Frequently Asked Questions

Medicare Shared Savings Program

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General Questions

Q: What is the definition of an ACO participant and why is this concept important to understand?

A: *An ACO participant is defined at §425.20 as an individual or group of ACO providers/suppliers that is identified by a Medicare-enrolled tax ID number (TIN), that alone or together with one or more other ACO participants comprises the ACO, and that is included on the list of ACO participants required to be submitted as part of the application and updated at the start of each performance year and at other times as specified by CMS. An ACO participant bills Medicare for services through its Medicare-enrolled TIN, or CMS Certification Number (CCN). ACO participant billing TINs (or CCNs) are the basis for establishing eligibility, assignment of beneficiaries, computation of the benchmark, and quality assessment.*

As part of its application, the ACO will be required to submit a list of ACO participants. Examples of ACO participants are: a group practice, an acute care hospital, a pharmacy, a solo practice, a Federally Qualified Health Center, a Critical Access Hospital, a Rural Health Center, and other entities that are Medicare-enrolled and bill Medicare for services though a Medicare-enrolled TIN.

Q: What is the definition of an ACO provider/supplier?

A: An ACO provider/supplier means an individual or entity that is a Medicare provider or supplier enrolled in Medicare and bills for services under an ACO participant TIN. For example, a large group practice may qualify as an ACO participant. A Medicare enrolled physician billing under the practice TIN would be an ACO provider/supplier.

Q: We are a large group practice that meets the definition of an ACO participant. We have many ACO providers/suppliers that bill under our practice TIN. May we form an ACO using only a subset of our ACO providers/suppliers?

A: No. When an ACO participant agrees to participate in the Shared Savings Program, it does so on behalf of all the ACO providers/suppliers that bill under its Medicare-enrolled TIN. All contracts or arrangements between or among the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities must require compliance with the requirements and conditions of the Shared Savings Program.

Q: I (we) meet the definition of an ACO participant, however, I (we) do not bill for primary care services. May I (we) form or participate in a Shared Savings Program ACO?

A: Any Medicare-enrolled provider or supplier that bills Medicare directly for services may be an ACO participant, however, a Medicare-enrolled provider that bills Medicare directly but does not bill for primary care services (as defined in 42 CFR Part 425.20) is not eligible to form an ACO unless joined by Medicare-enrolled providers or suppliers that bill Medicare directly for primary care services since primary care services are the basis for assigning patients to the ACO for purposes of measuring quality and financial performance.

Q: When an ACO applies for participation in the Medicare Shared Savings Program, must the ACO have agreements with all ACO participants at that time?

A: Yes. As part of its application, the ACO must certify that the ACO, its ACO participants, and its ACO providers/suppliers have agreed to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO (42 CFR 425.204(a)). We note that, as part of the application, the ACO must submit to CMS documents (for example, participation agreements, employment contracts, and operating policies) sufficient to describe, among other things, the ACO participants' and the ACO providers'/suppliers' rights and obligations in and representation by the ACO (42 CFR 425.204(c)). The ACO is responsible for ensuring each ACO participant, ACO providers/supplier billing through each ACO participant, and other individuals or entities performing functions or services related to ACO activities agree to and are in compliance with the requirements of the program (42 CFR 425.210).

Q: I (we) meet the definition of an ACO participant. Do I (we) bill for primary care services?

A: *For purposes of the Medicare Shared Savings Program, primary care services mean the set of services identified by the following HCPCS codes: 99201-99215, 99304-99340, 99341 through 99350, G0402, G0438, G0439. Primary care services are also defined as revenue center codes 0521, 0522, 0524, 0525 when submitted by FQHCs (for services furnished prior to January 1, 2011) or by RHCs Any Medicare provider that bills using these codes will be used to determine an ACOs assigned patient population.*

Q: I (we) meet the definition of an ACO participant. Must I (we) be exclusive to a single Medicare Shared Savings Program ACO?

A: ACO participants that bill for primary care services must be exclusive to a single Medicare Shared Savings Program ACO.

Q: I (we) want to participate in an ACO. How do I find out about ACOs forming in my region?

A: *We recommend that you contact other potential ACO participants in your region or the relevant state or national professional association to see whether others are developing or considering developing a Medicare Shared Savings Program ACO.*

Q: I am an individual practitioner and have a solo practice. May I form an ACO by myself?

