



Medicare Shared Savings Program

2017 Application Reference Manual

**(for use by Applicants Applying in Calendar Year 2016
for the 2017 Performance Year)**

June 2016

Version 3

Revision History

Version	Date	Revision/change description	Affected area
2	6/9/2016	Reference to CMS User ID request inquiries.	Sec. 2.5 ; Sec. 9.3 , Bullet 2
2	6/9/2016	Updated to reflect the Medicare Shared Savings Program ACO Revised Benchmark Rebasing Methodology final rule displayed June 6, 2016.	Appendix C – Renewal Application
3	7/12/2016	<ul style="list-style-type: none"> • Changed reference to SNF 3-Day Rule Waiver • Modified reference to employed and/or contracted practitioners (NPIs) billing through the ACO participant TIN • Added additional instructions for Section 5 – Financial Relationships. Removed supporting documents requirement from Appendix D, Section 4 - Care Management Plan 	<ul style="list-style-type: none"> • Appendix A, Sec. B- Organizational Structure Scenario Chart – For Initial Applicants • Appendix D-SNF 3-Day Rule Waiver Application: Sec. 4, Sec. 5

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DISCLAIMER

This manual was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents are provided within the document for your reference.

This manual was prepared as a service to the public and is not intended to grant rights or impose obligations. This manual contains references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

1.0 Introduction

The purpose of the Medicare Shared Savings Program (Shared Savings Program) Application Reference Manual is to guide Accountable Care Organizations (ACOs) through the Shared Savings Program application process for the January 1, 2017 program start date. This manual provides instructions and guidance on how to submit three types of applications:

1. **Initial Application:** Available for ACOs not currently participating in the Shared Savings Program (initial applicants).
2. **Renewal Application:** Available for currently participating ACOs with a 2014 start date that intend to renew their participation agreement with CMS (renewal applicants).
3. **Skilled Nursing Facility (SNF) 3-Day Waiver Application:** Available for initial and renewal applicants applying to the Shared Savings Program under Track 3; and, ACOs currently participating in the Shared Savings Program under Track 3. (Note: The SNF 3-Day Rule Waiver is only available to Track 3 ACOs.)

ACOs will submit their application(s) directly through the Centers for Medicare & Medicaid Services (CMS) Health Plan Management System ([HPMS](#)), the application system of record. This reference manual provides information on completing your application(s), submitting your application(s) through HPMS, responding to Requests For Information (RFI), next steps to either accept or decline participation (for approved applicants), instructions for requesting reconsideration (for denied applicants), links to program regulations and guidance, and lastly, who to contact for assistance.

Additionally, there are appendices at the end of this reference manual that provide ACO organization structure examples, detailed walk through of each application, how to submit documents, regulation references, and data elements for claims and claims line feed files. See the following appendices for further details:

- [Appendix A: Organization Structure](#)
- [Appendix B: Application Reference Table – For Initial Applicants](#)
- [Appendix C: Application Reference Table – For Renewal Applicants](#)
- [Appendix D: Application Reference Table – For SNF 3-Day Rule Waiver Applicants](#)
- [Appendix E: Data Elements - Claims and Claims Line Feed Files](#)

Renewal applicants will see reminders like the example below throughout this document to highlight important information specific to the renewal application.

Reminder for Renewals: Information in these boxes is specific to renewal applicants.
Read carefully.

2.0 Completing Your Application

All applicants (initial, renewal, and SNF 3-Day Rule Waiver) must first submit a Notice of Intent to Apply (NOIA) to the Shared Savings Program during the NOIA period. If you did not complete this first step by submitting a NOIA by the May 31, 2016 5:00 p.m. Eastern Time deadline, you may not apply for participation in the Shared Savings Program or for the SNF 3-Day Rule Waiver beginning January 1, 2017. If you missed the NOIA period for January 1, 2017, you may apply for January 1, 2018 during the NOIA submission period next year.

For applicants who submitted an Initial Application or a Renewal Application:

After your NOIA submission period, your last opportunity to change your Track to a two-sided risk model (Track 2 or Track 3) is in response to your first Request for Information (RFI-1). If you determine that you want to change to Track 3 and apply to the SNF 3-Day Rule Waiver after you receive RFI-1, you must notify us immediately. We will give you an opportunity to submit your SNF 3-Day Rule Waiver application with the same deadline as the response to RFI-1. Please be advised that while we are giving you this flexibility, this is your only opportunity to add all of your SNF Affiliates and we will not extend the due date. We encourage you to consider this option prior to submitting your application by July 29, 2016 by 5:00 p.m. Eastern Time, due to the limited opportunity to complete your SNF 3-Day Rule Waiver application in response to RFI-1. This does not apply to ACOs currently participating in the program under Track 3. ACOs currently participating in the program under Track 3 must submit their NOIA by the deadline. See [Application Cycle Deadlines](#).

2.1. Application Cycle Deadlines

Deadlines associated with the NOIA and application process are provided in this section and on our [How to Apply](#) web page. We will not accept late submissions.

Throughout the application review period, you will receive periodic notices and important information about the review of your application, deadlines, webinars and actions you are required to take. Notices are generally sent to your ACO Executive, Application (primary and secondary) contacts, and CMS Liaison (renewing ACOs only). Please monitor for notices sent via email from SSPACO_Applications@cms.hhs.gov. Please contact the information technology services within your company to make certain that this email address is not blocked or that it does not go into junk mail.

2.1.1. Notice of Intent to Apply Deadlines

Notice of Intent to Apply (NOIA) Process	Deadlines ¹
NOIA Memo Posted to CMS Website under Step 1 below (provides detailed information on the requirements for submitting a NOIA)	April 1, 2016
NOIA Submission Period	May 2, 2016 – May 31, 2016 "Closed"
NOIA Deadline	May 31, 2016, at 5:00 p.m. Eastern Time
CMS System User ID Forms Submission Period (new users only)	May 5, 2016 – June 3, 2016

2.1.2. Application Process Deadlines

Application Process	Deadlines ¹
2017 Application Form Posted to CMS Website (sample only for initial, renewal and Skilled Nursing Facility (SNF) 3-Day Waiver ² applications)	Spring 2016
Application Submission Period (for initial, renewal and SNF 3-Day Rule Waiver applications)	July 1, 2016 – July 29, 2016
Application Deadline (for initial, renewal and SNF 3-Day Rule Waiver applications)	July 29, 2016, at 5:00 p.m. Eastern Time
RFI-1 Response Due from Applicants RFI-1 will contain deficiencies found with your attestations, certifications, supporting documentation, ACO Participants, ACO Participant Agreements, SNF Affiliates and SNF Affiliate Agreements ² . It also will contain your ACO's estimated assigned beneficiary count for Initial and Renewal Applicants (not applicable to SNF 3-Day Waver Applicants). Actions you can to take: <ul style="list-style-type: none"> • Correct attestation responses and supporting documentation • Correct ACO Participant and SNF Affiliate Agreements • Final opportunity to change track selection to Track 2 or Track 3 (two-sided shared savings/losses model) • Final opportunity to Add ACO participants and SNF affiliates for the 2017 performance year. • Edit, withdraw, delete or modify ACO participants and SNF affiliates for the 2017 performance year. 	September 6, 2016 at 5:00 p.m. Eastern Time
Second Request for Information (RFI-2) Response Due from Applicants RFI-2 will contain deficiencies found with your attestations, certifications, supporting documentation, ACO Participants, ACO Participant Agreements, SNF Affiliates and SNF Affiliate Agreements. It will also contain your ACO's estimated assigned beneficiary count for Initial and Renewal Applicants (not applicable to SNF 3-Day Waver Applicants).	October 5, 2016 at 5:00 p.m. Eastern Time

<p>Actions you can take:</p> <ul style="list-style-type: none"> • Correct attestation responses and supporting documentation • Correct ACO Participant and SNF Affiliate Agreements • Withdraw, or delete ACO Participants and SNF Affiliates for the 2017 performance year. • You can no longer add ACO Participants or SNF Affiliates for the 2017 performance year. 	
<p>Third Request for Information (RFI-3)-Notice of Intent to Deny (NOID) Response Due from Applicants</p> <p>RFI-3-NOID will contain deficiencies found with your attestations, certifications, supporting documentation, ACO Participants, ACO Participant Agreements, SNF Affiliates and SNF Affiliate Agreements. It will also contain your ACO's estimated assigned beneficiary count for Initial and Renewal applicants (not applicable to SNF 3-Day Waiver Applicants).</p> <p>Actions you can take:</p> <ul style="list-style-type: none"> • Final opportunity to correct attestation responses and supporting documentation • Final opportunity to correct ACO Participant and SNF Affiliate Agreements • Final opportunity to withdraw or delete ACO Participants and SNF Affiliates for the 2017 performance year. 	<p>October 26, 2016 at 5:00 p.m. Eastern Time</p>
<p>ACO Participant List Evaluation and Final Estimated Assignment Notice and SNF Affiliate List Evaluation Notice</p> <p>This fourth notice contains the final results of your ACO Participant List and SNF Affiliate List and includes:</p> <ul style="list-style-type: none"> • Final estimated assigned beneficiary count for Initial and Renewal applicants (not applicable to SNF 3-Day Waiver Applicants). • ACO participants and SNF Affiliates that did not meet program requirements to be included in your ACO for the 2017 performance year. <p>There are no actions for ACOs to take in response to this notice.</p>	<p>Late November 2016</p>
<p>Application Approval or Denial Decision Sent to Applicants</p>	<p>Late Fall 2016</p>
<p>Reconsideration review deadline</p>	<p>15 Days from Notice of Denial</p>

¹ All deadline dates are subject to change.

² SNF Affiliate Lists and SNF Affiliate Agreements are associated with the SNF 3-Day Rule Waiver Application.

2.2. What is the Application Toolkit

The [Application Toolkit](#) web page contains materials to help you complete your application(s). It serves as a reference page for quick access to the Application Reference Manual (this document), forms, guidance, instructions and templates. Links to these documents are also available throughout this Application Reference Manual and in the appendices. The following materials are included in the [Application Toolkit](#):

- How to Complete Your Application
- Resources for Initial and Renewal Applicants
 - How to Complete Form CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement
 - How to Complete the Governing Body Template
 - How to Complete the ACO Participant List
 - How to Complete the ACO Participant Agreement Template
- Resources for SNF 3-Day Rule Waiver Applicants (Available to Track 3 ACOs only)
 - How to Complete the SNF Affiliate List
 - How to Complete the ACO SNF Affiliate Agreement Template
- Requests for Information
- Request to Withdraw a Pending Application
- Application Determination Reconsideration Review Process
- Who to Contact for Assistance

2.3. How to Use the Application Reference Tables in the Appendices

The Application Reference Tables, provided in the Appendices in this manual, are your step-by-step guides and organization structure examples to accurately complete each application question. Be sure to use the required templates, correct file format(s), naming conventions and the guidance referred to in these tables. A separate Application Reference Table is available for each application:

- [Appendix A Organization Structure](#)
- [Appendix B Application Reference Table - For Initial Applicants](#)
- [Appendix C Application Reference Table - For Renewal Applicants](#)
- [Appendix D Application Reference Table - For SNF 3-Day Rule Waiver Applicants](#)

2.4. When to Use your ACO ID

Once CMS processes your NOIA, we will issue you an ACO identification number (ACO ID). Your ACO ID is a five-character ID beginning with an “A” and proceeded by four- digits (e.g. A0001). We sent your ACO ID in the NOIA confirmation email (from SPPACO_Applications@cms.hhs.gov) to the individual your ACO designated as its Application Contact (primary) at the time of NOIA submission.

