MEDICARE SHARED SAVINGS PROGRAM

MEDICARE SHARED SAVINGS PROGRAM Beneficiary Incentive Program 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 – CERTIFY YOUR ACO TRACK

1. I certify that my ACO is participating under or applying to a Shared Savings Program two-sided risk model (Track 2, Track 3, Levels C, D, or E of the BASIC track, or the ENHANCED track).

   ☐ Yes

SECTION 2 – CERTIFY YOUR PERFORMANCE YEAR

2. I certify that, if this application is approved, my ACO will operate its beneficiary incentive program for an initial period of 18 months beginning on July 1, 2019, or 12 months beginning on January 1, 2020.

   ☐ Yes

   NOTE: For each consecutive year that your ACO wishes to operate its beneficiary incentive program after such initial period, your ACO must first certify the following by a deadline specified by CMS: (1) its intent to continue to operate the Beneficiary Incentive Program as approved by CMS for the entirety of the relevant performance year; and (2) that the Beneficiary Incentive Program meets all applicable requirements.

SECTION 3 – CERTIFY YOUR COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS

3. I certify that, if this application is approved, my ACO will operate its beneficiary incentive program in accordance with all applicable law, including Section 1899(m) of the Social Security Act, the Beneficiary Incentive Program requirements at 42 CFR § 425.304(c), and the public reporting requirements at 42 CFR § 425.308(b)(7).

   ☐ Yes

SECTION 4 – DESCRIBE YOUR PROPOSED BENEFICIARY INCENTIVE PROGRAM

4. Describe in writing the nature of your ACO's proposed beneficiary incentive program and how, if approved, your ACO will implement its beneficiary incentive program. The description must include the following:
   a. The value of each incentive payment that the ACO would issue for each qualifying service (up to $20 per qualifying service);
   b. The form of incentive payment (e.g., check, debit card, or specified traceable cash equivalent);
   c. How the ACO would notify ACO participants and assigned beneficiaries about the beneficiary incentive program;
   d. How the ACO would distribute incentive payments to beneficiaries (e.g., by mail, electronically, etc.);
   e. When incentive payments would be distributed and by whom;
   f. How the ACO would track whether a beneficiary is entitled to receive an incentive payment;
   g. How the ACO would track whether a beneficiary has been furnished an incentive payment; and
   h. How the ACO would maintain records related to the beneficiary incentive program in accordance with 42 CFR §§ 425.304(c)(4) and 425.314.

   Please note that, if your proposed beneficiary incentive program is approved, you will be required to implement such program in the manner described in the approved application. In addition, you will be unable to make a material change to your beneficiary incentive program as described in the approved application unless the material change has been approved by CMS under 42 CFR § 425.304(c)(2)(iii).

SECTION 5 – DESCRIBE YOUR COMPLIANCE PLAN

5. Describe whether and how your ACO will update the compliance plan maintained in accordance with 42 CFR § 425.300 to reflect regulatory compliance obligations under 42 CFR § 425.304 for Beneficiary Incentive Programs. If the ACO's compliance plan will not be updated at this time, specify why not.

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 submitting this application, 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.

☐ I agree