



# MEDICARE SHARED SAVINGS PROGRAM

## RENEWAL APPLICATION Performance Year 2017

PAPER APPLICATIONS ARE NOT ACCEPTED.

USE THIS DOCUMENT TO HELP YOU GET STARTED PREPARING YOUR RESPONSES. SUBMIT YOUR APPLICATION ONLINE.

Please see the [Application Toolkit](#)<sup>1</sup> for instructions on completing this application.

Note: If your currently approved legal entity has changed, you may not be able to apply as a renewing Medicare Shared Savings Program ACO. For example, if your ACO is transitioning from a single TIN ACO (comprised of one ACO participant) into an ACO that is comprised of multiple ACO participants, we consider your ACO a new entity. Accordingly, you must apply as a new Medicare Shared Savings Program applicant entering under a new agreement period for the January 1, 2017 start date per the instructions in the [NOIA Memo](#).

Information submitted in your Renewal Application is effective for your subsequent agreement period with CMS.

### SECTION 1 – ACO entity information

Review, update, and confirm your ACO legal entity information in HPMS. Some information in this section is pre-populated.

- ACO Trade Name/DBA (if applicable);
- ACO Mailing Address;
- ACO Composition;
- ACO Contacts; and
- ACO Public Reporting URL

### SECTION 2 – General information about your ACO

Information in this section is pre-populated in HPMS with your ACO data from your previous Agreement Period. Review this information for your next Agreement Period. Send CMS a request to change your ACO's information by following the instructions in the [Application Reference Manual](#).

#### I AM A:

- Renewing Medicare Shared Savings Program Applicant (Shared Savings Program ACO who will (or is scheduled to) complete a 3 year agreement period ending December 31, 2016)

ACO LEGAL ENTITY NAME: [pre-populated]

MEDICARE SHARED SAVINGS PROGRAM TRACK: (Select Only One Track)

- Track 1 (one-sided model: shared savings)
- Track 2 (two-sided model: shared savings/losses)
- Track 3 (two-sided model: shared savings/losses)
- Extend your first agreement period under Track 1 for a fourth performance year and participate under Track 2 (two-sided model: shared savings/losses) for your second agreement period
- Extend your first agreement period under Track 1 for a fourth performance year and participate under Track 3 (two-sided model: shared savings/losses) for your second agreement period

<sup>1</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/MSSP-Toolkit.html>

Please note, if you are currently participating under Track 1 and applying to extend your first agreement period under Track 1 for a fourth performance year and are deferring by one year your entrance into a second agreement period under a performance-based risk model (Track 2 or Track 3), you must submit this renewal application as a Track 2 or Track 3 ACO and meet all repayment mechanism requirements per 42 CFR 425.204. Note: See the [Application Reference Manual](#) for instructions.

### SKILLED NURSING FACILITY (SNF) 3-DAY WAIVER (For Track 3 only)

If you selected Track 3, will you be applying for the Skilled Nursing Facility 3-Day Waiver? §425.612

- Yes  
 No

**Note:**

1- If you select YES, you must complete a separate SNF 3-Day Waiver application in addition to this application.

2- If you chose to extend your first agreement period under Track 1 for a fourth performance year and chose to participate under Track 3 (two-sided model: shared savings/losses) for your second agreement period, you do not need to submit the SNF 3-Day Waiver Application at this time. See the Application Reference Manual for instructions.

ACO TAXPAYER IDENTIFICATION NUMBER (TIN): [pre-populated]

### DATE OF FORMATION

The date on the ACO Certificate of Incorporation or other formation documentation: [pre-populated]  
(DD/MM/YYYY)

### YOUR BUSINESS STRUCTURE: (Select One)

- |  |  |
|--|--|
| <input type="checkbox"/> Sole Proprietorship         | <input type="checkbox"/> Limited Liability Company                             |
| <input type="checkbox"/> Partnership                 | <input type="checkbox"/> Other (specify) <u>[pre-populated, if applicable]</u> |
| <input type="checkbox"/> Publicly-Traded Corporation |  |
| <input type="checkbox"/> Privately-Held Corporation  |  |

### YOUR TAX STATUS: (Select One)

- Not-for-profit  
 For profit

### REPAYMENT MECHANISM:

*\* Track 2 and Track 3 (Two-Sided Model: Shared Savings/Losses Only)*

The repayment mechanism must be capable of repaying an amount of shared losses equal to at least one (1) percent of total per capita Medicare Parts A and B fee-for-service expenditures for your assigned beneficiaries based on expenditures used to calculate the benchmark for the applicable agreement period, as estimated by CMS at the time of participation agreement renewal.

What repayment mechanism will you use to repay CMS for any losses owed to CMS?