Your ACO ID must be included in all application materials and communications with CMS to process your request in a timely manner. It will not change and is used throughout the application process and, if your application is approved, will continue to be used throughout the ACO’s participation in the Shared Savings Program.

Reminder for Renewals: You will retain your existing ACO ID, which is also included in the NOIA confirmation email sent from SSPACO_Applications@cms.hhs.gov to your Application (primary and secondary) and ACO Executive contacts.

2.5. When to Use your CMS Issued User ID

ACO users who require access to CMS Systems must obtain a four-character CMS issued User ID. You must use your CMS issued User ID to access HPMS and submit your application. If we approve your ACO to participate in the program, you will also access other CMS systems to receive and transmit data to CMS throughout your agreement period. For additional guidance about obtaining and maintaining your CMS User ID, see the [HPMS User ID Process](#) web page. For additional guidance about CMS systems ACO Contacts will access, see [Section 10-Managing ACO Contacts](#). Please allow 2-3 weeks for processing time prior to submitting an inquiry for CMS User ID requests.

3.0 How to Submit Your Application in HPMS

You must submit your application electronically through [HPMS](#). Paper applications are not accepted. Use instructions in this section to submit attestation responses, upload supporting documentation and certify your application in the “SSP ACO Application Submission” module in HPMS.

Detailed instructions on how to use the “SSP ACO Application Submission” module will be made available in the “Medicare Shared Savings Program: Training on HPMS ACO Application” module webinar located on the [Shared Savings Program Applications Teleconferences and Events](#) web page.

Also, see the “2017 Accountable Care Organization (ACO) Quick Reference Guide” located in the “SSP ACO Application Submission” module, under the “ACO Module User Manual” section in HPMS. This guide provides users with high-level module functionality.

To submit your application, you will need the following:

- ACO ID
- User ID
- This Application Reference Manual, including Appendices
- Forms, guidance, instructions and templates referenced in this document and included in the [Application Toolkit](#).

You will log into [HPMS](#) to access the “SSP ACO Application Submission” module under the ACO Management drop down menu.

HPMS supports the following web browsers:

- Microsoft Internet Explorer version 9.0 or higher (for Windows)
- Mozilla Firefox (latest release) (for Windows and Mac)

We continue to work toward full support of the Safari (for Mac only) and Chrome (for Windows and Mac) web browsers. For additional questions concerning web browsers, screen resolutions, response design, and instructions for Mac users, please visit the HPMS [System Requirements](#) web page.

As you work through your application in HPMS, you may save your work as you go by clicking **Submit** on each page. You may also go back to your saved work and change any information. The **Submit** button is the equivalent to saving your information.

When you have finalized your application, click **Final Submit** to send your application to CMS for evaluation. Once you click **Final Submit**, you will not be able to make any changes. Should we need additional information, we will notify you by sending you a RFI, which will allow you to revise your application (see [Section 2.1 Application Cycle Deadlines](#) and [Section 4 How to Respond to Requests for Information](#) for more details). You should receive a confirmation email from CMS once you click **Final Submit** notifying you that we received your application.

3.1. How to Enter and Update your ACO Contacts

ACOs submit, review, update and maintain 16 required and 2 optional ACO contacts on the “Contact Data” page in HPMS. These ACO contacts are considered representatives of the ACO and will receive important program information throughout the application cycle, and during the agreement period, if your ACO is approved to participate. You may identify one person for multiple contacts; however, we strongly recommend that you diversify your contacts to ensure the distribution of important program information to appropriate personnel within your organization.

The ACO is responsible for distributing information to other ACO staff within its organization that not listed in HPMS.

Please note that you must identify two different people for the following contacts:

- DUA Requestor and DUA Custodian
- Contacts identified as “primary” and “secondary”
 - Authorized to Sign Contacts
 - Application Contacts
 - Quality Contacts
 - Marketing Contacts
 - Information Technology Contacts

When entering contact information, confirm each contact’s email address is accurate and follows the guidance below:

- Email addresses must be specific to the individual person identified as the contact.
- Emails must not be generic to the organization.
- Email addresses should identify the organization (e.g. ACO legal business name, ACO trade name/dba, consultant’s company legal business name, etc.).
- Do not use non-company provided email addresses (e.g. Yahoo, Hotmail, Gmail, etc.). It is highly recommended to use a company-issued email. This is not required, but strongly recommended.

See [Section 10 Managing ACO Contacts](#) for the list of ACO Contacts, contact definitions and HPMS Electronic Signature Management (ESM) designation.

Reminder for Renewals: You must confirm that all contacts previously entered into HPMS are valid.

3.1.1. Contacts Required Upon Application Submission

ACOs are required to confirm the contacts listed in the [Table 1](#) before completing their application submission. (See [Section 10.1 Contacts Required Upon Application Submission](#) for contact definitions.)

Table 1. Contacts Required Upon Application Submission

Contact Type	Contact Type
ACO Executive ¹	Medical Director
CMS Liaison	Application Contact (Primary)
Authorized to Sign Contact (Primary) ^{1,2}	Information Technology (IT) Contact (Primary)
Financial Contact	DUA Custodian ^{1,2}
Compliance Contact	DUA Requestor ^{1,2}

¹Electronic Signature Management (ESM) Designee contact. If we approve your application, your ESM designee will electronically sign required program participation documents in HPMS.

²You must identify two different people for: Contacts identified as “primary” and “secondary”. You must also identify two different people for both the DUA Custodian and DUA Requestor.

3.1.2. Contacts Required Upon Application Approval

ACOs are required to identify the additional contacts listed in [Table 2](#) below before completing the program acceptance process. (See [Section 10 Managing ACO Contacts](#).)

Table 2. Contacts Required Upon Application Approval

Contact Type	Contact Type
Authorized to Sign Contact (Secondary) ^{1,2}	Public Contact
Quality Contact (Primary) ²	Marketing Contact (Primary) ²
Quality Contact (Secondary) ²	Marketing Contact (Secondary) ²

¹ESM Designee contact. If we approve your application, your ESM designee will electronically sign required program participation documents in HPMS.

²You must identify two different people for contacts identified as “primary” and “secondary”.

3.1.3. Optional Contacts

ACO’s may choose to identify additional contacts listed in [Table 3](#) below before completing the program acceptance process. (See [Section 10 Managing ACO Contacts](#).)

Table 3 Optional Contacts

Contact Type
Application Contact (Secondary) ¹
Information Technology (IT) Contact (Secondary) ¹

¹You must identify two different people for contacts identified as “primary” and “secondary”.

3.2. How to Submit Attestation Responses

The majority of attestation and certification responses require you to select YES, NO, or N/A. For other attestation questions, you may select all that apply. [Appendix B](#), [Appendix C](#), and [Appendix D](#) identify when narratives or attestations are applicable for each application question.

HPMS is programmed to issue an on-screen error message if there is a problem with your attestation responses. This message will only appear after you click **Final Submit**. If you receive an error message when you click **Final Submit**, carefully read the message to identify and correct the responses that were not accepted. Once you correct the errors, click **Final Submit** again to submit your application.

3.3. How to Submit Supporting Documentation

You may be required to submit additional information or documentation to support your responses to your application. In some cases, if you answer NO to an attestation question, an upload is required. In other cases you are instructed to upload a narrative or documentation to respond to the application question.

When an upload is required, you must use a PDF or specified format as instructed in [Appendix B](#), [Appendix C](#), and [Appendix D](#). All files must be compressed using file compression software, such as WinZip. Once compressed, upload the zip files in the upload section of the “SSP ACO Application Submission” module. The upload section of the module is broken out by each section of the application. Keep in mind the following guidelines when uploading your documentation:

- **Do Not** combine all your documents into one PDF. Each narrative and supporting document must be separate in each zip file. See the first page of [Appendix B](#), [Appendix C](#), and [Appendix D](#) for further instructions on uploading zip files.
- **Do** upload documents into the correct section. Pay particular attention to which question and section of the application you are responding to make it easier for your reviewer to evaluate your application.
- **Do Not** upload your executed ACO Participant or ACO SNF Affiliate agreements in the “SSP ACO Application Submission” module. Upload your executed ACO Participant Agreements in the “SSP ACO Participant List Management” module, and your executed SNF Affiliate Agreements in the “SSP ACO SNF Affiliate List Management” module in HPMS.
- **Do Not** upload your [Form CMS-588](#) or Repayment Mechanism documentation (Track 2 and Track 3 applicants only) into HPMS. You are required to submit your hard copy by traceable mail directly to CMS.

3.4. How to Request Changes to Pre-Populated Information

We pre-populated HPMS with the information you provided in your NOIA. ACOs cannot change the following pre-populated information:

- ACO Taxpayer Identification Number (ACO TIN)
- ACO Legal Entity Name (also referred to as “Legal Business Name”)
- ACO Entity
- Date of Formation (DOF)
- Tax Status

If you find an error in any of the above pre-populated information, an authorized ACO contact (ACO Executive, Authorized to Sign (primary or secondary), CMS Liaison, or Application Contact (primary or secondary) must follow the steps below:

- Send an email to the Application Mailbox at SSPACO_Applications@cms.hhs.gov.
- In the subject line, include your ACO ID and the words “Request Change to Pre-populated Information.”
- In the body of the email, include your ACO ID and the ACO Legal Business Name submitted in your NOIA.
- Identify the information as it currently appears in HPMS, and provide the corrected information and an explanation for the requested change.

3.5. How to Certify Your Application

To finalize your application submission, you must certify to the accuracy of its contents by selecting “I agree” or “I disagree” on the Application Submission page.

Once you select “I agree” and click **Final Submit**, your application is certified. CMS will not process your application if you do not complete this step. You must complete this step each time you submit your application during your initial submission as well as in response to any RFI.

4.0 How to Respond to Requests for Information

This section provides instruction on what you can submit during each RFI request, how to re-submit responses to your attestation questions and supporting documentation uploads, as well as the ACO Participant List and SNF Affiliate List submission in HPMS.

During CMS's review of your application, we may ask you to submit additional information to support the statements you made in your application. You will receive at least two RFI notices (RFI-1, RFI-2). You will receive the third RFI (RFI-3) as your Notice of Intent to Deny (NOID) your application, only if CMS continues to identify non-compliant issues with your application. Each RFI will identify the areas in the application that require correction, instructions to make and submit corrections and other pertinent information, such as your estimated assigned beneficiary count. We will send RFIs to the ACO Executive and the Application Contacts (primary and secondary) by email from SSPACO_Applications@cms.hhs.gov. You must submit the requested information by the date specified in the RFI notice for CMS to consider it as part of your application.

CMS will only accept responses received through HPMS (except where specified for Form CMS-588 and Repayment Mechanism responses). Remember to submit all your RFI responses through HPMS. If you need assistance in completing your response to an RFI, contact your application primary reviewer, whose contact information will be provided to you in your first RFI. For more information, refer to [Section 9.3 Who to contact](#).

Note: If you submitted both a Shared Savings Program Initial or Renewal application and a SNF 3-Day Rule Waiver application, you will receive an RFI via separate emails for each application.

4.1. How to Correct Attestation Response(s)

To correct the attestation or certification questions identified in your RFI:

Step 1: Log into [HPMS](#).

Step 2: Access the SSP ACO Application Submission Start Page:

Home Page, go to **ACO Management**>> **SSP ACO Application Submission**>> **PY2017**>>Click **Select Agreement** from the right menu option >> Enter your ACO ID and click **Next**. You are now on the SSP ACO Application Submission Start Page.

