate documents concerning the Shared Savings Program. So you essentially electronically sign these documents in our HPMS system if you decide – if you're approved and you ultimately decide to participate.

These documents include the data use agreement and the participation agreement between us and the ACO. If your application is denied, you will receive an email giving you the reason for the denial and you may have the opportunity to request a reconsideration. If you are eligible to submit a reconsideration request, we must receive it within 15 days of the date of your denial email.

Now please note that there are several statutory reasons for denial that are not subject to judicial or administrative review. For example, if your ACO fails to meet the 5,000 assigned beneficiary threshold, you are not permitted to request for a consideration.

Slide 22. If at any time you have questions throughout the application process, which is from now until when we make application determinations, again, you can email your inquiry to sspaco_applications@cms.hhs.gov. At this time, we'd like to reiterate that the application submission deadline is Thursday, July 31st, 2014, at 8 p.m. Eastern Time. We will not accept applications submitted after this deadline. If you miss the deadline, your next opportunity to participate in the Shared Savings Program will be for the 2016 program year start date.

Lessons Learned

Slide 23, 24, and 25 represent the lessons we have learned over the past application cycles. In our experiences, these issues have reportedly caused challenges for ACO applicants. Fortunately, you can benefit from these lessons learned so that you don't repeat the same mistakes.

First, it is imperative that you are aware of the application teleconferences and events we have provided and continue to provide you, the applicant. See the Shared Savings

Program Application Teleconferences and Events webpage for previous calls and materials provided. Of special interest to you are the two calls we had in April that target specific areas of the applications that may be challenging. We recommend that you refer to this material prior to and during your application submission preparation.

Secondly, we strongly recommend that you use, again, the 2015 Application Reference Guide and application toolkit as you prepare your application. If a problem arises in your ACO during the application review period that can negatively affect your application or eligibility, please contact us at sspaco_applications mailbox. The sooner we know about an issue, the better we can work with you to try to resolve it.

Third, on slide 24, we'd like to remind you that if you answer "Yes" to question one and when you certify that your ACO is a newly formed entity, we will share that application information with the Department of Justice and Federal Trade Commission. It would benefit you to review and understand the implications of the antitrust policy statement.

Fourth, you must comply fully with the requirement concerning the governing body. For instance, your ACO participants must have at least 75 percent control of the ACO's governing body. Additionally, be sure to avoid the appearance of a conflict of interest when selecting the beneficiary to serve on the ACO's governing body. For example, the beneficiary representative that is also an ACO provider/supplier would appear to be – would appear to set up a conflict between the beneficiary input and provider input into the governing body decisions.

In terms of ACO participants, on slide 25, you must include on the ACO participant list only those participants who have agreed to join your ACO and for whom you have signed ACO participant agreement. So only include ACO participants who have both agreed to join your ACO and for whom you have a signed participant agreement. These agreements must be in place prior to your application submission. Carefully review the ACO Participant Agreement Guidance and ACO Participant List Guidance for Applicants that I previously mentioned. There's also additional guidance for Medicare Shared Savings Program ACOs and ACO participant list FAQs that you can refer to when preparing your application.

On slide 26, our next call will be on July 8th, in which we will provide training in HPMS. The people on your ACO who are responsible for submitting the application should attend this session. We will go through the entire application process, including answering attestation questions, uploading narratives, and additional supporting documents and the required template.

On July 15th, we will have an application question-and answer-session. We will provide you with the opportunity to ask questions a full 2 weeks before the application submission deadline. We urge you to go over the application thoroughly so that we can address important questions in this session that may affect a large portion of applicants. We stress the importance of being familiar with the application prior to this call. It will

only be helpful if you have already read and attempted to complete – and attempted to complete the 2015 application.

We anticipate that you will have questions throughout the process. So when questions arise, please call or email the appropriate contact indicated on slide 27. We would like to reiterate that it is critical to meet all deadlines in order for your applications to be accepted. Any applications or supporting documentation 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 account for submission in HPMS.

So this concludes the prepared portion of the Shared Savings Program 2015 application National Provider Call. I'll turn it back over to Amanda, and we're happy to accept any questions at this time. Amanda.