Ways you may repay CMS are: (Check All That Apply)

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

## SECTION 3 – Tell us if your ACO meets the Antitrust Agencies’ definition of “newly formed”

### JOINTLY NEGOTIATED CONTRACTS WITH A PRIVATE PAYOR(S)

1. Is the ACO “newly formed”? An ACO is not “newly formed” if it is comprised solely of providers and suppliers who jointly negotiated or jointly signed any contracts with a private payor(s), on or before March 23, 2010. If the ACO includes any providers or suppliers who 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 we will share a copy of your renewal 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)

## SECTION 4 – Your ACO legal entity

- 2a. I certify that my ACO is a legal entity that meets the requirements of 42 CFR 425.104

YES

- 2b. Submit a narrative describing any substantive changes to your organization and/or affiliations since the approval of your initial application..

3. I certify that my ACO meets the governing body requirements under 42 CFR 425.106, including having a identifiable governing body with ultimate authority to execute the functions of your ACO as defined in the Medicare Shared Savings Program regulations at 42 CFR Part 425.

YES  NO

Note: If you seek to differ from this requirement above (42 CFR 425.106), submit a narrative explaining why and provide supporting documentation showing how your ACO provides for meaningful representation of Medicare fee-for-service beneficiaries in ACO governance. See the [Application Reference Manual](#) for upload instructions.

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

YES

5. Submit your ACO’s organizational chart showing the flow of responsibility. Include committees and the name of each committee member, as well as the senior administrative and clinical leaders of your ACO.
6. Submit your ACO’s governing body template.

## SECTION 5 –Managing your ACO’s shared savings

7. Select your symmetrical Minimum Loss Rate (MLR)/Minimum Savings Rate (MSR) for your 3-year agreement period (Select One)

Note: ACOs applying to renew under Track 1 must select N/A. ACOs applying to renew under Track 2 or Track 3 must select any other option.

- 0.0% MLR/MSR
- 0.5% MLR/MSR
- 1.0% MLR/MSR
- 1.5% MLR/MSR
- 2.0% MLR/MSR
- Symmetrical Variable MLR/MSR (based on the size of your ACO’s assigned population)
- N/A (Select this option if you are applying under Track 1)

### BANKING INFORMATION

8. I certify that my banking information on file with CMS for the Shared Savings Program is current.

YES  NO

Note: See the [Application Reference Manual](#) for instructions on contacting CMS to confirm what is currently on file for your ACO.

## SECTION 6 – Your ACO Participants

9. Submit your ACO Participant List and ACO Provider/Supplier List by confirming through HPMS.

Follow the instructions in the Toolkit to confirm the ACO participant Taxpayer Identification Numbers (TINs) that have agreed to continue participating in your ACO for the next agreement period, or to submit changes to your ACO participant TINs, including additions, deletions, and modifications to your currently approved ACO Participant List.

Note: See the [Application Reference Manual](#) for guidance on submitting your ACO Provider Supplier List (NPIs).

### MEANINGFUL COMMITMENT

10. I certify that each ACO participant and each ACO provider/supplier demonstrates a meaningful commitment to the mission of the ACO to ensure the ACO’s likely success.

YES

## EMPLOYMENT AGREEMENTS

11. I certify that my ACO is a single entity ACO (Scenario 2) and that the ACO participant TIN and the ACO legal entity TIN are the same number.

YES  NO

If you answered **YES**:

- You are attesting that if your participation agreement is renewed, you will notify each ACO provider/supplier of their participation in the Medicare Shared Savings Program.
- You must submit a copy of the employment agreement you have in place for ACO providers/suppliers that are employed by the ACO legal entity, and as a condition of employment, are required to participate in the Medicare Shared Savings Program.
- You must submit a sample ACO provider/supplier agreement you have in place for your ACO providers/suppliers that are not required as a condition of employment to participate in the Shared Savings Program.
- DO NOT complete questions 12 and 13.

If you answered **NO**, you are certifying that your ACO legal entity is separate and distinct from any of your ACO participants (e.g. Scenario 1 or 3). You must complete questions 12 and 13.

Note: See the [Application Reference Manual](#) for a description of Scenarios 1, 2 and 3.

## ACO PARTICIPANT AGREEMENT

12a. Submit a sample of the agreements you are currently using between the ACO and ACO participant Taxpayer Identification Number (TINs), ACO providers/suppliers, or other individuals and entities performing functions or services related to ACO activities. Your ACO Participant Agreement(s) must also comply with the requirements in the regulation and must not include language requiring Medicare referrals to ACO participants or their associated ACO provider/suppliers or to any other provider or supplier, except under the specific and limited circumstances expressly permitted by the regulations. All ACO providers/suppliers that have reassigned their billings to the TIN of an ACO participant must also agree to participate in the ACO and to comply with all applicable laws and regulations, including the regulations in 42 CFR Part 425.

12b. Submit the ACO Participant Agreement Template to identify the location of program requirements in your ACO Participant Agreement.

