MEDICARE SHARED SAVINGS PROGRAM

MEDICARE SHARED SAVINGS PROGRAM Initial Application | Agreement Period Beginning on July 1, 2019 or January 1, 2020

Please refer to the Application Toolkit for instructions and eligibility requirements for completing this application.

PAPER APPLICATIONS ARE NOT ACCEPTED. USE THIS DOCUMENT TO PREPARE YOUR RESPONSES. SUBMIT YOUR APPLICATION ONLINE VIA THE ACO MANAGEMENT SYSTEM (ACO-MS).

SECTION 1 – ACO LEGAL ENTITY INFORMATION

Review and update your ACO information in ACO-MS. Some information in this section is pre-populated.

Confirm ACO Legal Entity Information

1. Confirm the following information from your Notice of Intent to Apply (NOIA):

   - ☐ Legal entity name
   - ☐ Trade name/doing business as (DBA) name
   - ☐ Mailing address
   - ☐ Relationship to Medicare Shared Savings Program (Shared Savings Program)
     - New Applicant (including previously withdrawn or denied applicants)
     - Re-entering Shared Savings Program ACO Applicant
       1. Is the same legal entity as an ACO that previously participated in the program and is applying to participate in the program after a break in participation, because it is either an ACO whose participation agreement expired without having been renewed; or an ACO whose participation agreement was terminated under § 425.218 or § 425.220.
       2. Is a new legal entity that has never participated in the Shared Savings Program, and more than 50 percent of its ACO participants were included on the ACO participant list under § 425.118 of the same ACO in any of the 5 most recent performance years prior to the agreement start date.
   - ☐ Taxpayer identification number (TIN)
   - ☐ Date of formation
   - ☐ Legal entity type (i.e., sole proprietorship, partnership, publicly-traded corporation, privately-held corporation, limited liability company, or other)
   - ☐ Tax status (i.e., for-profit or not-for-profit)
   - ☐ Management company or parent company (if the ACO is owned or operated by a management company or parent company, specify who)

2. Was the ACO newly formed after March 23, 2010, as specified in § 425.202(a)(3)? An ACO is not newly formed if it is comprised solely of providers and suppliers that signed or jointly negotiated any contracts with a private payer(s), on or before March 23, 2010. If the ACO includes any providers or suppliers that were not part of the prior joint negotiation or joint contracting, it is newly formed.

   - ☐ Yes
   - ☐ No

   If you answer **Yes**, you understand and agree that CMS will share a copy of your application (including all information and documents submitted with the application) with the Federal Trade Commission (FTC) and the Antitrust Division of the Department of Justice (DOJ).

ACO Public Reporting Webpage

3. Provide the address of your ACO's public reporting webpage, as required under § 425.308. If your ACO's public reporting webpage is not operational at the time of application submission, describe your ACO's plan for ensuring that the webpage is operational and in full compliance with program requirements by July 1, 2019 (for a July 1, 2019 start date) or January 1, 2020 (for a January 1, 2020 start date).

Banking Information

4. You must establish a relationship with a banking partner that meets the Internal Revenue Service (IRS) requirements (bank, insurance company, or other entity) as set out in the Treasury Regulation sections 1.408-2(e)(2) through (e)(5)(viii)(F). This checking account must be associated with the legal entity name and TIN designated for the ACO. Shared savings, if earned, will be deposited directly into the account you indicate.

    a. Complete the Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588). Use the ACO Banking Form Guidance to help you complete the form.

    b. Send your completed Form CMS-588, with an original authorized signature and a voided check using tracked mail, such as United States Postal Service certified mail, Federal Express, or United Parcel Service, to:

> Centers for Medicare & Medicaid Services
> Attention: Carrie Sena
> 7500 Security Blvd.
> Mail Stop C5-15-12
> Location C5-16-05
> Baltimore, MD 21244-1850

The EFT Authorization Agreement is a required part of your ACO's application. We will not consider your application complete until we receive this completed form.