Keypad Polling

Amanda Barnes: Thank you Laura. 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 minutes of silence while we tabulate the results.

Holley, we're ready to start the polling.

Operator: CMS greatly appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person on the room, enter 1. If there are between two and eight listening in, enter the corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

And that will conclude the polling portion of today's call. Amanda, I'll turn it back over to you.

Question-and-Answer Session

Amanda Barnes: Thank you. Our subject matter experts will now take your questions. But before we begin, I'd 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 as many questions as possible, we ask that you limit your question to just one. If you'd like to ask a followup question or have more than one question, you may press star 1 to get back in the queue, and we will address additional questions as time permits.

Holley, 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. Please remember

to pick up your handset before asking your question to assure clarity. And please note, your line will remain open during the time you are asking your question so anything you say or any background – any background noise, rather, will be heard in the conference.

And your first question will come from the line of Joshua Brinkley.

Joshua Brinkley: So, this is Josh Brinkley from MissionPoint Health Partners. We were wondering if a – if we sign up a large physician group that has multiple physicians who would be participating in the MSSP, would we need a signed agreement or a signed Joinder page for each separate participant physician?

Amanda Barnes: One second.

Dr. Terri Postma: I can answer it. Hi, this is Terri Postma. So that's a – that's a great question and I think that if you look at the agreement guidance that's in the toolkit or associated with the toolkit, some of these questions might be answered, so I'd refer you there. But the general principle is that each ACO participant TIN that's put on the list, the ACO needs to have an ACO participant agreement with that entity. And that agreement, you should either make sure in that agreement that the entity, the ACO participant TIN, ensures that each of the providers that bill through it have agreed to participate and comply so that in that way you have a direct association with each of those practitioners or you can choose to directly contract with each of those – each of those practitioners.

But if you do that, you still have to have that ACO participant agreement directly with the Medicare-enrolled entity TIN, that is, the group practice. Does that make sense?

Joshua Brinkley: Yes, thank you.

Operator: And your next question will come from the line of Jennifer Teeter. Jennifer, your line's open. You might be on mute.

Amanda Barnes: Next question Holley.

Operator: The next question will come from the line of Jennifer Connor.

Jennifer Connor: Hi, this is Jennifer Connor, Atrius Health, can you hear me?

Amanda Barnes: We can.

Jennifer Connor: OK. My question has to do with the TIN NPI list, the participant list. And I'm not sure, did I hear that you said we should not list nurse practitioners on the list, only physicians?

Kari Vandegrift: This is Kari Vandegrift. That is correct. You are just listing the physicians on the participant list for the FQHCs and RHCs that you're listing.

Jennifer Connor: Great, thank you.

Kari Vandegrift: Yes.

Operator: Your next question comes from the line of Michelle Ilitch.

Michelle Ilitch: Hi, this is Michelle Ilitch from CHE Trinity Health. On slide 21, it was mentioned that if you failed to meet the 5,000 beneficiary live criteria in the first submission by July 31st, you will not be permitted to have your application re-reviewed. I just wanted to confirm that that is the case, that you will have no further opportunity to send in an additional list.

Laura Dash: Hi Michelle, it's Laura Dash. I would encourage you to look at the agreement guidance that we have, the ACO Participant Agreement Guidance and ACO Participant List Guidance for Applicants that's on our website currently and we link to it in several slides. And that outlines the various times you'll be able to make changes to your ACO participant list.

I think what you keyed in on was the appeal if you're denied because you're below the 5,000 requirement, that's unfortunately not an appealable denial. However, you will have one opportunity to add TINs to your ACO participant list during the application cycle and that's detailed in that guidance document.

Michelle Ilitch: Thank you.

Operator: And your next question will come from the line of Michelle Crespo.

Michelle Crespo: Hello?

Amanda Barnes: Yes?

Michelle Crespo: OK, I was wondering if there's a CMS definition for integrated delivery systems.

Dr.Terri Postma: This is Terri Postma. The Shared Savings Program rules do – do not define that term.

Michelle Crespo: OK, Thank you.

Operator: And your next question will come from the line of Nora Medrano.

Nora Medrano: Hi, my question is if a participant provider is a part of another ACO and wishes to opt out of that ACO to join our ACO, is that something that will cause a problem with the application process?