A: No. The Shared Savings Program is designed to provide an incentive for individuals and groups of practitioners to come together to form an ACO. Solo practitioners whose practices have a Medicare-enrolled TIN and bill Medicare for services may wish to become an ACO participant by joining with other ACO participants to form an ACO. Talking with other Medicare-enrolled providers and suppliers in your region may be good way to determine who may be interested in forming an ACO.

Q: We are a small group practice. May we form an ACO?

A: We believe it would be difficult for a small group practice to meet the requirements for participation (one example is the requirement to have at least 5,000 fee-for-service beneficiaries assigned to the ACO participants) in the Shared Savings Program, which is designed to provide an incentive for individuals and groups of providers and suppliers to come together to form an ACO. Small group practices that have a Medicare-enrolled TIN and bill Medicare for services may wish to become an ACO participant by connecting with other ACO participants to form an ACO. Talking with other Medicare-enrolled providers and suppliers in your region may be a good way to determine who may be interested in forming an ACO.

Q: We are a non-Medicare-enrolled entity. Can we form or participate in a Shared Savings Program ACO?

A: The Shared Savings Program is designed to provide an incentive to Medicare-enrolled providers and suppliers that come together to form an ACO. Therefore, non-Medicare-enrolled entities are not eligible to form a Medicare Shared Savings Program ACO. However, it was our intent in the final rule to provide flexibility for Medicare-enrolled providers and suppliers to join with others, including non-Medicare-enrolled entities, and to include them in the ACO's governing body structure, at the discretion of the ACO, provided that at least 75% control of the ACO's governing body is held by ACO participants.

Q: I am a physician who just graduated from residency. I just started a primary care practice, have become Medicare-enrolled and have a brand new billing TIN. Can I form or participate in a Shared Savings Program ACO?

A: *As a newly enrolled Medicare physician practice that bills Medicare directly for services, you are eligible to be an ACO participant. However, because your billing TIN does not have a history, you must come together with other ACO participants that furnish primary care services in order for CMS to set a benchmark based on expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period.*

Q: How are beneficiaries assigned to an ACO?

A: Beneficiaries will be assigned to an ACO, in a two-step process, if they receive at least one primary care service from a physician within the ACO:

1) The first step assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. Primary care physicians are defined as those with one of four specialty designations: internal medicine, general practice, family practice, and geriatric medicine or for services furnished in a federally qualified health center (FQHC) or rural health clinic (RHC), a physician included in the attestation provided by the ACO as part of its application.

2) The second step only considers beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO. Under this second step, a beneficiary is assigned to an ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO.

A plurality means the ACO participants provided a greater proportion of primary care services, measured in terms of allowed charges, than the ACO participants in any other ACO or Medicare-enrolled provider TIN, but can be less than a majority of services.

Q: How is a benchmark determined for the ACO?

A: *The benchmark for the ACO is calculated based on the per capita Medicare costs of beneficiaries that would have been assigned to ACO participants in each of the three years before the start of the agreement. For example, for ACOs starting in 2012, benchmarking years will be 2009, 2010, and 2011. The assignment algorithm described in the final rule will be applied to each of these years. The ACO's benchmark is not set for individual ACO participants, rather, the benchmark is set for the ACO as a whole based on the per capita Part A and B expenditures for all beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period. The benchmark is trended using national Medicare expenditure growth factors and risk adjusted to reflect the most recent benchmark year, which is also weighted the most in establishing the 3 year historical benchmark. The benchmark is updated annually by the projected absolute amount of growth in national Part A and B fee-for-service expenditures.*

Q: I (we) are billing under a brand new Medicare-enrolled billing TIN. How will my benchmark be calculated and how will beneficiaries be assigned?

A: *Benchmarks are not set for individual ACO participants, rather, the benchmark is set for the ACO as a whole based on the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period. When you come together with other ACO participants to form a Shared Savings Program ACO, the ACO's benchmark will be based on the Part A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO on the basis of services furnished by your fellow ACO participants. During the course of the year, your patients that receive a plurality of their primary care services from you and the other ACO participants in the ACO will start to show up in the preliminary assignment lists that are provided on a quarterly basis, and also in the final assignment report at the end of the year.*

Q: Once an ACO has signed an agreement with CMS, may ACO participants be added or subtracted during the course of the agreement period?

