MEDICARE SHARED SAVINGS PROGRAM

Skilled Nursing Facility (SNF) 3-Day WAIVER APPLICATION Performance Year 2017

PAPER APPLICATIONS ARE NOT ACCEPTED.
USE THIS DOCUMENT TO HELP YOU GET STARTED PREPARING YOUR RESPONSES. SUBMIT YOUR APPLICATION ONLINE.

*This application is only applicable to ACO applicants applying to Track 3 or existing ACOs currently in Track 3.

Please see the Application Toolkit[1] for instructions on completing this application.

Section 1 – General

1. I certify that my ACO has the capacity to identify and manage beneficiaries who are either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than 3 days.
   ☐ Yes

Section 2 – Communication Plan

2. I certify that my ACO has (a) created and will implement a Communication Plan between the ACO and all of its SNF affiliates as required in the Medicare Shared Savings Program regulations at 42 CFR 425.612(a)(1)(i)(A)(*1*) and (b) that the Communication Plan includes the following:
   a. The process the ACO will use to evaluate and periodically update its Communication Plan with its SNF affiliates;
   b. How your ACO will identify and designate person(s) at the ACO with whom SNF affiliates will communicate and coordinate admissions;
   c. How each SNF affiliate will identify and designate person(s) at the SNF affiliate with whom your ACO will communicate and coordinate admissions, including monitoring SNF length of stay;
   d. How information will be shared across sites of care and made available to all members of the care team for optimal care integration, including identification of HIPAA-compliant communication tools that will be used by the care team to ensure that the designated person(s) at the ACO is (are) aware of admissions to SNF affiliates pursuant to the waiver and appropriately involved in the clinical management of the beneficiary, including a plan for communicating necessary information when key contacts are not available;
   e. How frequently communications will take place between the ACO and its SNF affiliates;
   f. How the ACO will communicate the Beneficiary Evaluation and Admission Plan and the Care Management Plan to the SNF affiliates and other individuals or entities responsible or involved in providing or coordinating services under the waiver.
   g. How the ACO will respond to questions and complaints related to the ACO's use of the SNF 3-day waiver from SNF affiliates, ACO participants, ACO providers/suppliers, beneficiaries, acute care hospitals, and other stakeholders.

   ☐ Yes

3. Submit your Communication Plan, approved by your ACO's governing body that addresses each of the requirements above.

[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/MSSP-Toolkit.html

Section 3 – Beneficiary Evaluation & Admission Plan

4. I certify that my ACO has established, and will evaluate and periodically update a Beneficiary Evaluation and Admission Plan for beneficiaries admitted to a SNF affiliate pursuant to the waiver that is approved by the ACO medical director and the healthcare professional responsible for the ACO's quality improvement and assurance processes under 425.112.

   ☐ Yes

5. I certify that the Beneficiary Evaluation and Admission Plan includes at least the following:
   a. A protocol for an ACO provider/supplier who is a physician to evaluate and approve admissions to a SNF affiliate pursuant to the waiver and consistent with the beneficiary eligibility requirements described at 425.612(a)(1)(ii);
   b. A protocol for educating and training SNF affiliates regarding waiver requirements and the ACO's Communications Plan, Beneficiary Evaluation & Admission Plan, and Care Management Plan for purposes of the SNF 3-Day Waiver;
   c. A protocol for admitting beneficiaries to a SNF directly from home or an outpatient setting under the waiver;
   d. A protocol for admitting beneficiaries to a SNF when it has been determined that the beneficiary does not need the full 3-day inpatient hospital stay;
   e. A protocol for informing beneficiaries about the waiver and their options for care settings;

   ☐ Yes

6. I certify that as part of the Beneficiary Evaluation & Admission Plan, a beneficiary eligibility review process will be implemented in order to ensure that each beneficiary who will receive covered SNF services under the waiver will meet the following requirements:
   a. Is prospectively assigned to my ACO for the performance year in which the beneficiary is admitted to the SNF affiliate;
   b. Does not reside in a SNF or other long-term care facility;
   c. Is medically stable;
   d. Does not require inpatient or further inpatient hospital evaluation or treatment;
   e. Has a certain and confirmed diagnosis;
   f. Has an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient;
   g. Has been evaluated and approved for admission to the SNF within 3 days prior to the SNF admission by an ACO provider/supplier in my ACO who is a physician, consistent with the Beneficiary Evaluation and Admission Plan.