Step 3: Access Your Attestation Data

1. Select **Attestation Data** from the right menu option. This brings you to the Attestation Data Page.
2. Correct only the attestation questions identified in this notice on the **Enter Application Attestation Data** page by selecting the correct response.
3. **Do not** make changes to attestation questions not identified in your RFI.
4. Click **Next**.
5. If all information is correct on the confirmation page, click **Submit**.
6. If any information is incorrect, click **Back** and go through steps 2 through 5.

4.2. How to Submit Revised Narratives and Supporting Documentation

If we ask you to clarify or submit a revised narrative or other supporting documentation, please submit only the supporting documentation identified in the RFI. We will not review any additional information you provide that is not mentioned in the RFI. If unrequested changes are made, they could cause your application to be denied.

Step 1: How to prepare your revised narrative and supporting documentation file(s) for upload

1. If you are submitting new ACO Participant(s) or SNF Affiliates you must submit executed agreement(s) in a zip file and upload that file through the “SSP ACO Participant List Management” or the “SSP ACO SNF Affiliate List Management” module in HPMS, as appropriate.
 - For ACO Participants
 - See the “Accountable Care Organization (ACO) Participant List and Agreement Guidance” located in the [Application Toolkit](#) web page.
 - Also see [Appendix B](#) for initial applicants ([Sec. 9, Questions 27a & 27b](#)), and [Appendix C](#) for renewal applicants ([Sec. 6, Question 9](#)).
 - For SNF Affiliates
 - See the “SNF 3-Day Rule Waiver Guidance” located on the [Application Toolkit](#) web page.
 - Also see [Appendix D](#) for SNF 3-Day Rule Waiver applicants ([Sec. 6, Questions 14, 15 & 16](#)).
2. Continue to use the file naming convention provided in [Appendix B](#), [Appendix C](#), and [Appendix D](#) for submitting supporting documentation.
3. To identify new or revised documents, include the **date** and **.rev** at the end of the file name.
Example: Axxxx_S4_Q8_OrgChart_mmddyyyy.rev.pdf
4. Save these documents in a zip file. (**Do not** include any documentation in your zip file(s) other than what was requested in your RFI.)
5. Upload page, upload the zip file(s) in the appropriate section. (**Do not** include executed ACO participant and ACO SNF Affiliate agreements in this section.)

Step 2: Access the Upload Application Files Start Page

From the HPMS Home Page go to **ACO Management>> SSP ACO Application Submission>> PY2017>>Click **Select Agreement**** from the right menu option >> Enter your ACO ID and click **Next**. This brings you to the “SSP ACO Application Submission Start Page”.

1. Select the appropriate section of the application
2. Click **Upload** option from the right menu option.
3. Click the **Browse** button to upload your new zip file.
4. Select the new zip file for upload.
5. Click **Ok**. The file name will then appear in the “Last Uploaded File” section with the date and time.
6. Click **Submit**.
7. Once you successfully upload your file, you will see the date and time stamp next to the zip file.

8. If you determine that you've made an error in your upload, repeat steps 4 through 7 again.
Note: you may upload documents more than once, but CMS will only review the last successfully uploaded item per section.

4.3. How to Submit Your Revised ACO Participant List

Deficiencies related to your Participant List will be included in your RFI and NOID. For step-by-step instructions on how to create or modify your ACO Participant List in HPMS, see the "HPMSSSP ACO Participant List Management Module User Guide". This user guide is available in HPMS under the User Manual section of the "SSP ACO Participant List Management" module and on the Portal under "Resources" (for ACOs participating in the program only). For additional guidance about ACO participants, see the "[ACO Participant List and ACO Participant Agreement Guidance](#)" document.

Important notes on this action include:

- The last opportunity to add additional ACO participants during your application review period is the date your response to RFI-1 is due. (See [Section 2.1.2 Application Process Deadlines](#).)
- If you are submitting new ACO participant(s) (TINs), you must submit the corresponding executed ACO Participant Agreement between the ACO and the ACO participant(s) in the "SSP ACO Participant List Management" module in HPMS.
- For additional guidance, see [Appendix B \(Sec. 9, Question 23\)](#) for initial applicants and [Appendix C \(Sec. 6, Question 9\)](#) for renewal applicants.

4.4. How to Submit Your Revised SNF Affiliate List (Track 3 ACOs Only)

Deficiencies related to your SNF Affiliate List will be included in your RFI and NOID. For instructions on how to create or modify your ACO SNF Affiliate List in HPMS, see the HPMS User Guide section for additional guidance about SNF Affiliates and see SNF 3-Day Rule Waiver Guidance document located on the [Application Toolkit](#) web page.

Important notes on this action include:

- The last opportunity to add additional SNF Affiliates during your application review period is the date your response to RFI-1 is due. (See [Section 2.1.2 Application Process Deadlines](#).)
- If you are submitting new SNF Affiliate(s), you must submit the corresponding executed SNF Affiliate Agreement between the ACO and the SNF Affiliate(s) in the "SSP ACO SNF Affiliate List Management" module in HPMS.
- For additional guidance, see [Appendix D Sec. 6, Question 14 and 15](#) for Skilled Nursing Facility 3-Day Waiver applicants.

4.5. How to Submit Your Revised Application

After you correct any attestation response(s), upload revised narratives, supporting documentation, and/or revise your ACO Participant List or SNF Affiliate List, you must complete the following steps to submit your revised application.

1. Go to your ACO Application Management Start Page.
2. Click Final Submit Application from the left menu option.

3. Read the information and certification on the Final Submit Application page.
4. Click the “I agree” check box.
5. Click Submit.
6. Once you submit your application, you cannot make any changes and information will only be available in a “view only” format.
7. Click Back and go through the steps in the following sections, if you need to correct an item:
 - [How to correct attestation response\(s\)](#),
 - [How to submit your revised narrative and supporting documentation](#), and/or
 - [How to submit your revised ACO Participant List](#)
 - [How to submit your revised ACO SNF Affiliate List](#)
8. Click the **Final Submit** button to submit your response to this notice even if you are only submitting supporting documentation and did not make any changes to the attestation response.
9. You MUST click **Final Submit** to respond to your RFI letter.

5.0 How to Request to Withdraw a Pending Application

To withdraw a pending application, you must submit a written request on your organization's letterhead, signed by an ACO authorized official (ACO Executive, Authorized to Sign (primary or secondary) or Financial contact) before the date responses for the final RFI or (NOID) is due back to CMS. Your letter must include:

- Your organization's legal entity name
- ACO ID
- Complete address
- Point of contact information (phone number and E-mail address)
- Exact description of the nature of the withdrawal

Send the request to withdraw as a PDF to SSPACO_Applications@cms.hhs.gov with your ACO ID and the words 'Withdrawal Request' in the subject line of the e-mail.

6.0 Application Approval – Acceptance process

If we approve your application, you will receive an approval notice instructing your ACO how to accept participation in the Shared Savings Program. Approved ACOs will be required to certify and electronically sign official documents related to participation in the Shared Savings Program through the HPMS "SSP ACO ESM" module. ACO contacts in HPMS with ESM authority are designated to certify and electronically sign documents on behalf of the ACO. (See [Section 3.1](#) to identify contacts with ESM designation, and see [Section 10](#) for ACO contact definitions.)

The "SSP ACO ESM" module provides ACOs and CMS a mechanism to certify and electronically sign official documents related to participation in the Shared Savings Program. In addition, electronically signed documents are stored in HPMS and accessible to ACOs at any time. Documents stored in the ESM include your Shared Savings Program ACO Participant List Certification, ACO Provider/Supplier List Certification, Data Use Agreement (DUA), SNF Affiliate List Certification, and DUA Amendment. We will not accept or process any of these forms outside of HPMS (except where specified for Form CMS-588 and Repayment Mechanism responses). During the application review process, ACOs will receive a CMS notification to participate in training on the "SSP ACO ESM" module and final requirements to accept participation into the Shared Savings Program.

7.0 Application Denial – Reconsideration Review Process

If your application is denied, you may have the right to request a reconsideration review. See the [Guidelines for Reconsideration Review Process](#) for additional instructions.

8.0 Approved Applicants – Next Steps and Expectations

If CMS approves your application and you accept participation in the Shared Savings Program, we will notify you about our kick-off webinar for newly approved ACOs and ACOs that renewed their participation agreement with CMS with a program start date of January 1, 2017. During the webinar, we will discuss information such as:

- Marketing overview, requirements and tools,
- How to contact your assigned CMS Coordinator who will be your liaison to the Shared Savings Program,
- Overview of Shared Savings Program data, and
- An introduction to the Shared Savings Program resources.

9.0 Resources

CMS will provide information via several sources including webinars, email notifications, and through your primary application reviewer. Applicants are urged to monitor our [program website](#) frequently for updates to regulation and guidance.

9.1. Program Web Pages and Regulation Links

- [Final Rule Published in the Federal Register on June 9, 2015](#)
- [Skilled Nursing Facility \(SNF\) 3-Day Waiver](#)
- [Shared Savings Program – Applications Web site](#)
- [Statutes/Regulations/Guidance](#)
- [Shared Savings Program Frequently Asked Questions](#)
- [Medicare Shared Savings Program Fraud and Abuse Waivers](#)

9.2. Shared Savings Program Application Teleconferences and Events

Please see the [Shared Savings Program Applications Teleconferences and Events](#) page for a history of calls held to date, including presentation materials and transcripts, and upcoming events. Visit this page frequently for updated information and materials.

Subscribe to the weekly [MLN Connects Provider eNews](#) to receive announcements for the Shared Savings Program, including upcoming MLN Connects Calls on the application process. Locate past issues of *MLN Connects Provider eNews* at [eNewsArchive](#).

9.3. Who to Contact

If you need assistance during the application submission process, use the following contact information:

- For NOIA, CMS User ID and application process questions: SSPACO_Applications@cms.hhs.gov
- For help with Form CMS-20037 and CMS User ID requests (Allow 2-3 weeks for User ID request inquiries): HPMS_Access@cms.hhs.gov or 1-800-220-2028
- For help with your consultant authorization access request: HPMSConsultantAccess@cms.hhs.gov
- For help with using HPMS and HPMS technical assistance: CMSHPMS@cms.hhs.gov or 1-800-220-2028
- For password resets and if your account is locked: CMS_IT_SERVICE_DESK@cms.hhs.gov or 1-800-562-1963

As noted in [Section 4](#), after your application has been submitted, you will receive an RFI that may request clarification to specific application responses. Your initial RFI will provide contact information for your ACO's application primary reviewer. Your application primary reviewer is available to assist with questions pertaining to your application and the application process.

10.0 Managing ACO Contacts

ACOs are required to submit, review, update and maintain active ACO contacts listed in HPMS on an ongoing basis. [Section 10.2](#) provides a list of contacts required upon application approval. [Table 1](#) depicts required and optional contacts. Optional contacts are not required, but are recommended. This section provides the contact definition, ESM designation, and CMS systems each contact will access regularly. All contacts require access to CMS systems including HPMS, Managed File Transfer (MFT), and, upon application approval, the Shared Savings Program ACO Portal (SSP ACO Portlet).

Important things to note on this action include:

- One individual can serve as more than one ACO contact. However, we recommend you diversify your contacts by identifying more than one person to serve each role.
- Please be mindful that the Authorized to Sign primary and secondary contact must be two different people, and the DUA Requestor and DUA Custodian must be two different people.
- It is critical that all ACO contacts listed in [HPMS](#) login to the system to verify that their contact information is correct. Please verify email addresses in particular.
- We use HPMS for all Shared Savings Program correspondence, including the ACO Spotlight Newsletter (for ACOs participating in the program).
- Update the “Contact Data” page in HPMS with the appropriate contact information when there is a change in ACO contacts within your ACO (e.g., new personnel, departing personnel, change in roles), be sure to make.