Laura Dash: Hi Nora, this is Laura, and I may defer to Kari Vandegrift on this, too, but no, that's not a problem. The key thing to keep in mind is that the existing ACO must submit a request to us through HPMS to delete that participant from its ACO participant list and it must do that before September 8th, which is our cutoff for existing ACOs to make changes to their participant list for their next performance year. So as long as they submitted that delete request by the September 8th deadline, there should not be an issue. If they do not do that, then it will be unlikely that you'd be able to add that participant because it would overlap and therefore not be allowed on your list.

Nora Medrano: I actually had – last year we had a provider opt out of another ACO and, for some reason, they sent a letter and everything like that, but they were still a part of the ACO. It's like they didn't get a correspondence back from their current ACO that they were deleted. So they have to like confirm it with them and get like a letter that states that they will be deleting them, is that correct?

Laura Dash: Well, how they adjudicate that is certainly between the participant and the ACO, but we must receive the delete request no later than September 8th from the existing ACO through HPMS.

Nora Medrano: OK, I understand. Thank you.

Amanda Barnes: Next question Holley.

Operator: And your next question will come from the line of Charles Dunham.

Charles Dunham: Hi, yes. I would actually like to follow up on that last inquiry regarding participants in a currently existing ACO that decide to opt out and join a new ACO. There are certainly – will be conflict with an existing ACO in losing a participant. You suggest that it must be resolved between the two parties. Is there not a manner in which the participant themselves can submit to CMS indicating that they have notified the currently existing ACO to opt out and they've made no efforts in responding and CMS can address that with the ACO? I know that this is – that this has been a question of concern for developing ACOs where the former ACO has not been successful.

Laura Dash: Hi Charles, this is Laura. Generally speaking, we will not intervene in these matters. We have had a couple of instances where participants were able to come to us and demonstrate that an ACO was completely unresponsive. My only caution with that is that it still has to be adjudicated in the system by September 8th. So if this is something that our participant wants to do now and you're talking to them about it now and they've had two, three, or multiple discussions with the ACO, they've requested evidence, they've been deleted for HPMS, and are kind of at the end of the rope, they can certainly raise that issue with us. But generally speaking, we will not get involved in those requests unless there's some type of real egregious case for us to intervene. And I can assure you they're very rare.

Charles Dunham: Oh, I understand. And my quick question, with respect to the beneficiary participant on the – I'm sorry, not participant, but there's the beneficiaries participating on the governing body as required. Does that beneficiary need to be identified at the time of submitting the application? I'm concerned with, you know, having to identify that individual.

Laura Dash: Karmin, Terri, can one of you answer that?

Dr. Terri Postma: Yes, this is Terri. So, it's best that that beneficiary is identified at the time of your submission. And – but if you don't have it initially at the time of submission, during the submission process you can give us a projected date by which that beneficiary will be determined. And it should be – so that you're in compliance with the program rules, it should before the start date of your agreement period.

Just one point of clarification I want to make is that some ACOs have erroneously thought that that beneficiary has to be from their assignment list, and that's not the case. This is just any fee-for-service beneficiary that has served by any of the ACO participants. OK? So I hope that helps.

Charles Dunham: Thank you.

Operator: And your next question will come from the line of Debra Karnasiewicz .

Debra Karnasiewicz: Hi, this is Debra Karnasiewicz. I'd like to revisit the issue of if you do not make the 5,000 lives. Can you please reference the document where we could find that information? And your opportunity to resubmit, is it before the July 31st deadline or does that come up after?

Laura Dash: Debra, I might ask you to clarify your first question. On the second question, the guidance, ACO Participant Agreement Guidance and ACO Participant List Guidance for Applicants – that's the title of just one guidance document, actually details the timing and information around when you'll be able to do that.

And can you clarify your first question? I'm sorry, I didn't quite follow it.

Debra Karnasiewicz: Well, I think you just answered it. I wanted to know where to reference that information.

Laura Dash: It is on …

Debra Karnasiewicz: … but I don't – I had perused that, I didn't see – so, I guess my other question is, your one opportunity, does it come before the July 31st final application or after?

Laura Dash: Well, it's during the RFI period.