   ☐ Yes

7. I certify that the ACO medical director and the healthcare professional responsible for the ACO's quality assurance and improvement program will be available to respond timely to inquiries related to the application of the SNF 3-Day Waiver, including the ACO's Beneficiary Evaluation and Admission Plan from ACO participants, ACO providers/suppliers, SNF affiliates, beneficiaries, and other stakeholders.

   ☐ Yes

8. Submit your ACO's Beneficiary Evaluation and Admission Plan, approved by the ACO medical director and the healthcare professional responsible for the ACO's quality improvement and assurance processes under 425.112, that includes the requirements above.

Section 4 – Care Management Plan

9. I certify that my ACO (a) will implement an individualized Care Management Plan for each beneficiary admitted to a SNF affiliate as required in the Medicare Shared Savings Program regulations at 42 CFR 425.612(a)(1)(i)(A)(2), and (b) that the Care Management Plan will:
   a. Designate the ACO provider/supplier responsible for initiating the admission and Care Management Plan;
   b. Designate a person from the SNF affiliate responsible for accepting the beneficiary and implementing the Care Management Plan;
   c. Contain a certification by the designated ACO provider/supplier and the designated person from the SNF affiliate that the beneficiary meets requirements to receive covered SNF services under the waiver, as described in 425.612(a)(1)(ii);
   d. Contain a plan for how the beneficiary's care will be managed at the SNF affiliate, including how the beneficiary's care will seamlessly transition upon discharge from the SNF affiliate to the beneficiary's primary care provider or other provider as determined by the care team and beneficiary;
   e. Ensure the provision of high quality and efficient care delivery (including facilitating optimum length of stay)
   f. Designate the aspects of the Communication Plan to be implemented by the providers and suppliers responsible for the beneficiary before, during and after the SNF admission.
   g. Contain contact information for the ACO's medical director and the health care professional responsible for the ACO's quality assurance and improvement program as resources to respond to inquiries about the Care Management Plan from the designated ACO provider/supplier, designated person from the SNF affiliate, beneficiary, and other stakeholders.

   ☐ Yes

10. Submit a sample of your ACO's Care Management Plan meeting the requirements above that will be individualized for each beneficiary admitted to a SNF affiliate under the waiver.

Section 5 – Financial Relationships

11. Submit a brief description of any financial relationships between your ACO, SNF affiliates, and any acute care hospitals.

Section 6 – SNF Affiliates

12. Submit a list of SNF affiliates with whom the ACO will partner. Please make sure to include the following:

    a. SNF Tax Identification Number (TIN)
    b. SNF Legal Business Name
    c. SNF CCN
    d. SNF CCN Legal Business Name
    e. Identify SNF's current star rating reported on CMS' Nursing Home Compare Website[2]

13. (a) Submit documentation demonstrating that each SNF affiliate has an overall quality rating of 3 or more stars under the CMS 5 Star Quality Rating System, as reported on the Nursing Home Compare Website.

    (b) I certify that each SNF affiliate has an overall quality rating of 3 or more stars under the CMS 5 Star Quality Rating System, as reported on the Nursing Home Compare Web site.

    ☐ Yes

14. Submit a sample of the SNF Affiliate Agreement your ACO uses.

[2] https://www.medicare.gov/nursinghomecompare/search.html

15. Submit the SNF Affiliate Agreement Template to identify where in your SNF affiliate agreement the required elements described at 425.612(a)(1)(iii)(B) can be found including, but not limited to, the following:
    - Agreement to comply with the requirements and conditions of the Medicare Shared Savings Program found at 42 C.F.R. Part 425, including but not limited to those specified in the participation agreement with CMS.
    - Effective dates of the SNF Affiliate Agreement
    - Agreement to implement and comply with the ACO's Beneficiary Evaluation and Admission Plan and the Care Management plan.
    - Agreement to validate the eligibility of the beneficiary to receive covered SNF services in accordance with the waiver prior to the admission of the beneficiary to the SNF affiliate.
    - Remedial processes and penalties that will apply for non-compliance.

16. Submit a signed SNF Affiliate Agreement for each SNF affiliate entered on your SNF Affiliate List which is signed by individuals authorized to sign on behalf of the ACO and SNF affiliate. Include the first page and signature page of each agreement. If you do not have an executed SNF Affiliate Agreement for the SNF affiliate, the SNF affiliate cannot be included on your SNF Affiliate List.

Section 7 – 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".*

17. 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 all applicable laws and regulations. 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.