10.1. Contacts Required Upon Application Submission

- **ACO Executive:** Person holding an executive leadership office in the ACO and vested by the ACO’s governing body with the legal powers to commit the ACO to a binding agreement. This person may or may not be the same as the Authorized to Sign contact. Documents requiring an authorized signature include, but are not limited to, the agreements between CMS and the ACO. Upon application approval, this person is designated to sign documents on behalf of the ACO in the HPMS “SSP ACO ESM” module. Person receives and has access to all correspondence from CMS to the ACO, including program announcements. Person has access to CMS systems including HPMS, and upon application approval, MFT, and Shared Savings Program ACO Portlet.
- **CMS Liaison:** Serves as the ACO’s primary point of contact for communication between the ACO and CMS. Person receives and has access to all correspondence from CMS to the ACO, including program announcements. Upon application approval, this person is designated to sign documents on behalf of the ACO in the HPMS “SSP ACO ESM” module. Person has access to CMS systems including HPMS and, upon application approval, MFT, and Shared Savings Program ACO Portlet.
- **Application Contact (Primary):** Serves as the primary point of contact for the ACO’s application to participate in the Medicare Shared Savings Program. Person receives and has access to all correspondence from CMS to the ACO, including program announcements related to the application. Person has access to HPMS.
- **Information Technology (IT) Contact (Primary):** Serves as the ACO’s primary point of contact for data transfers between the ACO and CMS. Person receives and has access to all correspondence from CMS to the ACO; including those regarding data transfer, and program announcements related to data. Person has access to CMS systems including HPMS, MFT, and, upon application approval, Shared Savings Program ACO Portal.

- **Financial Contact:** Serves as the ACO’s point of contact for banking and payment information. Person is the ACO’s authorized official recorded on the ACO’s Form CMS-588 and owner of the ACO’s bank account. Person receives correspondence to the ACO including banking information, the Electronic Funds Transfer (EFT) between CMS and the ACO, and program announcements related to financial issues. Person has access to CMS systems upon application approval, including HPMS, MFT, and Shared Savings Program ACO Portal.
- **Medical Director:** This senior-level position is held by a board-certified physician who is licensed in the state where your ACO operates, and 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. Person provides leadership and oversight of the ACO’s clinical management and is familiar with the ACO’s organizational culture and day-to-day operations.
- **Compliance Contact:** Serves as the ACO’s point of contact for program compliance and monitoring activities. Person receives and has access to all correspondence from CMS to the ACO. This includes compliance and monitoring activities such as Corrective Action Plan (CAP), and program announcements related to compliance and monitoring. Person has access to CMS systems including HPMS, and, upon application approval MFT, and Shared Savings Program ACO Portal.
- **Authorized to Sign (Primary):** Person appointed by the ACO as an agent of the organization and vested by the ACO’s governing body with the legal powers to commit the ACO to a binding agreement. This person may or may not be the same as the ACO Executive (Authorized Official) contact. Documents requiring an authorized signature include, but are not limited to, agreements between CMS and the ACO, agreements between the ACO and ACO participants, etc. Upon application approval, this person is designated to electronically sign documents on behalf of the ACO in the HPMS “SSP ACO ESM” module. Person receives and has access to correspondence from CMS to the ACO, including program announcements. Person has access to CMS systems including HPMS and, upon application approval, MFT, and Shared Savings Program ACO Portal.
- **DUA Custodian:** Serves as the person responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in the DUA to prevent unauthorized use. This person cannot be the same as the DUA Requestor.
- **DUA Requestor:** Serves as the person authorized to legally bind the ACO to the terms of the DUA. This person cannot be the same as the DUA Custodian.

10.2. Contacts Required Upon Application Approval

- **Quality Contact (Primary):** Serves as the ACO’s primary point of contact for quality issues related to internal reporting on quality metrics. Person receives and has access to correspondence from CMS to the ACO and program announcements related to quality. Person has access to CMS systems upon application approval including HPMS, MFT, and Shared Savings Program ACO Portal.
- **Quality Contact (Secondary):** Serves as the ACO’s secondary point of contact for quality issues related to internal reporting on quality metrics and serves as the back-up to the primary quality contact. Person receives and has access to correspondence from CMS to the ACO and program announcements related to quality. Person has access to CMS systems upon application approval including HPMS, MFT, and Shared Savings Program ACO Portal.
- **Marketing Contact (Primary):** Serves as the ACO’s point of contact for marketing materials and activities provided on behalf of the ACO. Person receives and has access to all correspondence from CMS to the ACO about marketing materials and activities, including program

announcements related to marketing. Person has access to CMS systems including HPMS, and upon application approval, the Shared Savings Program ACO Portal.

- **Marketing Contact (Secondary):** Serves as the ACO's secondary point of contact for marketing, and serves as the back-up to the primary marketing contact. Person receives and has access to all correspondence from CMS to the ACO about marketing materials and activities, including program announcements related to marketing. Person has access to CMS systems including HPMS, and upon application approval, the Shared Savings Program ACO Portal.
- **Public Contact:** Serves as the ACO's point of contact for the public about the ACO. Person **must** be accessible by phone or email. Person receives and has access to all correspondence from CMS to the ACO about public reporting information, updates to the ACO's website, and program announcements related to public reporting. Person has access to CMS systems including MFT and Shared Savings Program ACO Portal, upon application approval.
- **Authorized to Sign (Secondary):** Person appointed by the ACO as an agent of the organization and vested by the ACO's governing body with the legal powers to commit the ACO to a binding agreement. This person may or may not be the same as the ACO Executive (Authorized Official) contact. Documents requiring an authorized signature include, but are not limited to, agreements between CMS and the ACO, agreements between the ACO and ACO participants, etc. Upon application approval, this person is designated to sign documents on behalf of the ACO in HPMS "SSP ACO ESM" module. Person receives and has access to correspondence from CMS to the ACO, including program announcements. Person has access to CMS systems including HPMS and, upon application approval, MFT and Shared Savings Program ACO Portal.

10.3. Optional Contacts

- **Application Contact (Secondary):** (Optional) Serves as the secondary point of contact for the ACO's application to participate in the Medicare Shared Savings Program, and serves as the back-up to the primary application contact. Person receives and has access to all correspondence from CMS to the ACO, including program announcements related to the application. Person has access to HPMS.
- **Information Technology (IT) Contact (Secondary):** (Optional) Serves as the ACO's secondary point of contact for data transfers between the ACO and CMS, and serves as the back up to the primary IT contact. Person receives and has access to all correspondence from CMS to the ACO; including those regarding data transfer, and program announcements related to data. Person has access to CMS systems including HPMS, MFT, and, upon application approval, Shared Savings Program ACO Portal.

Appendix A. Organizational Structure

A. Organizational Structure Description

Below are the most common types of organizational structures for Medicare Shared Savings Program ACOs. Use this chart to guide you in your application submission.

Figure 1 Common ACO Organizational Structures

ACO STRUCTURE	NOTES
<p>Traditional ACO (most common ACO structure)</p>	<ul style="list-style-type: none"> Multiple ACO participants joined to form the ACO. The ACO is a separate legal entity from the ACO participants. Submit sample ACO participant agreement and all executed ACO participant agreements.
<p>Single TIN ACO</p>	<ul style="list-style-type: none"> The ACO is comprised of one ACO participant. The ACO and ACO participant <u>are the same</u> legal entity. This structure does not permit participation of other ACO participants. Submit sample employment agreement and/or sample ACO provider/supplier agreement.
<p>Single TIN ACO set up as Traditional</p>	<ul style="list-style-type: none"> The ACO is comprised of one ACO participant. The ACO and ACO participant <u>are different</u> legal entities. This structure allows the ACO to add ACO participants in the future. Submit sample ACO participant agreement and executed ACO participant agreement.

Initial Applicants will make the following selection in response to [Question 2a](#). The below selection is **not applicable** to renewal applicants.

- **Scenario 1 – Traditional ACO:** ACO TIN and ACO participant TINs are **different**; This ACO Participant List will include multiple TINs.
- **Scenario 2A – Single TIN Entity ACO:** ACO TIN and sole ACO Participant TIN are the same; all practitioners billing through the ACO TIN are **employed**
- **Scenario 2B – Single TIN Entity ACO:** ACO TIN and sole ACO Participant TIN are the same; all practitioners billing through the ACO TIN are **contracted**.
- **Scenario 2C – Single TIN Entity ACO:** ACO TIN and sole ACO Participant TIN are the same; practitioners billing through the ACO TIN are **both** contracted **and** employed.
- **Scenario 3 – Single TIN Entity ACO Structured as a Traditional ACO:** ACO TIN and sole ACO Participant TIN are **different**.
- **Other:** If other, you must describe your ACO organizational structure.

B. Organizational Structure Scenario Chart – For Initial Applicants

The purpose of this chart is to provide initial applicants the appropriate response to application questions based on the most common Shared Savings Program ACO organizational structures.

HPMS is programmed to issue an on-screen error message if there is a problem with your attestation responses based on the organizational structure you selected in response to [Question 2a](#). If you receive an error, read the error message carefully to correct your response and submit your application. You will not be able to submit your application until the error is corrected.

Figure 2 Organizational Structure Scenario Chart

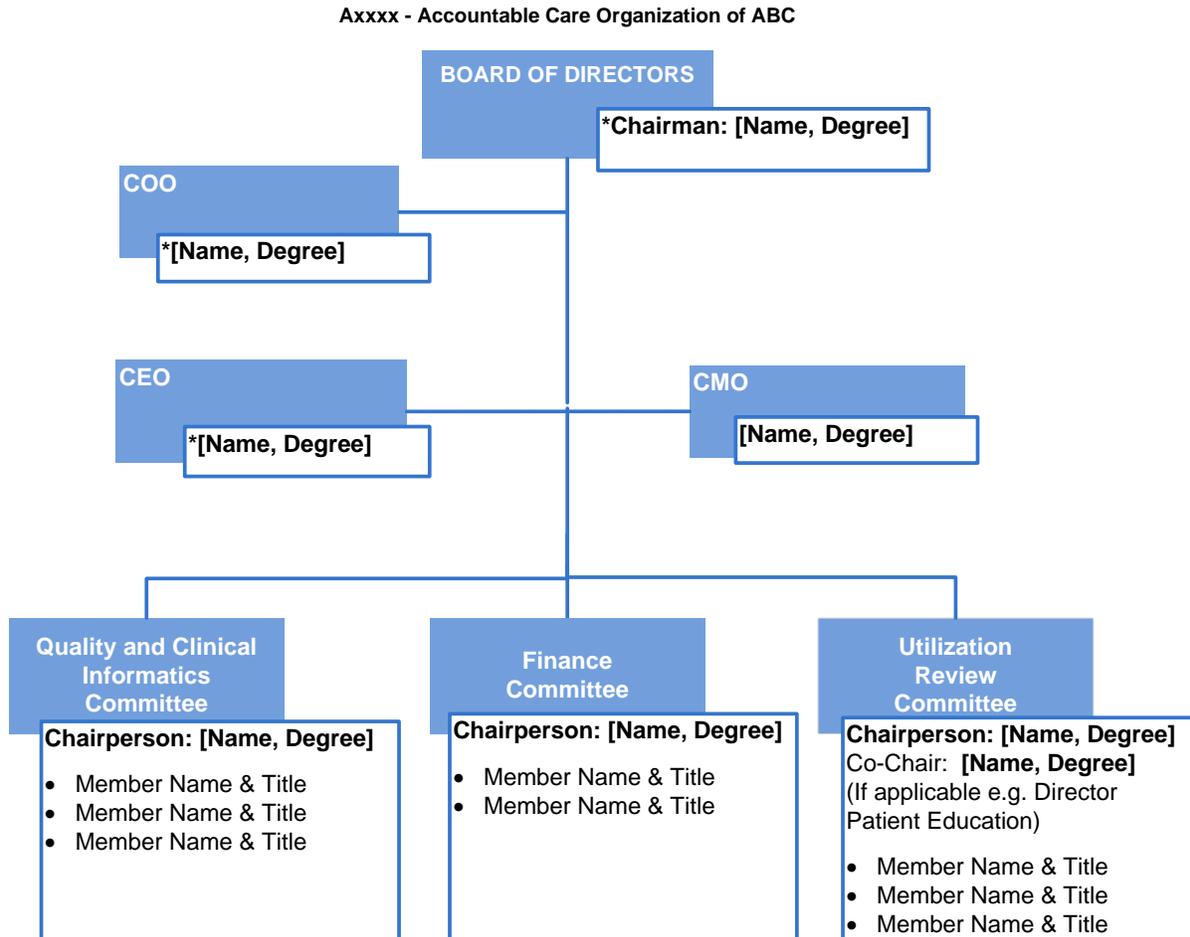
SCENARIO	Q4	Q5	Q6	Q26	Q27	Q28	Q29
1 - Traditional ACO	YES	YES	N/A	N/A	Must submit sample ACO participant agreement	YES	Must submit executed agreements for each ACO participant
2A - Single TIN ACO* (employed practitioners (NPIs) billing through the TIN)	NO	N/A	NO	YES – must submit a copy of the employment agreement	N/A - SKIP	N/A	N/A - SKIP
2B - Single TIN ACO* (contracted practitioners (NPIs) billing through the TIN)	NO	N/A	NO	NO	Must submit sample ACO provider/supplier agreement	YES	N/A - SKIP
2C – Single TIN ACO* (employed & contracted practitioners (NPIs) billing through the TIN)	NO	N/A	NO	Yes – Must submit a copy of the employment agreement	Must submit a sample ACO provider/supplier agreement	YES	N/A SKIP
3 - Single TIN ACO set up as Traditional	NO	N/A	YES	N/A	Must submit sample ACO participant agreement	YES	Must submit executed agreements for the sole ACO participant. TIN Legal Name & ACO participant TIN on the ACO Participant List must be different