A: Although each ACO participant TIN is required to agree to commit to a 3-year agreement with CMS to participate in the Shared Savings Program, we recognize there may be reasons why an ACO participant may leave or be added to an ACO during the course of the agreement period. When such changes occur, the ACO must notify CMS within 30 days of the change. Additionally, the ACO must provide an updated ACO participant list at the beginning of each performance year and at such other times as specified by CMS. The ACO's eligibility to participate may be affected by such changes. Additionally, such changes may necessitate adjustments to the ACO's benchmark or cause changes to risk scores or preliminary prospective assignment.

Q: Our group practice is applying for participation in the Medicare Shared Savings Program. We recently purchased two small primary care practices. The primary care providers from those small 5

practices are now employees of our group practice and have reassigned their billing to our group practice TIN. Is there a way to take into account the information from the small group practices on my application for the Medicare Shared Savings Program for purposes of benchmarking and preliminary prospective assignment?

A: *Yes. Under certain circumstances, CMS may take TINs acquired through purchase or merger into account:*

• The ACO participant must have subsumed the acquired TIN in its entirety, including all the ACO providers/suppliers that billed under that TIN.
• All the ACO providers/suppliers that billed through the acquired TIN must reassign their billing to the ACO participant TIN.
• The acquired TIN must no longer be used.

In order to assess the impact of these acquired TINs on the ACO's application, the ACO applicant must:

• Submit acquired TINs on the ACO participant list, along with an attestation stating that all ACO providers/suppliers that previously billed under the acquired TIN have reassigned their billings to the current ACO participant TIN.
• Flag acquired TINs and which ACO participant acquired them for the CMS application reviewer.
• Submit supporting documentation demonstrating that the TIN was acquired by an ACO participant through a sale or merger and submit a letter attesting that the TIN will no longer be used.

ACO Participant List

Q: What is an ACO Participant?

A: *An ACO participant is defined at 42 CFR §425.20 as an individual or group of ACO providers/suppliers that is identified by a Medicare-enrolled tax ID number (TIN), that alone or together with one or more other ACO participants comprises the ACO, and that is included on the list of ACO participants required to be submitted as part of the application. This list of ACO participants is also to be updated at the start of each performance year and at other times as specified by CMS.*

The Medicare Shared Savings Program uses ACO participant billing TINs (in addition to CCNs in the case of FQHCs, RHCs, and Method II critical access hospitals) as the basis for establishing eligibility, assignment of beneficiaries, computation of the benchmark, and quality assessment.

As part of its application, the ACO will be required to submit a list of ACO participants. Examples of ACO participants are: a group practice, an acute care hospital, a pharmacy, a solo practice, a federally qualified health center, a critical access hospital, a rural health center, and other entities that are Medicare-enrolled and bill Medicare for services though a Medicare-enrolled TIN.

Q: Who is an ACO provider/supplier?

A: *An ACO provider/supplier is an individual or entity that is a provider or supplier enrolled in Medicare, bills for items and services under an ACO participant tax ID number (TIN), and is included on the list of ACO participants required to be submitted as part of the application and updated as required by CMS. For example, a large group practice may qualify as an ACO participant. A Medicare enrolled physician billing under the practice's TIN would be an ACO provider/supplier.*

Q: When should I include CCN information on the ACO Participant List, and why is this important?

A: *You must include the CMS Certification Number (CCN) information if the ACO participant is a federally qualified health center (FQHC), rural health center (RHC) or Method II Critical Access Hospital (Method II CAH). We use the CCN to identify primary care service claims submitted by those types of providers when*

assigning beneficiaries to your ACO (for all other types of providers, we use the tax ID number (TIN) to identify those claims.)

Q: Will I have to identify the NPIs of ACO providers/suppliers billing under my ACO participants?

A: *You must include the National Provider Identifier (NPI) information for physicians who directly provide patient primary care services in an FQHC or RHC on the ACO Participant List submitted as part of your application. By including the NPI information for these physicians, you attest that the individual NPIs are physicians who directly provide patient primary care services in the FQHC or RHC as required under 42 CFR §425.404. We use this information to identify the pool of eligible beneficiaries for assignment, although all NPIs under the FQHC or RHC CMS Certification Number (CCN) are part of the ACO as ACO providers/suppliers.*

In the application, you will not have to identify any NPIs on the ACO Participant List for physicians who do not provide primary care services under an FQHC or RHC. However, if we accept your application to the Medicare Shared Savings Program we will identify all the Medicare enrolled providers and suppliers associated with your ACO participants using the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). All ACO providers/suppliers billing under an ACO participant tax ID number (TIN) are a part of the ACO. Once we identify the providers and suppliers associated with your ACO participants, we will send you a list of those NPIs for your review. You should note any corrections to the list, certify the accuracy of the list (as corrected, if necessary), and return the certified list to CMS.