Organization Contacts

5. Review and update information on your ACO's contacts in ACO-MS: name, title, mailing address, phone number, and email address. Some information in this section is pre-populated.

Required contacts:

- ☐ ACO Executive
- ☐ CMS Liaison
- ☐ Application Contact (primary)
- ☐ Information Technology (IT) Contact (primary)
- ☐ Financial Contact
- ☐ Compliance Contact
- ☐ Authorized to Sign (primary)
- ☐ Data Use Agreement (DUA) Requestor
- ☐ DUA Custodian
- ☐ Medical Director

Additional required contacts (not required for application submission, but must be entered before the first day of the first performance year):

- ☐ Authorized to Sign (secondary)
- ☐ Quality Contact (primary and secondary)
- ☐ Marketing Contact (primary and secondary)
- ☐ Public Contact

Optional contacts:

- ☐ Application Contact (secondary)
- ☐ Information Technology (IT) Contact (secondary)

SECTION 2 – PROGRAM PARTICIPATION

6. Select a Shared Savings Program track and, if applicable, payment model. (Note: You should ensure your ACO is eligible for the track (and, if applicable, the payment model) selected based on the program requirements specified in 42 C.F.R. Part 425. CMS will also verify the ACO's eligibility to participate in the track and, if applicable, payment model selected.):

   BASIC track:

   - ☐ Level A of the BASIC track (one-sided model)
   - ☐ Level B of the BASIC track (one-sided model)
   - ☐ Level C of the BASIC track (two-sided model)
   - ☐ Level D of the BASIC track (two-sided model)
   - ☐ Level E of the BASIC track (two-sided model)

   ENHANCED track:

   - ☐ ENHANCED track (two-sided model)

7. Indicate your ACO's symmetrical minimum savings rate (MSR)/minimum loss rate (MLR):

   - ☐ 0.0% MSR/MLR
   - ☐ 0.5% MSR/MLR
   - ☐ 1.0% MSR/MLR
   - ☐ 1.5% MSR/MLR
   - ☐ 2.0% MSR/MLR
   - ☐ Symmetrical MSR/MLR (based on the number of beneficiaries assigned to your ACO)

8. Select a beneficiary assignment methodology:

   - ☐ Prospective assignment
   - ☐ Preliminary prospective assignment with retrospective reconciliation

   ACOs may elect to change their beneficiary assignment methodology selection prior to the start of each performance year.

Repayment Mechanism

Information on a repayment mechanism is only applicable to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track).

9. Select the repayment mechanism(s) that your ACO intends to use to repay CMS for any losses owed:

   - ☐ Funds placed in escrow
   - ☐ Surety bond
   - ☐ A line of credit that the Medicare program can draw upon, as evidenced by a letter of credit

   Upload a draft repayment mechanism.

Skilled Nursing Facility (SNF) 3-Day Rule Waiver

Information on the SNF 3-Day Rule Waiver is only applicable to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track).

10.1. Is your ACO electing to apply for a Skilled Nursing Facility (SNF) 3-Day Rule Waiver?

   - ☐ Yes
   - ☐ No

   If you select **Yes**, you must complete a separate SNF 3-Day Rule Waiver application in addition to this application.

Beneficiary Incentive Program

Information on the Beneficiary Incentive Program is applicable only to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track).

10.2. Does your ACO intend to establish a Beneficiary Incentive Program as described in § 425.304(c)?

- ☐ Yes
- ☐ No

If you select **Yes**, you must complete a separate Beneficiary Incentive Program application in addition to this application.

SECTION 3 – LEADERSHIP AND GOVERNANCE

11. Provide a brief overview of your ACO's history, mission, and organization, including your ACO's affiliations.

12. If your ACO has participated in the Shared Savings Program in the past, has your ACO (check all that apply):

- ☐ Failed to meet the Shared Savings Program quality performance standard for two or more years
- ☐ Failed to timely repay shared losses
- ☐ Generated losses outside its negative corridor for two or more years
- ☐ Voluntary or involuntarily terminated from the Shared Savings Program
- ☐ None of the above

Provide a narrative for each selection above (with the exception of the “None of the above” selection) that demonstrates your ACO has corrected the deficiencies that caused any noncompliance, and how it will remain in compliance with the terms of the new participation agreement.