NOTE FOR SCENARIO 2: For Questions 11 and 14, the ACO automatically meets the 75% ACO Participant rule because the existing governing body is 100% representative of the single TIN.

C. Organizational Chart – Acceptable (SAMPLE)

The purpose of the Organization Chart sample is to provide ACOs with an example of acceptable Organizational Chart. Refer to regulation requirements §425.204 (c)(1)(iii) & §425.108.

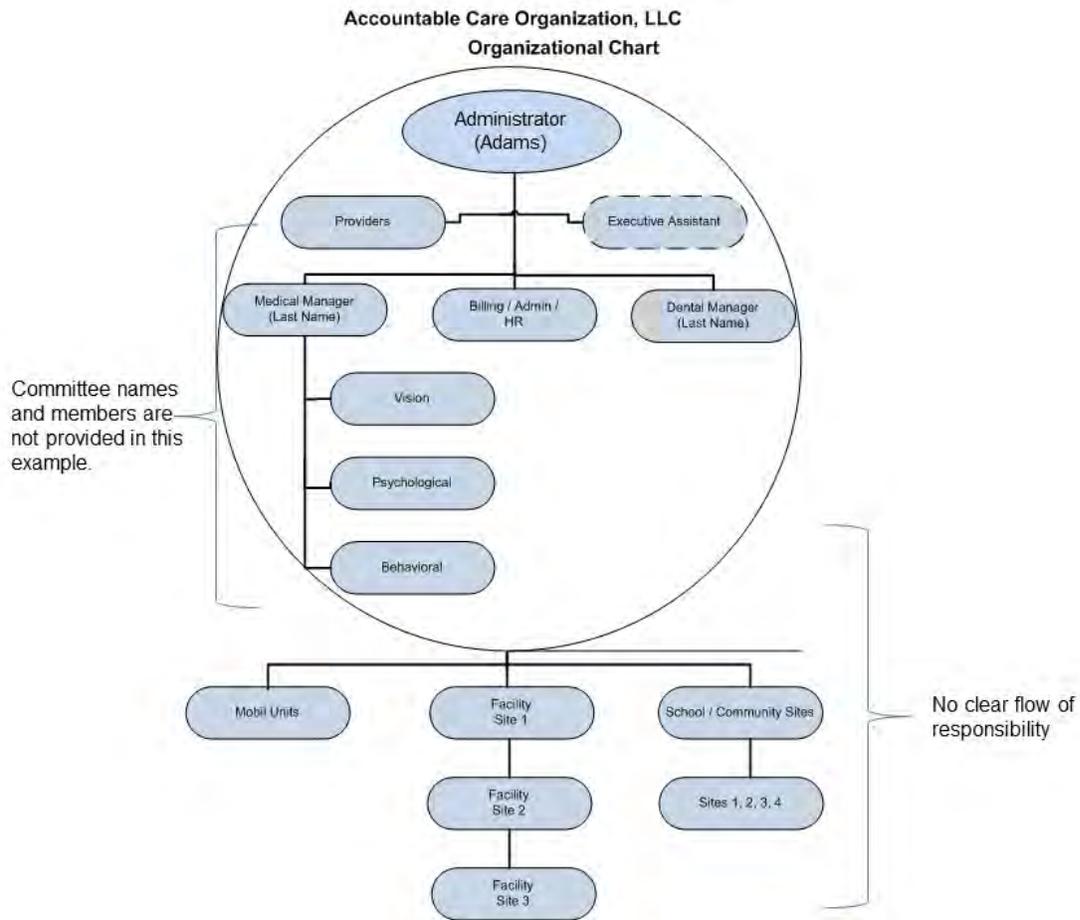
Figure 3 Acceptable Organizational Chart



D. Organizational Chart – Unacceptable (SAMPLE)

Organizational charts must show the flow of responsibility and include committees and the name of each committee member, as well as the senior administrative and clinical leaders of your ACO. This example does not include some of the required elements. For a comprehensive overview of all of the requirements, refer to the final rule §425.204 (c)(1)(iii) & §425.108

Figure 4 UnAcceptable Organizational Chart



Appendix B. Application Reference Table – For Initial Applicants

Purpose: This Application Reference Table guides initial applicants through each application question, one-by-one, providing additional guidance to assist you in answering questions accurately and completely.

All documents you submit must include your ACO legal entity name and ACO ID per the instructions in this appendix.

Use the zip file naming conventions below for each upload section of the application. All documents included in the zip file must follow file naming conventions provided in the table below.

- [Section 1:](#) Axxx_S1_mmddyyyy.zip
- [Section 2:](#) Axxx_S2_mmddyyyy.zip
- [Section 3:](#) n/a
- [Section 4:](#) Axxx_S4_mmddyyyy.zip
- [Section 5:](#) Axxx_S5_mmddyyyy.zip
- [Section 6:](#) Axxx_S6_mmddyyyy.zip
- [Section 7:](#) Axxx_S7_mmddyyyy.zip
- [Section 8:](#) Axxx_S8_mmddyyyy.zip
- [Section 9:](#) Axxx_S9_mmddyyyy.zip
- [Section 10:](#) Axxx_S10_mmddyyyy.zip
- [Section 11:](#) Axxx_S11_mmddyyyy.zip
- [Section 12:](#) n/a

Application Reference Table Layout:

- Column 1: Application Question Number (Q#) – You may also use this column to check-off completed items
- Column 2: Instructions to aide you in answering application questions and the type of document requested
- Column 3: Regulation reference
- Column 4: Indicator for determining if supporting documentation and/or a narrative is required and the File naming convention, if applicable.

Section 1 – Give us your contact information			
Q#	Description /Instructions <i>*Information in this section is pre-populated from your NOIA. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i>	Regulation Reference	Support Documents / Narrative Required / Naming convention
	<p>ACO Address – Review and confirm your ACO legal entity name, ACO Trade name or DBA (if applicable), mailing address, and ACO tax identification number (TIN)</p> <p>ACOs can edit the following information on the Basic Agreement Data page:</p> <ul style="list-style-type: none"> • ACO Legal Entity Name, • ACO Trade Name/DBA (if applicable), • Mailing Address, and • ACO Tax Identification Number <p>If you identify an error with your ACOs data, other than the information you can change, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information to notify CMS.</p>	N/A	No
	<p>Organization Contacts – Enter the following information about your ACO contacts on the Contact Data page: name, title, mailing address, phone number, and email address.</p> <p>Use the contact guidance below to help you complete your ACO Contact information:</p> <ul style="list-style-type: none"> • Section 3.1 How to Enter and Update your ACO Contacts • Section 3.1.1 Contacts Required Upon Application Submission • Section 3.1.2 Contacts Required Upon Application Approval • Section 10 Managing ACO Contacts 	N/A	No

Section 2 – Tell us some general information about your ACO			
Q#	Description /Instructions <i>*Information in this section is pre-populated from your NOIA. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i>	Regulation Reference	Support Documents / Narrative Required <i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i>
	<p>I Am A (Application Type) – Confirm your application type. In your NOIA, you indicated your ACO is one of the following: New applicant to the Shared Savings Program (including previously withdrawn or denied applicants); Re-Applicant to the Shared Savings Program (if you have previously been terminated from the Medicare Shared Savings</p>	§425.202, §425.222	No

Section 2 – Tell us some general information about your ACO			
Q#	Description /Instructions <i>*Information in this section is pre-populated from your NOIA. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i>	Regulation Reference	Support Documents / Narrative Required <i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i>
	<p>Program (voluntarily or involuntarily) and are re-applying); Physician Group Practice (PGP) Transition Demonstration Participant; Former Pioneer Accountable Care Organization Model (requesting a condensed application); or Former Pioneer Accountable Care Organization Model (not eligible for condensed application).</p> <p>ACOs who formerly participated in the Pioneer Accountable Care Organization Model may request to submit a condensed application, if all of the following requirements are met:</p> <ul style="list-style-type: none"> • The applicant is the same legal entity as the Pioneer ACO. • ACO Participant List does not contain any ACO participant TINs that did not appear on the “Confirmed Annual TIN/NPI List” (as defined in the Pioneer ACO Model Innovation Agreement with CMS) for the applicant ACO's last full performance year in the Pioneer ACO Model. • The applicant is not applying to participate in Track 1 (one-sided shared savings model). <p>If a former Pioneer qualifies to submit a condensed application, they must notify CMS by sending an email to SSPACO_Applications@cms.hhs.gov. In the Subject Line, include your ACO ID and the phrase “Former Pioneer Requesting Condensed Application”, in the body of the email, include your ACO ID, ACO Legal Entity Name, and your request to submit a condensed application. We will provide you with further guidance.</p>		
	<p>Composition of ACO Participants Eligible to Form the ACO – Confirm your selection. In your NOIA, you identified the composition of your ACO Participants. These categories represent ACO participants that are eligible to form an ACO. Your ACO must be composed, at a minimum, of at least one of the following:</p> <ul style="list-style-type: none"> • ACO professionals in a group practice arrangement, • A network of individual ACO professionals, 	§425.102	No