It is important that all your ACO participants and ACO providers/suppliers verify that their PECOS enrollment is up to date. Your ACO participants, and the ACO providers/suppliers billing under those TINs must update their own enrollment information in PECOS. Instructions are available through the CMS Web site at https://pecos.cms.hhs.gov/pecos/login.do.

Q: What is the purpose of the ACO Participant List?

A: *The Participant List is the official list of the ACO participants in your ACO. We use this list: (1) to identify and screen the ACO participants, (2) to identify and screen all ACO providers/suppliers associated with the ACO participants' tax ID numbers (TINs) submitted (and CCNs, as appropriate), and (3) as a way for applicants that include FQHC/RHC participants to meet the attestation requirement under 42 CFR §425.404. Such applicants are required to attest that the individual NPIs included in Column I of the Participant List template are physicians who directly provide patient primary care services in the FQHC or RHC.*

We also use this information to identify the beneficiaries for preliminary prospective and final retrospective assignment. (For more information about beneficiary assignment, see this CMS factsheet.)

Q: How do I add/remove ACO participants to/from my ACO Participant List?

A: *During the application period, you will have limited opportunities to add or remove ACO participants to or from this list. Once the ACO agreement period begins, pursuant to 42 C.F.R. §425.304(d), the ACO must maintain, update, and annually furnish the list to CMS at the beginning of each performance year and at other such times as specified by CMS. Consistent with this requirement, you must notify CMS of any changes to the ACO Participant List within 30 days of such a change.*

Q: According to guidance issued by CMS, under certain circumstances merged TINs can be included on the ACO Participant List in order to help create an accurate benchmark for our ACO. What constitutes "supporting documentation" demonstrating that TINs were acquired by an ACO participant?

A: *"Supporting documentation" is any documentation that demonstrates to us that the TIN is newly acquired (e.g. merger agreement, bill of sale, etc.) and meets the other requirements outlined in the guidance.*

Form CMS-588 Electronic Funds Transfer (EFT)

Q. We already receive Electronic Funds Transfer (EFT) payments from Medicare. Do we need to submit a new Form CMS-588 *Electronic Funds Transfer (EFT) Authorization Agreement* or can we use our existing Form CMS-588?

A. *Yes. Please submit a new Form CMS-588 to participate in the Shared Savings Program.*

Q. Will the Form CMS-588 jeopardize or cause issues with our current method for receiving Medicare reimbursement?

A. *No. It will not affect your existing Medicare payments.*

Q. If we already have a Form CMS-588 on file with Medicare, should we check the "New EFT" box at the top or leave it blank?

A. *This will always be a 'New EFT' payment used only for Shared Savings Program payments. Payments for the Shared Savings Program will be made through a different payment system than that used for other Medicare payments and will have no effect on EFTs set up for other Medicare payments.*

Q. We are applying for BOTH the Shared Savings and the Advance Payment ACO model. Do we need two separate Forms CMS-588?

A. *No. You do not have to submit an additional Form CMS-588 for advance payments if you are using the same account to receive shared savings. In your Advance Payment ACO model application, specify that you will use the banking information provided in your Shared Savings Program application.*

Q. Does the bank account have to be set up under the ACO TIN and ACO legal name? Can it be a bank account set up under one of the ACO provider members' TIN and legal name?

A. *The banking information must be associated with the ACO's TIN/EIN, not one of the participants TINs. Shared savings payments can be made to a parent or chain organization, or under a DBA ('doing business as') name if this information is clearly stated in the Form CMS-588.*

Q. The Form CMS-588 has a line for a National Provider Identifier (NPI.) We are an ACO. Do we need an NPI for this form to be complete?

A. *No. You do not need an NPI to complete the Form CMS-588 for the Shared Savings Program.*

Q. When filling out the Form CMS-588, it says that the signer must be one of the 'designated persons' from the Form CMS-855. What is the proper 855 form for an ACO to file?

A. *You do not need to complete a Form CMS-855. This form is used in the provider enrollment process, and it does not apply to the payment of ACOs in the Shared Savings Program.*

Q. Who is an acceptable person to sign as the Authorized Official? The instructions state that the person must be the same person listed as the Authorized Official on the Form 855 (provider Medicare enrollment file). Would the CFO or CEO of our ACO be ok? They are identified in our ACO application.