13. I certify that my ACO is a legal entity that meets the requirements of 42 CFR § 425.104.

- ☐ Yes

By selecting "Yes" to question 13, I certify that my ACO legal entity can:

a. Receive and distribute shared savings;
b. Repay shared losses or other monies determined to be owed to CMS;
c. Establish, report, and ensure provider compliance with health care quality criteria, including quality performance standards; and
d. Fulfill other ACO functions identified in 42 CFR part 425.

14. Submit an organizational chart for your ACO.

ACO Governing Body

15. I certify that my ACO has an identifiable governing body with ultimate authority to execute the functions of the ACO as defined in the Shared Savings Program regulations at 42 CFR part 425.

- ☐ Yes

By selecting "Yes," I certify that:

a. The governing body is the same as the governing body of the legal entity that is the ACO;
b. The governing body is separate and unique to the ACO and is not the same as the governing body of any ACO participant in the case of an ACO that comprises two or more ACO participants;
c. The governing body has responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO’s activities as described in 42 CFR part 425;
d. The governing body has a transparent governing process;
e. The governing body members have a fiduciary duty to the ACO, including the duty of loyalty, and must act consistent with that fiduciary duty.

16. Do any other individuals or entities have input into decisions made by your ACO's governing body (e.g., management company or parent company)?

    ☐ Yes
    ☐ No

    If you answered **Yes**, please describe the entity that has input or influence on decisions made by your ACO's governing body, the input/influence they have, and how your ACO plans to ensure compliance with rules related to governing body.

17. I certify that my ACO's leadership and management meet the requirements of the Shared Savings Program at 42 CFR § 425.108.

    ☐ Yes

18. I certify that my ACO has established a mechanism for shared governance among the ACO participants that formed the ACO and that my ACO provides for meaningful participation in the composition and control of the ACO's governing body for ACO participants or their designated representatives.

    ☐ Yes

19. Enter your ACO's governing body members in ACO-MS. Include:

    a. All governing body members (include first and last name)
    b. Title/position
    c. Voting power (Enter voting power as either a number or percentage (not both). Enter "0" for non-voting members.)
    d. Membership type (i.e., ACO Participant Representative, Medicare Beneficiary Representative, Community Stakeholder Representative, Other)
    e. ACO participant TIN legal business name (For ACO participant representatives, type the ACO participant taxpayer identification number (TIN) legal business name as it appears on the ACO Participant List, including any name extensions (e.g., LLC, Incorporated, M.D., P.A., etc.). Do not include the ACO participant TIN's DBA name. For Medicare FFS Beneficiary and Community Stakeholder Representatives, type N/A.)

20. Do your ACO participants have at least 75 percent control of your ACO's governing body?

    ☐ Yes
    ☐ No

20.1. If you answered **No**, submit a narrative explaining why you seek to differ from this requirement and how your ACO will involve ACO participants in innovative ways in ACO governance.

21. Does your governing body include at least one Medicare fee-for-service beneficiary who is served by the ACO, is not an ACO provider/supplier, does not have a conflict of interest with your ACO, and has no immediate family members with a conflict of interest with your ACO?

    ☐ Yes
    ☐ No

21.1. If you answered **No**, submit a narrative explaining why you seek to differ from this requirement and how your ACO will provide for meaningful representation of Medicare fee-for-service beneficiaries in ACO governance.

22. I certify that my ACO's governing body has a conflict of interest policy that applies to members of the governing body. The conflict of interest policy:

    a. Requires each member of the governing body to disclose relevant financial interests;
    b. Provides a procedure to determine whether a conflict of interest exists, and sets forth a process to address any conflicts that arise; and
    c. Addresses remedial action for members of the governing body that fail to comply with the policy.