Section 2 – Tell us some general information about your ACO			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
	<p><i>*Information in this section is pre-populated from your NOIA. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p>		<p><i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i></p>
	<ul style="list-style-type: none"> • A partnership or joint venture arrangement between a hospital and ACO professionals, • A hospital employing ACO professionals, • A Critical Access Hospital (CAH) billing as Method II, • A Federally Qualified Health Center (FQHC), • Rural Health Clinic (RHC), or • Electing Teaching Amendment (ETA) Hospital <p>You should choose the one(s) that best represent your organization.</p>		
	<p>Medicare Shared Savings Program Track – Make your selection to participate in Track 1 (one-sided model: shared savings), Track 2 (two-sided model: shared savings/losses) or Track 3 (two-sided model: shared savings/losses) on the Basic Agreement Data page in HPMS.* This question will only appear on this page.</p> <ul style="list-style-type: none"> • You may only make this selection in HPMS at the time of your application submission. • Once you make the selection, you will not be able to change it in HPMS. If you identify an error, you must notify CMS at SSPACO_Applications@cms.hhs.gov to make the correction. • See Section 3.4 How to Request Changes to Pre-Populated Information. <p>ACOs participating under the two-sided model accept liability for losses and have the chance for greater reward (savings). Track 3, in comparison to Track 2, offers greater risk and greater opportunity for reward.</p> <p>If you select Track 2 or Track 3, you must indicate your Repayment Mechanism selection on the Basic Agreement Data page once you make your selection. The Repayment Mechanism section will not appear for ACOs who select Track 1.</p>	<p>§425.204 (e)(1) §425.600</p>	<p>No</p>

Section 2 – Tell us some general information about your ACO			
Q#	Description /Instructions <i>*Information in this section is pre-populated from your NOIA. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i>	Regulation Reference	Support Documents / Narrative Required <i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i>
	Skilled Nursing Facility (SNF) 3-Day Waiver (For Track 3 only) - If you are applying as a Track 3 ACO and would also like to apply for the SNF 3-Day Rule Waiver, you must complete a separate SNF 3-Day Rule Waiver application in addition to this application	§425.612	Yes. You must complete a separate SNF 3-Day Rule Waiver application in addition to this application.
	ACO Tax Payer Identification Number (TIN) – Confirm your ACO’s TIN used to establish the ACO as a legal entity. *This is the TIN that will receive and distribute shared savings to your ACO participants. If you have chosen Track 2 or Track 3, this TIN will be responsible for paying shared losses. This TIN will also be responsible for regulatory requirements.	§425.104 & §425.204	No
	Date of Formation – Confirm your ACO’s legal date of formation. This date should match the information on your entity formation documentation (e.g. Certificate of Incorporation).	§425.104 & §425.204	No
	Your Business Structure – Confirm your ACO’s Legal Entity type: sole proprietorship, partnership, publicly-traded corporation, privately-held corporation, limited liability company or Other. * If you select “Other”, indicate the type of Legal Entity in the text box provided.	§425.104 & §425.204	No
	Your Tax Status – Select the ACO’s tax status. Please select only one: Not-for-profit, or For profit.	§425.104 & §425.204	No
	Repayment Mechanism – Complete this section on the Basic Agreement Data page once you select your Medicare Shared Savings Program Track. You will ONLY see this selection if you are applying for Track 2 or Track 3. Indicate which repayment mechanism(s) you will use. Select all that apply from the following options: <ul style="list-style-type: none"> • Funds placed in escrow • Surety bonds 	§425.204 (f)	No

Section 2 – Tell us some general information about your ACO			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
	<p><i>*Information in this section is pre-populated from your NOIA. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p>		<p><i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i></p>
	<ul style="list-style-type: none"> • A line of credit the Medicare program can draw upon, as evidenced by a letter of credit <p>You may only make this selection in HPMS at the time of your application submission. Once you make the selection, you will not be able to change it in HPMS. If you identify an error, you must notify CMS at SSPACO_Applications@cms.hhs.gov to make the correction. See Section 3.4 How to Request Changes to Pre-Populated Information.</p> <p>Your ACO is not required to submit repayment mechanism documentation with the initial/renewal application submission. However, you should begin discussions with a financial institution or insurance company of your choice as soon as your ACO decides to apply for a two-sided risk model. After you submit your application and during the application review process, you will receive a letter from CMS outlining the process for the submission and review of your repayment mechanism and key deadlines. The letter will also include the estimated dollar amount for your repayment mechanism. A fully funded repayment mechanism must be in place and approved by CMS before CMS will approve your Shared Savings Program application.</p> <p>Refer to the Repayment Mechanism Guidance for additional information.</p>		

Section 3 – Tell us if your ACO meet the `Antitrust Agencies’ definition of “newly formed”			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
1.	<p>Jointly negotiated contracts with a private payor(s)– Confirm whether your ACO has entered into any contracts with private payors prior to March 23, 2010. ACOs who HAVE signed or jointly negotiated any contracts with private payors after March 23, 2010, must agree to permit CMS to share a copy of this application with the Antitrust Agencies.</p> <p>An ACO is not newly formed if it is comprised solely of providers and suppliers that signed or jointly negotiated contracts with private payors on or before March 23, 2010.</p> <p>Read the Federal Trade Commission (FTC) and Department of Justice’s (DOJ) Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program Antitrust Policy Statement.</p>	<p>§425.202 (a)(3) & the Antitrust Policy Statement</p>	No

Section 4 – Tell us about your ACO’s legal entity			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
2a.	<p>Confirm how your ACO is structured (Scenario 1, Scenario 2A, Scenario 2B, Scenario 2C, Scenario 3, Other)–</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program; and • Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 4 based on your ACO’s organization structure. 	<p>§425.104; §425.204</p>	

Section 4 – Tell us about your ACO’s legal entity			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
2b.	Submit a narrative giving us a brief overview of your ACOs history, mission and organization, including your ACO’s affiliations. – You must also include this information for any and all of your ACO’s affiliates.	N/A	Yes, required. Name your file: Axxxx_S4_Q2b_Hist_mmddyyyy.pdf
3.	<p>Recognized Legal Entity – Indicate if your ACO is recognized as a legal entity formed under applicable State, Federal and Tribal law, is authorized to conduct business in each State in which it operates and fulfills the ACO functions as identified in the Shared Savings Program regulations.</p> <p>By selecting YES, you certify that your ACO legal entity can:</p> <ol style="list-style-type: none"> Receive and distribute shared savings; Repay shared losses or other monies determined to be owed to CMS; Establish, report, and ensure provider compliance with health care quality criteria, including quality performance standards; and Fulfill other ACO functions identified in 42 CFR Part 425. 	§425.104 & §425.204	No
4.	<p>ACO Separate Legal Entity Formation – Indicate if your ACO is formed among multiple, otherwise independent ACO participants.</p> <p>If your ACO is formed by a subset of the TINs that participate in an organization such as an integrated health delivery system or independent physician association, we consider your ACO to be formed by multiple independent TINs. Accordingly, these entities must answer YES to this question.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program; and Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 4 based on your ACO’s organization structure. 	§425.104 & §425.204	No

Section 4 – Tell us about your ACO’s legal entity			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
5.	<p>If you answered YES to Question 4, certify that your ACO is a legal entity separate from any of the ACO participants and comprised only of ACO participants.</p> <p>If you answered NO to Question 4, select N/A.</p> <p>An entity formed by a single ACO participant may use its existing legal entity and governing body, provided it satisfies all requirements.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program; and • Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 5 based on your ACO’s organization structure. 	§425.104 & §425.204	No
6.	<p>If you answered NO to Question 4, certify that your ACO is not required to be a separate legal entity. Indicate whether you have chosen to be a legal entity separate from the single ACO participant.</p> <p>If you answered YES to Question 4, select N/A.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program; and • Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 6 based on your ACO’s organization structure. 	§425.104 & §425.204	No

Section 4 – Tell us about your ACO’s legal entity			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
7.	<p>Certification of formation and operation of ACO: Legal Entity Documentation – Indicate if documentation (e.g., charters, by-laws, articles of incorporation, etc.) is available effectuating formation and operation of your ACO. You must retain this documentation and be able to provide it to CMS upon request.</p> <p>For example, you may be asked to provide to us charters, by-laws, articles of incorporation, partnership, joint venture, management or asset purchase agreements, financial statements and records, resumes and other documentation required for leaders of the ACO.</p> <p>If you are asked to provide information to CMS during the Request for Information (RFI) phases of the application cycle, use the naming convention indicated.</p>	<p>Antitrust Policy Statement §425.204</p>	<p>No. If requested, name your file: Axxxx_S4_Q7_[file name]_mmddyyyy.pdf</p>
8.	<p>Organization Structure – Upload your ACO's leadership and organizational chart(s) using the naming convention indicated. CMS will not be providing a template for this information.</p> <p>You must use the organizational chart that is established by your ACO.</p> <p>See Appendix A for samples Organizational Chart</p> <ul style="list-style-type: none"> • Section C Organizational Chart-Acceptable Sample • Section D. Organizational Chart – Unacceptable Sample 	<p>§425.204 (c)(1)(iii) & §425.108</p>	<p>Yes, required. Name your file: Axxxx_S4_Q8_OrgChart_mmddyyyy.pdf</p>

Section 5 – Tell us about your ACO’s governing body			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
9a.	<p>Certify that your ACO has an identifiable governing body with ultimate authority to execute the functions of your ACO and meets the requirements of the program.</p> <p>The ACO governing body must be the same as the governing body of the legal entity that is the ACO. The ACO’s governing body must also retain the ultimate authority to execute the functions of the ACO.</p> <p>1. The governing body of a Traditional ACO (Scenario 1) which includes multiple TINS, is precluded from being the same as the governing body of an ACO participant.</p>	§425.106	
9b.	<p>Indicate that no other individuals or entities have input or influence into decisions made by your ACO’s governing body.</p> <p>If you answered YES, that your ACO is affiliated with a parent company or vendor that exercises influence over the decisions of your ACO’s governing body, your narrative should clearly identify these parties and explain what input/influence they have on the governing body. Your narrative should also explain how the ACO plans to ensure compliance with rules related to governing body.</p>	§425.106 (b)	If applicable, name your file: Axxxx_S5_Q9b_GovBod_mmddyyyy.pdf
10.	Meaningful Participation – Indicate whether your ACO provides for meaningful participation in the composition and control of the governing body for ACO participants or their designated representatives.	§425.106	N/A

Section 5 – Tell us about your ACO’s governing body			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
11.	<p>Indicate whether your ACO participants have at least 75% control of the governing body.</p> <p>If you answered NO, describe why you seek to differ from this requirement and explain, with supporting documentation, how your ACO will involve ACO participants in ACO governance.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program 	§425.204 (c)(1)(iv)	If applicable, name your file: Axxxx_S5_Q11_75CtrlDif_mmddyyyy.pdf
12.	<p>Indicate whether your governing body includes one or more Medicare fee-for-service beneficiaries who is served by the ACO, who is not an ACO provider/supplier, who does not have a conflict of interest with your ACO, and who have no immediate family with a conflict of interest.</p> <p>An ACO provider/supplier is prohibited from being the Medicare Fee-for-Service beneficiary representative on the governing body.</p> <p>If you answered NO, describe why you seek to differ from this requirement and explain with supporting documentation how your ACO will ensure meaningful participation in ACO governance by Medicare beneficiaries.</p>	§425.204 (c)(v)	If applicable, name your file: Axxxx_S5_Q12_BoBDif_mmddyyyy.pdf

