CMS RELEASES UPDATED MEDICARE SHARED SAVINGS PROGRAM FAQS

This installment of Hall Render's Health Law Broadcast series on health care reform is designed to provide you with the insight, analysis and practical suggestions with respect to the various reform initiatives that will affect your organization.

The Centers for Medicare and Medicaid Services ("CMS") recently published an updated list of Medicare Shared Savings Program ("Program") Frequently Asked Questions ("FAQs"). These FAQs address various aspects of the Program ranging from general informational issues to the application process. The FAQs can be found here.

Select clarifications within the FAQs include:

1. When an accountable care organization ("ACO") participant agrees to participate in the Program, it must do so on behalf of all of the Medicare providers and suppliers that bill under the ACO participant's Medicare-enrolled tax identification number ("TIN"). An ACO participant may not be comprised of only a subset of the participant's providers and suppliers.
2. Medicare-enrolled providers that do not bill for primary care services, nonetheless, may form an ACO, so long as the ACO is joined by other enrolled providers/suppliers that do bill Medicare directly for primary care services. Primary care services are defined as those services identified by HCPCS codes 99201-99215, 99304-99340, 99341-99350, G0402, G0438 and G0439 and revenue center codes 0521, 0522, 0524 and 0525 when submitted by federally qualified health centers ("FQHC").
3. ACO participants that bill for primary care services may only participate in one ACO.
4. An individual solo practitioner may not him/herself form an ACO as, by definition, ACOs constitute individuals and groups of suppliers/providers coming together to take joint responsibility for the high quality and cost-effective care of a pool of Medicare beneficiaries. It is also unlikely that a small group practice alone would be able to meet all the requirements for participation in an ACO (e.g., an ACO must have no fewer than 5000 fee-for-services Medicare beneficiaries assigned to it.)
5. A beneficiary is assigned to an ACO if the beneficiary receives the "plurality" of his or her primary care services from primary care physicians within the ACO. "Plurality" means the ACO participants provided a greater portion of primary care services (but not necessarily a majority of these services) to a given beneficiary than the ACO participants in any other ACO or Medicare-enrolled provider TIN. If a beneficiary has not received primary care services from any primary care physicians, then a beneficiary is assigned to an ACO if the beneficiary received a plurality of his or her primary care services from specialist physicians and non-physician practitioners within the ACO.
6. Benchmarks are calculated for the ACO as a whole and not for individual ACO participants. Benchmarks are established based on the per capita Medicare Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the three most recent years prior to the start of the ACO agreement period.
7. ACO participants may be added or subtracted during the ACO agreement term. The ACO must notify CMS within 30 days of any change.
8. Upon considering a new application for the Program, CMS may take into account TINs recently acquired through purchase or merger if: a) the ACO participant has subsumed the acquired TIN in its entirety; b) all the ACO providers/suppliers that billed through the acquired TIN reassign their billing to the ACO participant TIN; and c) the acquired TIN no longer is used.
9. ACO applicants must submit the CMS Certification Number ("CCN") if the ACO participant is an FQHC, a rural health clinic ("RHC") or a method II critical access hospital. ACO applicants also must submit the national provider identifier ("NPI") information for physicians who directly provide primary care services in an FQHC or RHC on the ACO participant list, but need not submit NPIs for physicians who do not provide primary care services at FQHCs or RHCs.
10. Participation in the Program requires the submission of a new CMS-588 Electronic Funds Transfer Authorization Agreement, even if the

ACO participant already receives other types of electronic fund payments from Medicare. The ACO does not need an NPI to complete the Form CMS-588 for the Program.

11. The ACO bank account must be linked to the ACO's TIN/EIN, not one of the ACO participant's TINs. However, shared savings can be paid to a parent or chain organization or under a d/b/a (doing business as) name if this information is clearly set forth in the form CMS-588.
12. It is not necessary to file form CMS-855 (provider enrollment form) specifically for an ACO.
13. CMS suggests submission of the following information pertaining to the ACO's governing body: a) full name of the governing body's member; b) title (e.g., chair, president); c) number of votes the member has (may be zero for non-voting member); d) membership type (ACO participant representative, Medicare beneficiary representative, community stakeholder representative or other); and e) ACO participant TIN legal name (does not apply to members of the governing body who are Medicare beneficiary or community stakeholder representatives).
14. The ACO must submit the name of a "key leadership member" for each committee within the ACO's organizational structure. The ACO rules permit persons not serving on the governing board to serve on other ACO committees, including in positions of committee leadership.

Practical Considerations

As can be seen from daily headlines, ACO development is on the rise. CMS has indicated it has more than 400 applications pending for a January 1, 2013 start date. Perhaps more impressive are the substantial efforts being made by commercial payers to develop ACO-like collaborations with their participating providers. The application and development process to participate in the Program is extensive and challenging. But, there are many resources available for health care providers and suppliers who are either applying for the next Program commencement date of January 1, 2013 or who are considering future participation.

- Frequently check CMS's Shared Savings Program website.
  There is much information located at this site, including FAQs, CMS regional contact information and application materials.
- There are many consultants and provider consortiums available to assist providers and suppliers with various aspects of ACO development and the application process. Scrutinize the credentials and experience of possible consultants and obtain meaningful input directly from references.
- Experienced legal advisors can facilitate ACO formation and provide guidance necessary to comply with applicable federal and state laws.
- Don't forget about internal expertise. All organizations have a certain level of internal knowledge and experience that will be essential to structuring an ACO in a manner that is best situated to achieve success.

If you have any questions or would like additional information about this topic, please contact Adele Merenstein at (317) 752-4427 or amerenst@hallrender.com, Brian C. Betner at (317) 977-1466 or bbetner@hallrender.com or your regular Hall Render attorney.