Debra Karnasiewicz: So it's before July 31st then?

Laura Dash: It's after July 31st. You submit the application to us by July 31st and then if we have any information we need from you, we – we conduct this RFI period after July 31st and allow you an additional time to submit information to satisfy that need.

Debra Karnasiewicz: And that includes adding to your 5,000 lives if needed.

Laura Dash: Yes, but that's only one time as detailed in that guidance and I'm looking at it now, and it's on page 3.

Debra Karnasiewicz: Thank you so much.

Operator: And your next question will come from the line of Robert Ginsberg.

Robert Ginsberg: Hi. You've mentioned in the case of sole practitioners, they should be submitting both their SSN and TIN if they have both. And you mentioned that the TIN had to match the entity name from when the TIN was first obtained from the government. Is there a resource that the ACO can access to confirm the names of TINs? I'm a little concerned that if a physician got his TIN 22 years ago or she got her TIN, that they might not be using the name and I wouldn't want to have somebody denied because for non-match of name.

Laura Dash: Yes, Robert, this is Laura. That's a great question and that's one of the exact questions we aim to address in this new guidance document that we have for this application cycle. So for those of you that are scratching your heads, look at page – or slide 18, it's the first guidance document under the third bullet, ACO Participant Agreement Guidance and ACO Participant List Guidance for Applicants. And we actually included an appendix in this document, Robert, that addresses that very question.

If you look at Appendix B, we've laid out how an ACO participant can verify their legal business name in our enrollment system called PECOS. And throughout the document we also provide a couple of hints and tips, and one of them is that we strongly recommend you have your participant go in and provide you a printout showing what their proper legal business name is in our records, so that way you're executing an agreement with a proper entity and it's not rejected.

Robert Ginsberg: Great, thank you very much.

Laura Dash: Sure.

Operator: Once again, if you'd like to come in the queue, please press star 1 on your telephone keypad.

And your next question will come from the line of Jennifer Teeter.

Jennifer Teeter: Yes, can you hear me?

Operator: Yes, go ahead.

Jennifer Teeter: Yes. Has the application been fully access allowed on the HPMS website? The reason that I'm asking is that I go into the application and I see the ACO information that was uploaded automatically from the NOI. But when I get to the page that says, "To access the ACO application management start page, select Submit Application Data on the left navigation bar on the ACO agreement management start page," but I do not see that as an option on the HPMS system on that particular page yet. Has it not been put in for us to access that?

Karmin Jones: Hello, this is Karmin Jones. The application will be available in HPMS on July 1st …

Jennifer Teeter: Yes.

Karmin Jones … when you're able to access to submit your application. We also will be doing a training in HPMS to help you navigate through all the different training system with your application. So we also encourage you to attend that and you can look at the back of the presentation for the next call. We'll send out reminders to everyone who submitted an NOI to attend that call when it's available.

Jennifer Teeter: Thank you.

Amanda Barnes: Next question.

Operator: And your next question will come from the line of Anna Marcus.

Anna Marcus: Hi, this is Anna Marcus from Aledade. I just had a question about the medical directors. Do they have to be providing direct clinical care for the ACO?

Dr. Terri Postma: Hi, this is Terri. So no, they don't have to be providing direct clinical care, although many ACOs have told us that, that's actually helpful if a medical director does because then they can understand better the flow of processes and the processes that the ACO is putting into place for the practices that are involved with it. But did the – so, the answer is no.

Amanda Barnes: Next question Holley.

Operator: And your next question will come from the line of Lanny Polly.

Lanny Polly: I understand that the cutoff for moving into a new ACO from an existing ACO is 9-8. If notice is given and received and everything is done properly on that side, can the effective date of that switch or will the effective date of that switch be 12-31/1-1?

Laura Dash: Hi Lanny, yes, it's Laura. Yes, any existing ACO who submits a request to delete a participant, those are always effective at the end of the performance year, which is December 31st, 20 – in this case, 2014.

Lanny Polly: Thank you.

Operator: Your next question will come from the line of Diana Yates.

Diana Yates: Hi, my question is for the antitrust agency's definition of newly formed, could I have clarification of what that is please?