Section 5 – Tell us about your ACO’s governing body			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
13.	<p>Certify your ACO governing body has a conflict of interest policy – Indicate whether a conflict of interest policy exists for the governing body. Please note that the conflict of interest policy must meet the requirements specified in the regulations.</p> <p>By selecting YES, you certify that your conflict of interest policy:</p> <ol style="list-style-type: none"> Requires each member of the governing body to disclose relevant financial interests; Provides a procedure to determine whether a conflict of interest exists, and sets forth a process to address any conflicts that arise; and Addresses remedial action for members of the governing body that fail to comply with the policy. 	§425.106 (d)	No
14.	<p>Your governing body template – Upload the names, titles (e.g. Chair, Vice-Chair), and responsibilities for all members of the governing body. See the Governing Body FAQs for additional information.</p> <p>Please use the How To-Governing Body Template Instructions to submit the Governing Body Template identifying:</p> <ol style="list-style-type: none"> All governing body members; Position each member holds on the governing body; Voting power of each governing body member; and Indicate which ACO participant the governing body member represents; or indicate if the governing body member is a Medicare beneficiary representative, community stakeholder representative, or other. <p>NOTE: The Governing Body Template completes this requirement.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program 	§425.308 (c)(3) §425.106	Yes, required. Name your file: Axxxx_S5_Q14_GovBody_mmddyyyy.pdf

Section 6 – Tell us about your ACO’s leadership and management			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
15.	Indicate whether your ACO is 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.	§425.108 (b) & §425.204	No
16.	Indicate whether your ACO's clinical management and oversight is managed by a senior-level medical director who is a board-certified physician and licensed in a State in which your ACO operates, who is physically present on a regular basis at any clinic, office, or other location participating in the ACO, ACO participant or ACO provider/supplier. The medical director is not required to be an ACO provider/supplier.	§425.108 & §425.204	No
17.	I certify that my ACO has a compliance plan that includes the required elements: <ul style="list-style-type: none"> a. A designated compliance official or individual that is not legal counsel to the ACO and reports directly to the ACO’s governing body. b. Mechanisms for identifying and addressing compliance problems related to the ACO’s operations and performance. c. A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, or for other entities performing functions or services related to ACO activities, to report anonymously suspected problems to the compliance officer. d. Compliance training for the ACO, ACO participants, and ACO providers/suppliers. e. A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency. 	§425.300	Yes, upon CMS request after initial submission only. Name your file: Axxx_S6_Q17_CompPlan_mmddyyyy.pdf

Section 7 – Tell us about you plan to manage shared savings			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
18.	<p>Past Participation – Indicate if you, your ACO participants, or ACO provider/suppliers previously have ever been voluntarily or involuntarily terminated from the Shared Savings Program.</p> <p>If you answered YES, upload a narrative in HPMS describing the cause of termination and what safeguards are in place to enable your ACO, ACO participant, and/or ACO provider/supplier to participate in the program for the full agreement term.</p>	§425.204 (b)(3)	Yes, required. Name your file: Axxx_S7_Q18_TermSSP_mmddyyyy.pdf
19.	<p>Current Participation – Indicate if you, your ACO participants, or ACO provider/suppliers currently participate in any Medicare initiative involving a shared savings arrangement.</p> <p>If we did not list your program, confirm with your program whether it involves shared savings. If it does, select ‘Other’ and add the name of the initiative in the text box available in HPMS.</p> <p>If you answered YES, mark all of the programs that apply (Coordinated ESRD Care (CEC) Program, Independence at Home Medical Practice Demonstration, Multi-payer Advanced Primary Care Practice, Demonstration with a shared savings arrangement, Next Generation Accountable Care Organization Model, Other (please specify), and certify that you have completed participation in the program(s) by the start date for which you are applying.</p> <p>If you answered NO, you are certifying that neither your ACO nor any of your ACO participants currently are participating in any other Medicare initiative involving shared savings.</p>	§425.114	N/A

Section 7 – Tell us about you plan to manage shared savings			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
20.	<p>Future Participation – If you answered YES to question 19, confirm that you will complete participation in this/these programs by the Shared Savings Program start date for which you are applying.</p> <p>By selecting YES, you are certifying that neither your ACO nor any of your ACO participants will participate concurrently in any other Medicare initiative involving shared savings.</p>	§425.114	N/A

Section 8 – Tell us how you plan to manage shared savings			
	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
	<p><i>*The information on your Form CMS-588 must match the ACO legal entity name in HPMS. Failure to verify this information accurately and completely or sending the Form to an address other than what is in the application will delay processing your Form CMS-588.</i></p>		
21a.	<p>Shared Savings – Submit a narrative that clearly and completely describes the following:</p> <ol style="list-style-type: none"> How you intend to share savings with your ACO participants and ACO providers/suppliers, or to use the shared savings to reinvest in the ACO’s infrastructure, redesigning care processes, etc. The percentage of savings you intend to distribute to each category. If you intend to distribute shared savings among ACO participants and ACO providers/suppliers, please describe the criteria you intend to use for distributing those payments. Describe how this plan will achieve the specific goals of the Shared Savings Program and how this plan will achieve the general aims of better care for individuals, better health for populations, and lower growth in expenditures. 	§425.204 (d)	Yes, required. Name your file: Axxxx_S8_Q21_SS_mmdyyyy.pdf
21b.	<p>Select your symmetrical Minimum Loss Rate (MLR)/ Minimum Savings Rate (MSR) for your 3-year agreement period.</p> <p>ACOs applying under Track 1 must select N/A.</p>	42 CFR 425.604(b)	No

Section 8 – Tell us how you plan to manage shared savings			
	Description /Instructions <i>*The information on your Form CMS-588 must match the ACO legal entity name in HPMS. Failure to verify this information accurately and completely or sending the Form to an address other than what is in the application will delay processing your Form CMS-588.</i>	Regulation Reference	Support Documents / Narrative Required
	<p>ACOs applying under Track 2 or Track 3 must select any other option:</p> <ul style="list-style-type: none"> 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) <p>For more information regarding MLR/MSR, go to the Shared Savings and Losses and Assignment Methodology Specifications, applicable beginning Performance Year 2016 (version 4, Dec 2015).</p>		
22.	<p>Banking Information – You must establish a relationship with a banking partner that meets the Internal Revenue Service (IRS) requirements.</p> <p>Read the Shared Savings Program ACO Banking Form Guidance, and FAQs. Download and complete the Form CMS 588 ACO Cover Sheet and the Form CMS-588. Mail the completed form with the ORIGINAL signature (neither digital nor photocopied) using overnight mail that can be tracked (like FedEx or UPS) to:</p> <p>Centers for Medicare & Medicaid Services CM/PBPPG, Mailstop C5-15-12 7500 Security Blvd. Baltimore, MD 21244-1850 Attention: Jonnice McQuay Desk Location: C4-02-02</p>	Treasury Reg. Secs 1.408-2(e)(2)-(e)(5)	Send your Form CMS-588 by a traceable delivery method such as FedEx or UPS.

Section 9 – Tell us about your ACO participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
23.	<p>ACO Participants: You must enter all of your ACO participants in HPMS in the “SSP ACO Participant List Management” module. This list of TINs represents all of your ACO participants who have joined to form the ACO and certify that they are accountable for the quality, cost and overall care of the ACO’s beneficiaries. They also attest to comply with the requirements of the program found at 42 CFR Part 425.</p> <p>Follow the guidance at ACO Participant List and ACO Participant Agreement Guidance. For additional information about submitting your ACO participants in HPMS refer to the HPMS “SSP ACO Participant List Management” module User Guide found in HPMS under the User Manual section of the “SPP ACO Participant List Management” module.</p> <p>NOTE: If your ACO contains FQHC(s) and/or RHC(s), these ACO participants are also required to supply the National Provider Identifier (NPI) and other identifying information for each physician that directly provides primary care services on behalf of the participating FQHC and RHC. A template is available in HPMS to submit large numbers of primary care physicians for FQHCs and RHCs.</p>	§425.204 (c)(5) & §425.214 (a)	Yes, required but, you will enter your TINs individually in HPMS in the “SSP ACO Participant List Management” module.
24.	<p>Meaningful Commitment: Indicate if your ACO participants and each ACO provider/supplier demonstrate a meaningful commitment to the mission of the ACO to ensure the ACO’s likely success.</p> <p>Meaningful commitment may include, for example, a sufficient financial or human investment (for example, time and effort) in the ongoing operations of the ACO such that the potential loss or recoupment of the investment is likely to motivate the ACO participant and ACO provider/supplier to achieve the ACO's mission under the Shared Savings Program.</p> <p>A meaningful commitment can be shown when an ACO participant or ACO provider/supplier agrees to comply with and implement the ACO's processes required by §425.112 and is held accountable for meeting the ACO's performance standards for each required process.</p>	§425.108 (d)	N/A

Section 9 – Tell us about your ACO participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
25.	<p>Merged or Acquired TINs – Indicate if your ACO includes any TINs that have been subsumed into another ACO Participant TIN through a merger or acquisition within the 3 benchmarking years.</p> <p>If you answered YES, you must provide us with the acquired TINs on the ACO Participant List. You must also attest to which ACO Participant TINs merged or were acquired by your ACO, attest that all acquired TINs have reassigned their billing to your ACO TIN & the acquired TIN no longer is used for billing. You must upload documents that provide evidence of merger or the acquisition of the TINs.</p> <p>See ACO Participant List and ACO Participant Agreement Guidance for additional guidance about merged and acquired TINs.</p>	§425.204 (g)	Yes, if applicable. Name your file: Axxxx_S9_Q25_MergAcqTIN_mmddyyy.pdf
26.	<p>Employment Agreements: To answer question 26, review your responses to questions 4 and 6.</p> <ul style="list-style-type: none"> • Answer N/A, if you answered YES to either questions 4 or 6. • Complete each requirement based on your answer to question 26. • If you answered NO or N/A to question 26, you must complete questions 27 and 28, and submit all required documentation associated with these questions. • If you answered YES to question 26, you are attesting that, if accepted into MSSP, you will notify each ACO provider/supplier of their participation in the Medicare Shared Savings Program. You must submit a copy of their Employee Agreements. <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program. • Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 26 based on your ACO’s organization structure. 	§425.204 (c)(1)(i) §425.104 & §425.204 & §425.210	Yes, if applicable. Name your file: Axxxx_S9_Q26_EmplAgmt_mmddyyy.pdf

Section 9 – Tell us about your ACO participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
27a.	<p>ACO Participant Agreement – Upload sample ACO Participant Agreements between your ACO and the ACO Participants (TINs) and other entities furnishing services related to ACO activities. These agreements must require compliance with the requirements and conditions of the program, including those specified in the participation agreement with CMS.</p> <p>NOTE: If your ACO is a single entity ACO (Scenario 2) where the sole participant in the ACO has the same TIN as the ACO, upload the required document in the upload section of the “SSP ACO Application Submission” module in HPMS:</p> <ul style="list-style-type: none"> • Scenario 2a – upload your sample Employment agreement (if all the practitioners billing through the ACO TIN are employed), • Scenario 2B – upload your sample ACO provider/supplier agreement (if all the practitioners billing through the ACO TIN are contracted), or • Scenario 2C – upload your sample Employment and/or ACO provider/supplier agreement (if all the practitioners billing through the ACO TIN are employed or contracted). <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program, and • Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 27 based on your ACO’s organization structure. 	§425.204 (c)(1)(i) §425.104 §425.204 §425.210	Yes, if applicable. Name your file: Axxxx_S9_Q27a_AgmtSamp_mmddy yyy.pdf
27b.	<p>Use the ACO Participant Agreement Template to tell us where you state the requirements in your ACO Participant Agreement sample. For instructions, see How to Complete the ACO Participant Agreement Template.</p> <p>Read the following guidance for assistance completing this requirement:</p> <ul style="list-style-type: none"> • ACO Participant List and ACO Participant Agreement Guidance • ACO Participant TIN Exclusivity and Other Entities FAQs 	§425.204 (c)(1)(i) §425.304	Yes, required. Name your file: Axxxx_S9_Q27b_ AgmtTemp_mmddyyyy.pdf