    ☐ Yes

23. I certify that my ACO has a compliance plan that includes at least the following elements:

    a. A designated compliance official or individual who is not legal counsel to my ACO who reports directly to the ACO's governing body;
    b. Mechanisms for identifying and addressing compliance problems related to my ACO's operations and performance;
    c. A method for employees or contractors of my ACO, ACO participants, ACO providers/suppliers, or for other entities performing functions or services related to ACO activities, to anonymously report suspected problems related to my ACO to the compliance officer;
    d. Compliance training for my ACO, ACO participants, and ACO providers/suppliers; and
    e. A requirement for my ACO to report probable violations of law to an appropriate law enforcement agency.

    ☐ Yes

    A compliance plan is not required to be submitted with your application; however, it must be made available to CMS upon request at any time.

SECTION 4 – ACO PARTICIPANT LIST AND AGREEMENTS

24. If your ACO is formed by two or more ACO participants, each of which is identified by a unique TIN, do you certify that your ACO legal entity is different from the legal entity of any of the ACO participants?

    ☐ Yes
    ☐ No
    ☐ N/A

25. If your ACO is formed by only one ACO participant, is the ACO legal entity, as identified by the TIN, the same as the ACO participant's legal entity?

    ☐ Yes
    ☐ No
    ☐ N/A

    If you answer **Yes**, you are certifying that you understand that your ACO will not be eligible to add ACO participants to its ACO Participant List in subsequent performance years, assuming the ACO legal entity and the ACO participant's legal entity remain the same. Any changes to this ACO structure would need to be reviewed and approved by CMS.

    If you answer **No**, you are certifying that you understand that your ACO will be eligible to add ACO participants to its ACO Participant List in subsequent performance years.

26. If your ACO providers/suppliers are employed by the ACO legal entity, are they required to participate in the Shared Savings Program as a condition of employment?

    ☐ Yes
    ☐ No
    ☐ N/A

26.1. I attest that if accepted into the program, my ACO will notify each of the ACO provider/supplier(s) employed by the ACO of their participation in the Shared Savings Program.

    ☐ Yes

26.2. If you answered **Yes**, submit a sample employment agreement.

27. Upload a sample ACO Participant Agreement and complete the ACO Participant Agreement table in ACO-MS.

28. Submit evidence of a signed ACO Participant Agreement for each ACO participant (TIN) entered on your ACO Participant List, which is signed on behalf of the ACO and the ACO participant by individuals who are authorized to bind the ACO and the ACO participant, respectively. Evidence of a signed ACO Participant Agreement means the first and signature page of the agreement.

    You must submit a list of ACO participants in ACO-MS. An ACO participant means an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants that is required under § 425.118. DO NOT submit any ACO participants that have not signed an ACO Participant Agreement with the ACO.

29. I certify that each ACO participant and each ACO provider/supplier has demonstrated a meaningful commitment to the mission of the ACO to ensure the ACO's likely success.

    ☐ Yes

30. I certify that my ACO Participant or ACO Provider/Supplier Agreement(s) do not include language requiring Medicare referrals to ACO participants or their associated ACO providers/suppliers or to any other provider or supplier, except under the specific and limited circumstances expressly permitted by the regulations.

    ☐ Yes
    ☐ N/A

SECTION 5 – CERTIFICATIONS

ACO's Legal Entity

31. I certify that my ACO has available all documents (e.g., charters, by-laws, articles of incorporation, etc.) that effectuate the formation and provide for the continuing operation of the ACO.

    ☐ Yes

Data Sharing

32. I certify that I am requesting the following minimum necessary data:

For ACOs Electing Preliminarily Prospective Assignment with Retrospective Reconciliation

The name, date of birth, sex, and Health Insurance Claim Number (HICN) of beneficiaries who are preliminarily prospectively assigned and beneficiaries who have received a primary care service during the previous 12 months from an ACO participant that submits claims for primary care services used to determine the ACO's assigned population.