Dr. Terri Postma: Yes, this is Terri. The best clarification on that is to look at the policy document that was published concurrently by the antitrust agencies with the Shared Savings Program rule and you can access that form by going to our website – or that notification by going to our website. It's called the antitrust policy statement. And that's the best place to get information about that issue.

Diana Yates: OK, thank you much.

Dr. Terri Postma: You're welcome.

Operator: And your next question will come from the line of Linda Mack.

Linda Mack: Hi, can you hear me?

Amanda Barnes: Yes, we can.

Linda Mack: OK, great. I have a two-pronged question and I'm calling from the State of California and the various counties. We have a PCI process enrollment initiative for converting fee-for-service beneficiaries into managed care. Now from what I understand, that if they just move her last year and they just enrolled. Number one, will they be excluded completely from the ACO even if they've, let's say, for instance, enrolled for 1 month by accident because they didn't do and then find out they did enroll and then disenroll, will that automatically exclude them from ACO participation?

Dr. Terri Postma: Hi, this is Terri. So I think you're referring to the financial alignment demonstration. There are several states that are involved in that. We have developed some FAQs that can be found on our website about that demonstration and its potential impacts on ACOs. The short answer is that depends on the state and how the state has set it up.

So the beneficiaries may retain fee-for-service status, in which case, it is – they are still eligible for assignment to an ACO. But in cases like, I believe, California has opted to do more of a passive enrollment into managed care for dually eligible beneficiaries. And if that dually eligible beneficiary is passively enrolled in a managed care plan, then that

beneficiary no longer meets the definition of a fee-for-service beneficiary and is therefore no longer eligible for assignment to the ACO.

I also know that the MOU for California State outlines some exclusions and for dually eligible beneficiaries that might be in their financial alignment demonstration. And some of the exclusions have to do with geographic location of those beneficiaries. So you might want to go to the website. I think we reference it in our FAQs. Can you scroll down a little bit?

And so that will give you the page on which you can get more information – I'm sorry, I don't see it. Actually, if you Google financial alignment demonstration, you should find the homepage for that. And then that list, all of the MOUs for each state that's participating in this demonstration for dually eligible beneficiaries, and those MOUs give details for how each state has arranged it. So it's really state by state dependent. But I think between the FAQs and the MOUs, it should help you understand the alignment of dually eligible beneficiaries.

Linda Mack: Well, I have got it and I have read it, but again, just – for arguments sake in the sense that if a beneficiary ends up getting enrolled not by his or her choice just by because they were just passive. And they disenrolled and took the space of 1 month. Will that 1 month affect the – CMS's utilization of that patient for the ACO's assignment?

Dr. Terri Postma: I'm going to look to others who are more – know more about the alignment of beneficiaries, but I believe the specification document talks about eligibility criteria for fee-for-service beneficiaries and one of the eligibility criteria is that they had both Medicare fee-for-service Medicare Parts A and B for at least 1 month, right, during the performance year. So if they bounce back and forth between a managed care plan and fee-for-service Medicare, I think if they only had check that, look at the spec document, I believe that if the fee-for-service beneficiary had at least 1 month of Parts A and Part B under fee-for-service Medicare, that they are eligible for assignment.

Linda Mack: Oh, OK. – That's very good.

Dr. Terri Postma: But check that on the spec document because it's pretty detailed and it does give you …

Linda Mack: Yes.

Dr. Terri Postma: … 1 month.

Linda Matt: OK.

Dr. Terri Postma: Yes, we're looking at it, we think it's 1 month.

Linda Mack: OK. And really, the second question. Can a beneficiary elect to join an ACO?

Dr. Terri Postma: No. This is not like a managed care plan or anything like that. The assignment is always done retrospectively looking back at where fee-for-service beneficiary chose to receive a plurality of their primary care services.

Linda Mack: I see. OK, thank you very much.
Dr. Terri Postma: You're welcome.

Operator: Your next question will come from the line of Anna Marcus.

Anna Marcus: Hello. We just had a question about the distribution of savings. So, the application refers to each category of savings. Is there a defined list of these categories?

Amanda Barnes: 1 second.

Dr. Terri Postma: So this is Terri. I think I think if I heard the question correctly, you're asking how shared savings are divided among the ACO participants, and that's something that the ACO participants work out among themselves with the ACO. And so we really don't have any rule or specifications on how those shared savings are used or distributed.