## EXECUTED ACO PARTICIPANT AGREEMENTS

13. Submit your ACO Participant Agreements for each ACO participant (TIN) you included on your ACO Participant List.

Follow the instructions in the Toolkit to submit the executed ACO Participant Agreement for each ACO participant (TIN) that agrees to continue participating in your next agreement period **and** each new ACO participant (TIN) that is being added for the new agreement period. The ACO Participant Agreements must be signed on behalf of the ACO and ACO participant by individuals who are authorized to bind the ACO and the ACO participant, respectively. Include the first page and signature page for each agreement. If you do not have an executed ACO Participant Agreement with the ACO participant, the ACO participant (TIN) cannot be included on your ACO Participant List. The ACO participant agreement with each ACO participant must include the following:

- a. An explicit requirement that the only parties to the agreement are the ACO and the ACO participant.
- b. The agreement must be signed on behalf of the ACO and the ACO participant by individuals who are authorized to bind the ACO and the ACO participant, respectively.
- c. An explicit requirement that the ACO's participant agrees, and ensures that each ACO providers/suppliers that bill through the TIN of the ACO participant agrees to participate in the Shared Savings Program, and will comply with the requirements and conditions of the Medicare Shared Savings Program and all other applicable laws and regulations (42 CFR Part 425), including, but not limited to, those specified at §425.208(b); federal criminal law, the False Claims Act, the anti-kickback statute, the civil monetary penalties law, and the physician self-referral law.

- d. The ACO participants' and ACO providers'/suppliers' rights and obligations in, and representation by the ACO, including without limitation, the quality reporting requirements (42 CFR Part 425), the beneficiary notification requirements (§425.312), and how participation in the Shared Savings Program affects the ability of the ACO participant and its ACO providers/suppliers to participate in other Medicare demonstration projects or programs that involve shared savings..
- e. How the opportunity to get shared savings or other financial arrangements will encourage ACO participants and ACO providers/suppliers to follow the quality assurance and improvement program and evidence-based clinical guidelines.
- f. An explicit requirement that the ACO participant must update its Medicare enrollment information, including the addition and deletion of ACO professionals and ACO provider/suppliers billing through the TIN of the ACO participant, on a timely basis in accordance with Medicare program requirements and to notify the ACO of any such changes within 30 days after the change.
- g. Remedial actions that will apply to ACO participants and remedial actions the ACO participant will take against its ACO providers/suppliers, including imposition of a corrective action plan, denial of incentive payments, and termination of the ACO participant agreement, to address non-compliance with the requirements of the Medicare Shared Savings Program and other program integrity issues, including those identified by CMS.
- h. The agreement must be for a term of at least one performance year and must articulate potential consequences for early termination from the ACO.
- i. An explicit requirement for completion of a close-out process upon termination or expiration of the agreement that requires the ACO participant to furnish all data necessary to complete the annual assessment of the ACO's quality of care and addresses other relevant matters.

Note: Please refer to [Application Reference Manual](#) for details about ACO Participant Agreement requirements.

## SECTION 7 – Tell us about data sharing

14a. I certify that my ACO is requesting the following minimum necessary data:

For **Tracks 1 and 2**

- The name, date of birth, sex and Health Insurance Claim Number (HICN) of beneficiaries who are preliminarily prospectively assigned and beneficiaries that 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:
  - demographic data
  - health status information
  - utilization rates
  - expenditure information

For **Tracks 3**

- The name, date of birth, sex and Health Insurance Claim Number (HICN) of beneficiaries who are prospectively assigned to the ACO.
- Information in the following categories for beneficiaries that are prospectively assigned:
  - demographic data
  - health status information
  - utilization rates
  - expenditure information

YES  NO

14b. You certify that you are requesting beneficiary-identifiable Part A, B and/or D claims data referenced in the Application Reference Manual

YES  NO

14c. If you answered **YES** in response to question 14a or 14b, you certify that you are requesting this information 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 your ACO to conduct your own healthcare operations or the healthcare operations of your covered entity ACO participants and ACO providers/suppliers:

YES  NO

14d. You are attesting that you will maintain your CMS approved method for ensuring the privacy and security of data and the same intended uses of this data that you described in the narrative submitted with your initial application.

YES  NO

If you answered No, you must submit a new narrative describing the following requirements in both a and b,;

- a. How you will ensure privacy and security of data
- b. How you intend to use this 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 your assigned beneficiary population.

Note: If you are approved to participate in the Medicare Shared Savings Program for a subsequent agreement period, you must submit a Data Use Agreement (DUA) extension prior to receiving any data for the subsequent program year.

## SECTION 8 – Required clinical processes and patient centeredness

### ACCOUNTABILITY FOR BENEFICIARIES

15. I certify that my ACO agrees to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

YES

### REQUIRED CLINICAL PROCESSES

16. 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 9 – Certify your application

*\* We will not process your application if you do not complete this certification in HPMS. This page will appear at the end of your application. Select "I agree", or "I disagree." 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 and to bind my ACO to comply with the applicable laws and regulations of the Medicare program. 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 correct and/or complete 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.