Information in the following categories for beneficiaries that are preliminarily prospectively assigned:

a. Demographic data
b. Health status information
c. Utilization rates
d. Expenditure information

For ACOs Electing Prospective Assignment

The name, date of birth, sex, and HICN of beneficiaries who are prospectively assigned to the ACO.

Information in the following categories for beneficiaries who are prospectively assigned:

a. Demographic data
b. Health status information
c. Utilization rates
d. Expenditure information

☐ Yes
☐ No

33. I certify that I am requesting beneficiary-identifiable Part A, B, and/or D claims data referenced in the Application Reference Manual.

    ☐ Yes
    ☐ No

    The Application Reference Manual provides further details on these data. If your ACO is approved to participate in the Shared Savings Program, your ACO will be required to submit a Data Use Agreement (DUA) prior to receiving any data.

34. I certify my ACO is requesting information as described in Q32 and Q33 as a HIPAA-covered entity or as a business associate of a HIPAA-covered entity and that the requested data reflects the minimum data necessary for my ACO to conduct its own health care operations or the health care operations of its covered entity ACO participants and ACO providers/suppliers.

    ☐ Yes
    ☐ N/A (ACO has selected "No" for both question 32 and question 33.)

35. I certify that my ACO has documentation demonstrating the following:

    a. How the ACO will ensure privacy and security of data
    b. How the ACO intends to use these data:
        - To evaluate the performance of ACO participants and ACO providers/suppliers;
        - To conduct quality assessment and improvement activities; and
        - To conduct population-based activities to improve the health of the ACO's assigned beneficiary population.

    ☐ Yes
    ☐ N/A (ACO has selected "No" for both question 32 and question 33.)

    By selecting "Yes" to either question 32 or question 33, you acknowledge that if your ACO is approved to participate in the Shared Savings Program, your ACO will be required to submit a DUA prior to receiving any data.

ACO's Leadership and Management

36. I certify that my ACO's operations are managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body, and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes, and outcomes.

    ☐ Yes

37. I certify that my ACO's clinical management and oversight are managed by a senior-level medical director, who is a board-certified physician and licensed in a state in which the ACO operates, and who is physically present on a regular basis at any clinic, office, or other location of the ACO, an ACO participant, or an ACO provider/supplier.

    ☐ Yes

Managing Shared Savings

38. I certify that my ACO has a mechanism and plan to receive and use shared savings payments that includes:

    a. A description of how the ACO intends to share savings with ACO participants and ACO providers/suppliers or to use the shared savings to reinvest in the ACO's infrastructure, redesigning care processes, etc.; and

    b. The percentage of savings my ACO intends to distribute as re-investment into the ACO's resources as described above. If my ACO intends to distribute shared savings among ACO participants and ACO providers/suppliers, a description of the criteria my ACO intends to use for distributing those payments.

    ☐ Yes

    Documentation of your ACO's plan for distribution of shared savings is not required to be submitted with your application; however, it must be made available to CMS upon request at any time.

Accountability for Beneficiaries

39. I certify that my ACO, ACO participants, and ACO providers/suppliers agree to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

    ☐ Yes

Quality Assurance and Improvement Program

40. I certify that my ACO has a qualified health care professional responsible for the ACO's quality assurance and improvement program that encompasses all four of the following processes:

    a. Promoting evidence-based medicine;

    b. Promoting beneficiary engagement;

    c. Reporting internally on quality and cost metrics; and

    d. Coordinating care.

    ☐ Yes

41. I certify that my ACO will require ACO participants and ACO providers/suppliers to comply with and implement a quality assurance and improvement program including, but not limited to, processes to promote evidence-based medicine, beneficiary engagement, coordination of care, and internal reporting on cost and quality. I understand that CMS can request documentation at any time describing how the ACO will implement the required processes and patient-centeredness criteria, including descriptions of the remedial processes and penalties (including the potential for expulsion) that will apply if an ACO participant or an ACO provider/supplier fails to comply with and implement these processes.