Anna Marcus: OK, so when you refer to having a category, then we can kind of create that category name and you don't have a set list that we need to kind of …

Dr. Terri Postma: Yes, that's right. And generally, what we've seen on the categories that people talk about are things like building infrastructure, repaying investors, you know, distributing shared savings among specialists or among primary care providers, that kind of thing.

Anna Marcus: Great, thank you.

Amanda Barnes: You're welcome.

Operator: Once again, if you'd like to come in the queue, please press star 1 on your telephone keypad.

And your next question will come from the line of Lanny Polly.

Lanny Polly: To perseverate on the 9-8 cutoff, in order for members of existing ACOs to join a second ACO, you know, leave the first, join the second, how far in advance of 9-8 should the current ACO provide CMS with notice so that ACO number two can include them on their list?

Laura Dash: Hi Lanny, it's Laura. As long as it's by September 8, that will be sufficient.

Lanny Polly: Thank you.

Operator: Once again, if you'd like to come in the queue, please press star 1 on your telephone keypad. Again, star 1 to come into the question queue.

And your next question comes from the line of Anna Marcus.

Anna Marcus: Hi, we just have two quick questions. So, the first is that if we're submitting multiple applications and are planning a uniform approach to some of the issues, are we allowed to just cut and paste across applications? And then the second part of that question is just, what are some of your other rejection criteria for an ACO? So, one of them is just that if we have less than 5,000 beneficiaries, that's kind of automatic rejection, but are there any other criteria like that?

Amanda Barnes: Laura, are you going to respond to that?

Laura Dash: Yes, I can. So for the rejection question, Anna, I think I would take a look at all of the questions that we're asking you. If they're not answered sufficiently, then that could certainly be a reason why you're rejected. So it could be something as simple as you've submitted a participant on your ACO participant list that doesn't have – you haven't submitted agreement for or haven't submitted correct agreements for. We're looking at all of the questions on the application to make sure they're answered correctly and wholly.

And then for you first question, can you repeat it again? I just want to make sure I understood it.

Anna Marcus: Sure. So if we're going to be submitting multiple applications for different ACOs are planning a uniform approach for some of the issues on the application, are we able to just cut and paste across applications and obviously tailor it based on each ACO with you to kind of uniform approach like that?

Laura Dash: Yes, as long as it's correct and applicable to that particular ACO and it's a true and accurate representation of what that ACO is doing, that would be OK.

Ana Marcus: Alright, great. Thank you.

Operator: Once again, to come in the queue, please press star 1. And your next question comes from the line of Michelle Crespo.

Michelle Crespo: Hello. If a healthcare network owns hospitals, home care agencies, and a physician group practice, and the subsidiary of the network forms the ACO, do we have to list out each of the owned participants on the participant template, and do the physicians in the group practice need to have supplier – and do we need physicians in each practice to have an individual supplier agreement?

Amanda Barnes: Could you repeat that for us?

Laura Dash: A little louder please.

Amanda Barnes: Yes, Michelle, we're having a hard time hearing you.

Michelle Crespo: Alright, can you hear me now?

Amanda Barnes: Yes, just speak up.

Michelle Crespo: If a healthcare network owns hospitals, home care agencies, and physician group practices, and a subsidiary of the network forms the ACO, do we have to list out each of the owned participants on the template and do physicians in each group practice need to have supplier agreements?

Laura Dash: So, Michelle, I can give you a broad answer, which is simply that, irrespective of how the ACO is set up, for all of the participants, so it sounds like, yes, they all need to be listed as participants on your ACO participant list which means that they must have, you know, be listed on the list along with the Medicare enrolled TIN and all of the providers and suppliers billing through that TIN must agree to participate in the ACO. The participants or the ACO should have executed agreements with the providers/suppliers. While we don't ask for them, we do require them and that's highlighted in the guidance that I had mentioned earlier. You might want to check that out for some hints and tips around setting that type of an agreement up.

But yes, if there are participants coming together to form the ACO, they should be listed on the participant list. The ACO should have signed executed agreements with those participants, and either the ACO directly or indirectly through the participants should have agreements with the providers and suppliers.