A. *Either the CFO or the CEO may sign the form as the authorized official as long as they have the authority to legally bind the ACO and are identified by their title in the Form CMS-588.*

Q. Can we change the banking institution and account information at a later time?

A. *Yes, you may make changes at a later time. Please contact us immediately and submit a new Form CMS-588 with the updated information.*

Q. Can we submit a bank letter in lieu of a cancelled check?

A. *Yes, you may submit a bank letter in lieu of a canceled check. In fact, using a bank letter for account verification is encouraged. The bank letter needs to contain the ACO name, the account number and the routing number, all of which need to match the information entered in the Form CMS-588. The bank letter should be on the bank's letterhead and needs to be signed by a bank official.*

Q. Should the Form CMS-588 be mailed to the Medicare contractor in our area?

A. *No. The Form CMS-588 must be signed and sent to CMS Central Office in Baltimore. You must send the form via tracked mail, Federal Express or United Parcel Service to:*

Centers for Medicare &Medicaid Services
7500 Security Boulevard
OFM/FSG/DFSE, Mail Stop: N3-04-07
Baltimore, MD 21244-1850
Attention: Ed Berends

Governing Body

Q. What positions do we need to name for committees (e.g. chair, secretary, etc.)? Are there any guidelines concerning the number of members on a committee?

A. *Provided the requirements of 42 CFR 425.106 are met, the ACO has the flexibility to set up the governing body that best suits its needs. We have no requirements regarding specific board positions or the number of committee members.*

Q. How should we describe the "roles" of ACO committee members and the "structure" of ACO Committees? Do you mean that we should indicate who will be chairs and/or co-chairs of the

committees? Do you want us to describe members' current positions or roles within the ACO? Do you expect there to be sub-committees of committees? Is that what's meant by "structure"?

A. *Use the template provided to submit the names, titles and responsibilities for all members of the ACO's Governance Body. This template is not for any other committees the ACO has in its governance structure.*

1. *Name – First & Last*

2. *Member Position/Title – the title the member has on the governance body (e.g., Chair, President, Secretary, Treasurer, etc.)*

3. *Member's Voting Power – the number of votes the member has. Example: 1, 2, 3. Enter a 0 for nonvoting members.*

4. *Membership Type – ACO Participant Representative, Medicare Beneficiary Representative, Community Stakeholder Representative or Other (describe.) (Other could refer to any community organization members you may include on your Governing Body.)*

5. *ACO Participant TIN Legal Name – (For ACO Participant Representative only. Enter N/A for Medicare Beneficiary or Community Stakeholder Representative.) For members that are ACO participants use the legal name that appears on your "ACO Participant List".*

Q. Do I need to submit all the names for each committee member at the time of application or can I simply list a description of the types of individuals who will make up each committee?

A. *You must submit the name of a key leadership member for each committee within your organization. For example, a key member of a committee could be the chairman of the committee.*

Q. Would we meet the requirement for having a Medicare beneficiary on the governing body by including a beneficiary on the Advisory Board of the ACO?

A. *If the Advisory Board satisfies the requirements for the ACO governing body, then having a beneficiary on the Advisory Board would meet the requirement to include a Medicare beneficiary on the governing board.*

If the Advisory Board does not meet the requirements of the ACO governing body, then you should check "NO" and explain how you are providing for meaningful representation in ACO governance by including beneficiaries on the Advisory Board.

Q. Are non-board members of the ACO prohibited from serving as committee members or committee chairpersons? For example, the chairperson of the Finance Committee is not an ACO Governing Board member.

A. *No, we do not prohibit non-governing board members from participating on other ACO committees and they can serve as committee members and/or chairs.*

Q. Can the compliance officer and quality control person be the same person?

A. *We believe the compliance officer and healthcare professional responsible for the ACO's quality assurance and improvement program have different roles and responsibilities; accordingly, it may be*

difficult to find a single person who is qualified to fill both positions. However, the regulations do not require these roles to be filled by two different people.

Q. I know that an ACO must have a "qualified healthcare professional" responsible for the ACO's quality assurance and improvement program." Must that person be a physician?

A. *There is no requirement that the healthcare professional responsible for the ACO's quality assurance and improvement program be a physician; however, the ACO must have a qualified healthcare professional filling this role.*