    ☐ Yes

Promoting Evidence Based Medicine

42. I certify that my ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine, including:

    a. Applying evidence-based medicine to diagnoses with significant potential for the ACO to achieve quality improvements, while taking into account the circumstances of individual beneficiaries; and

    b. Employing internal assessments of cost and quality of care to improve continuously the ACO's care practices.

    I understand that CMS can request documentation regarding this requirement at any time.

    ☐ Yes

Promoting Beneficiary Engagement

43. I certify that my ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement, including:

    a. Evaluating the health needs of the ACO's assigned beneficiary population (including consideration of diversity in its patient population) and developing a plan to address the needs of its population. This plan should include a description of how the ACO partners with community stakeholders to improve the health of its population;
    b. Communicating clinical knowledge/evidence-based medicine to beneficiaries in a way they can understand;
    c. Engaging beneficiaries in shared decision-making in ways that consider beneficiaries' unique needs, preferences, values, and priorities;
    d. Establishing written standards for beneficiary access and communication as well as a process for beneficiaries to access their medical records; and
    e. Using the internal assessments of this process to improve continuously the ACO's care practices.

    I understand that CMS can request documentation regarding this requirement at any time.

    ☐ Yes

Internal Reporting on Quality and Cost

44. I certify that my ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics that lets the ACO monitor, give feedback, and evaluate ACO participant and ACO provider/supplier performance. My ACO uses these results to improve care and service over time and will use the internal assessments of this process to improve continuously the ACO's care practices.

    I understand that CMS can request documentation regarding this requirement at any time.

    ☐ Yes

Promoting Coordination of Care

45. I certify that my ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes, including methods and processes to coordinate care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO). My ACO will use internal assessments of these processes to improve continuously the ACO's care practices. My ACO has a written plan to:

    a. Implement an individualized care program that promotes improved outcomes for, at a minimum, high-risk and multiple-chronic-condition patients;
    b. Identify additional target populations that would benefit from individualized care plans, which must take into account the community resources available to the individual beneficiary;
    c. Encourage and promote use of enabling technologies for improving care coordination for beneficiaries. Enabling technologies may include one or more of the following:
        - Electronic Health Records and other health IT tools;
        - Telehealth services, including remote patient monitoring;
        - Electronic exchange of health information;
        - Other electronic tools to engage beneficiaries in their area.
    d. Partner with long-term and post-acute care providers, both inside and outside of the ACO, to improve care coordination for assigned beneficiaries.

    I understand that CMS can request documentation regarding this requirement at any time.

    ☐ Yes

Promoting Evidence-Based Medicine

46. I certify that my ACO has defined, established, implemented, and will evaluate and periodically update its processes to promote evidence-based medicine and beneficiary engagement, internally report on quality and cost measures, and coordinate care, including remedial processes and penalties (including the potential for expulsion) that would apply for non-compliance as required under 42 CFR § 425.112. I certify that the ACO has adopted a focus on patient centeredness that is promoted by the governing body and integrated into practice by leadership and management working with the ACO's health care teams.

    ☐ Yes

SECTION 6 – CERTIFY YOUR APPLICATION

*CMS will not process your application if you do not complete this certification in ACO-MS. This page will appear at the end of your application. You certify your application when you select "I agree."

I have read the contents of this application. I certify that I am legally authorized to execute this document on behalf of the ACO. By my signature, I certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this application is not true, accurate, or complete, I agree to notify CMS of this fact immediately and to provide the relevant complete and corrected information. If my ACO is newly formed according to the definition in the Antitrust Policy Statement, I understand and agree that CMS will share the content of this application, including all information and documents submitted with this application, with the Federal Trade Commission and the Department of Justice.

    ☐ I agree