Michelle Crespo: Is that like individual like each employed physician?

Laura Dash: Yes, all of the NPIs billing through the participant TIN should agree to participate in the ACO. And that again is highlighted in that guidance document I mentioned earlier that's on our website.

Michelle Crespo: OK, thank you.

Operator: And your next question comes from the line of Denise. Hi Denise, your line's open.

And that question has been withdrawn. And once again, if you'd like to come in the queue, please press star 1 on your telephone keypad. Your next question will come from the line of Jennifer Connor.

Jennifer Connor: Hi again. I have a question about submission through HPMS. And will it tell you as you enter each piece if a piece has been rejected? So are you able to enter

the information as you go and will it tell you or do you have to sort of fill everything in and then hit “Submit” and it will tell you reject or accept?

Karmin Jones: Hello, this is Karmin. So HPMS will tell you for each upload whether the upload has been accepted. Once you hit “Final Submit,” it will also indicate to you if there’s an issue with any of the ways that you have responded to your active facing questions. For instance, if there’s a discrepancy in section two with the way that you’ve answered a question in section four, it will let you know that and give you specific instructions on the page for how to correct that.

However, again, we’ll go over this in more detail on our next call on July 8th, where we talk about how to navigate through the screen and submit your information on the – in HPMS and we encourage you to attend that as well.

Jennifer Connor: OK.

Laura Dash: And Jennifer, this is Laura. Just to add to what Karmin said, I just want everyone to keep in mind that while we do our best to have error codes and that type of thing throughout the system, obviously the system can’t read and understand the various narratives that you’re submitting to us, and that’s one of the reasons for the RFI process, so we can ask questions and get – obtain additional information from you to help answer those questions we may have.

Jennifer Connor: Thank you.

Dr. Terri Postma: This is Terri. I also want to just backtrack to one of the discussions we were having about the financial alignment demonstration. So we looked up the specifications for assignment and they say that if a beneficiary has had 1 month or more of managed care – managed care enrollment, then they are not eligible for assignment to the ACO. So I just wanted to clarify that. Thanks.

Operator: And your next question will be your final question, and your final will come from the line of Shawn Franklin.

Shawn Franklin: Hi, good afternoon. Can you hear me?

Amanda Barnes: We can.

Shawn Franklin: OK. If you choose to contract with a physician as another entity, my understanding is that you don’t have to include them in your participant list nor do you have to have a signature page, so I’d like confirmation on that. And then part two of the question would be, if that other entity is contracted to perform certain services, does that template other entity agreement, do you need to provide examples of the various services that other entities could provide under that agreement?

Karmin Jones: Laura, did you want to take this question?

Laura Dash: Sure, sorry. My understanding is that, and Kari or Terri can correct me if I'm wrong, other entities do not require to be listed on our list or to have executed agreements. I think we do require as part of the application that you send a sample agreements of what you might have with those entities, but we don't require the actual executed agreement.

Karmin Jones: And just to add to that, we do require that the ACO have the agreement on hand in their facilities and make them available upon request, but they are not required to be submitted with the application. But you should have them on record.

Laura Dash: That's a good point. Thanks Karmin.

Operator: And that will be our last question. We'll turn the call back over to Amanda Barnes.

Amanda Barnes: Thank you.

Additional Information

Karmin Jones: This is Karmin Jones again. We just want to remind the upcoming calls that are referenced on slide 26. Please continue to visit our Teleconference and Event page for when those – when the registration is open, so attend those. Our next call is on July 8th, going over the training on HPMS application module submission. Thank you.

Amanda Barnes: Just a reminder, for the NOI submission and application question, please email sspaco_application@cms.hhs.gov. Again, that is S as in Sam, S as in Sam, P as in Paul, A as in Apple, C as in Charlie, O as in orange, underscore, application@cms.hhs.gov.

And audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 29 of today's presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and confidential and voluntary. We hope you'll take a few minutes – moments to evaluate your MLN Connects Call experience.

Again, my name is Amanda Barnes and I'd like to thank you – thank our presenters and also thank you for participating in today's MLN Connects Call. Have a wonderful day.

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

-END-

This document has been edited for spelling and punctuation errors.

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