Section 9 – Tell us about your ACO participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
28.	<p>Medicare referrals: Indicate if your ACO Participant Agreements do not require Medicare referrals to ACO participants or their associated ACO provider/suppliers except under the specific and limited circumstances expressly permitted in the regulations.</p> <p>If you answer YES to Question 28, you are attesting that your ACO Participant Agreements complies with the regulations.</p> <p>See the ACO Participant List and ACO Participant Agreement Guidance for more information about agreement requirements.</p>	§425.304 (c)(2)	N/A
29.	<p>Executed ACO Participant Agreements– Upload the executed ACO Participant Agreement(s) first page and signature page for ALL ACO Participant(s) identified on your ACO Participant List in HPMS in the Participant List Management Module.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program, and • Section B. Organization Structure Scenario Chart for guidance on providing the correct response to question 29 based on your ACO’s organization structure. <p>See ACO Participant List and ACO Participant Agreement Guidance for additional guidance about submitting your ACO Participants in the “SSP ACO Participant List Management” module in HPMS.</p> <ul style="list-style-type: none"> • The ACO Participant Agreements must have an original signature (ink on paper), not an electronic signature. • Each executed agreement must be a separate .pdf and use the specified naming convention shown at right. The naming convention must include the legal name of the ACO Participant as identified on the ACO Participant List. If the ACO Participant name is more than 8 characters, you must use an abbreviation. 	§425.306 §425.214 (a) §425.204 (c)(5)	<p>Yes, required but uploaded individually in HPMS in the Participant List Management Module. Name your file: Axxxx_ParAgmExec[TINName]_mmdyyyy.pdf</p> <p>If your ACO is a single entity, name your file: Axxxx_ParAgmtExec_SingleTIN_mmdyyyy.pdf</p>

Section 9 – Tell us about your ACO participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
	<ul style="list-style-type: none"> Example: A0001 has an agreement with ACO Participant John Doe Hospital. The naming convention for this agreement is: A0001_Q29_ExeAgmt_JDoeHosp.mmddy.pdf <p>NOTE: If your ACO is a single entity ACO where the sole participant in the ACO has the same TIN as the ACO, no executed Participant Agreement is required. However, an upload is required in the Participant List Management module for each ACO participant. For guidance on submitting documentation for the sole participant, refer to the HPMS “SSP ACO Participant List Management Module User Guide” found in HPMS under the User Manual section of the “SPP ACO Participant List Management” module.</p>		

Section 10 – Tell us about data sharing			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
30.	<p>Indicate if you are requesting the following minimum necessary data based on the Medicare Shared Savings Track you select:</p> <ul style="list-style-type: none"> 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. For Track 3: The name, date of birth, sex and Health Insurance Claim Number (HICN) of beneficiaries who are prospectively assigned to the ACO. 	<p>§425.700; §425.702; §425.710</p>	N/A

Section 10 – Tell us about data sharing																					
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required																		
	<ul style="list-style-type: none"> Information in the categories below for Track 1 and 2- beneficiaries that are preliminarily prospectively assigned; for Track 3- beneficiaries that are prospectively assigned: <ul style="list-style-type: none"> demographic data health status information utilization rates expenditure information <p>* The specific information provided in these categories will (1) be derived from Medicare Fee-for-Service claims and beneficiary eligibility data, and (2) be available as part of the quarterly and annual aggregate program reports. The type of information included in the quarterly and annual aggregate program reports are updated on an annual basis by the first quarter of any given program year.</p> <p>If you indicate YES to requesting the minimum necessary data, the CMS data files listed below (and subject to change) are covered in the Data Use Agreement (DUA) you will sign upon application approval (the DUA is not required at the time of your application submission).</p> <table border="1"> <thead> <tr> <th>Files</th> <th>System of Record</th> </tr> </thead> <tbody> <tr> <td>HIGLAS - Payment Data</td> <td>N/A</td> </tr> <tr> <td>NLR - Meaningful Use</td> <td>NCH</td> </tr> <tr> <td>RAS - Risk Adjustment Data</td> <td>IDR</td> </tr> <tr> <td>CAHPS - Beneficiary Survey Data</td> <td>IDR</td> </tr> <tr> <td>GPRO - Quality Measurement Data</td> <td>NCH</td> </tr> <tr> <td>NPIXW - NPI Crosswalk</td> <td>NPES</td> </tr> <tr> <td>PECOS - Provider Enrollment Data</td> <td>PECOS</td> </tr> <tr> <td>EDB - Beneficiary Enrollment Data</td> <td>CMS</td> </tr> </tbody> </table>	Files	System of Record	HIGLAS - Payment Data	N/A	NLR - Meaningful Use	NCH	RAS - Risk Adjustment Data	IDR	CAHPS - Beneficiary Survey Data	IDR	GPRO - Quality Measurement Data	NCH	NPIXW - NPI Crosswalk	NPES	PECOS - Provider Enrollment Data	PECOS	EDB - Beneficiary Enrollment Data	CMS		
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Section 10 – Tell us about data sharing			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
31.	<p>Indicate if you are requesting beneficiary identifiable Part A, B and D claims data.</p> <p>The minimum necessary Parts A, B, and D data elements are listed in Appendix D of this reference guide and are subject to change.</p> <p>If you want to receive data on a beneficiary-identifiable level, you must select YES. If you select YES, you may receive beneficiary-identifiable data AND aggregate data. If you select NO, you will receive aggregate data ONLY.</p>	§425.700; §425.704; §425.706; §425.708; §425.710	N/A
32.	<p>If you answered YES to either Question 30 or 31, you must 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.</p>	§425.700; §425.702; §425.704; §425.706; §425.708; §425.710	N/A
33.	<p>If you answered YES in response to question 30 or 31, describe in a narrative the following:</p> <ol style="list-style-type: none"> How you will ensure privacy and security of data How you intend to use this data: <ul style="list-style-type: none"> 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. <p>Note: If you are approved to participate in the Medicare Shared Savings Program, you must submit a Data Use Agreement (DUA) prior to receiving any data.</p>	§425.700; §425.702; §425.704; §425.706; §425.708; §425.710	Yes, if applicable. Axxxx_S10_Q33_DataShare_mmddyyyy.pdf

Section 11 –Tell us about your clinical processes and patient centeredness			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
34.	Accountability for beneficiaries – Confirm that your ACO, ACO participants, and providers/suppliers agree to be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.	§425.204 (a)	N/A
35.	Providing a quality assurance and improvement program – Verify that your ACO has a qualified health professional responsible for your ACO's quality assurance and improvement program that encompasses the four required processes (i.e., evidence-based medicine, beneficiary engagement, quality & cost metrics and coordination of care).	§425.112 & §425.204	N/A
36.	Upload a narrative in HPMS describing how your ACO requires your participants to comply with and implement quality assurance and improvement programs. You must also include your remedial processes and penalties that apply to ACO participants and/or ACO providers/supplies who fail to comply with these required processes.	§425.112 & §425.204	Yes, required. Name your file: Axxxx_S11_Q36_QARem_mmdyyy.pdf
37.	Promoting evidence-based medicine – Upload a narrative in HPMS describing how you define, establish, implement, evaluate, and periodically update your process to promote evidence-based medicine. This process should cover diagnoses with significant potential for the ACO to achieve quality improvements for overall care practices, taking into account the circumstances of individual beneficiaries and internal assessments of this process to continuously improve your ACO's care practices.	§425.112& §425.204	Yes, required. Name your file: Axxxx_S11_Q37_EBMed_mmdyyy.pdf

Section 11 – Tell us about your clinical processes and patient centeredness			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
38.	Promoting beneficiary engagement – Upload a narrative in HPMS that clearly and completely describes how you define, establish, implement, evaluate, and periodically update its process to promote patient engagement. Clearly and completely describe how the applicant addresses these requirements.	§425.112 & §425.204	Yes, required. Name your file: Axxxx_S11_Q38_BeneEng_mmddyyyy.pdf
39.	Internally reporting on quality and cost metrics – Upload a narrative in HPMS that clearly and completely describes how you define, establish, implement, evaluate, and periodically update your processes and infrastructure to support internal reporting on quality and cost metrics. Include in your narrative how this enables you to monitor, provide feedback, and evaluate ACO participant and provider/supplier performance. Your narrative should also explain how you use these results to improve care and service over time and how your internal assessment processes enable you to continuously improve the ACO's care practices.	§425.112 & §425.204	Yes, required. Name your file: Axxxx_S11_Q39_QulCstMet_mmddyyyy.pdf
40.	Promoting coordination of care – Upload a narrative in HPMS that clearly and completely describes how you define, create, put into place, evaluate, and periodically update your care coordination processes. You must include a description of each of the required elements listed in the application.	§425.112 & §425.204	Yes, required. Name your file: Axxxx_S11_Q40_CoC_mmddyyyy.pdf

Section 12 – Certify your application			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required
	You must select I agree to certify your application. Your application is complete and submitted once you select I agree .	§425.202 (a)(2) & §425.202 (a)(3)	N/A

Appendix C. Application Reference Table – For Renewal Applicants

Purpose: This Renewal Application Reference Table guides you through each application question, one-by-one, providing additional guidance to assist you in answering questions accurately and completely.

All documents you submit must include your ACO legal entity name and ACO ID per the instructions in this appendix.

Use the zip file naming conventions below for each upload section of the application. All documents included in the zip file must follow file naming conventions provided in the table below.

- [Section 1](#): n/a
- [Section 2](#): Axxxx_S2_mmddyyyy.zip
- [Section 3](#): n/a
- [Section 4](#): Axxxx_S4_mmddyyyy.zip
- [Section 5](#): Axxxx_S5_mmddyyyy.zip
- [Section 6](#): Axxxx_S6_mmddyyyy.zip
- [Section 7](#): Axxxx_S7_mmddyyyy.zip
- [Section 8](#): Axxxx_S8_mmddyyyy.zip
- [Section 9](#): n/a

Application Reference Table Layout:

- Column 1: Application Question Number (Q#). You may also use this column to check-off completed items
- Column 2: Instructions to aide you in answering application questions and the type of document requested
- Column 3: Regulation reference
- Column 4: Indicator for determining if supporting documentation and/or a narrative is required with the File naming convention

You must complete your renewal application in HPMS. Where applicable, your application has been pre-populated with information from your NOIA. The submission of your NOIA does not bind your ACO to submit an application. You can change the pre-populated information by notifying CMS with an email to SharedSavingsProgram@cms.hhs.gov following the normal procedure.

Section 1 – ACO entity information			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p><i>*Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information or the instructions below:</i></p> <p>ACO Address – Confirm and/or update your ACO legal entity name, Trade name or DBA (if applicable), mailing address, ACO composition, ACO contacts, and ACO Webpage URL</p> <p>ACOs can edit the following information on the Basic Agreement Data page:</p> <ul style="list-style-type: none"> ● ACO Trade Name/DBA (if applicable); ● ACO Mailing Address; ● ACO Composition; ● ACO Contacts; and ● ACO Public Reporting URL <p>If you identify an error with your ACOs data, other than the information you can change, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information to notify CMS.</p>	N/A	N/A
	<p>Organization Contacts – Enter the following information about your ACO contacts on the Contact Data page: name, title, address, email, and phone number. Use the guidance in Section below to help you complete your entry</p> <ul style="list-style-type: none"> ● Section 3.1 How to Enter and Update your ACO Contacts ● Section 3.1.1 Contacts Required Upon Application Submission ● Section 3.1.2 Contacts Required Upon Application Approval ● Section 10 Managing Your ACO Contacts for contact definitions 	N/A	N/A

Section 2 – General information about your ACO			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p><i>* Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p> <p><i>*Any changes to your Basic Agreement Data page will affect your current agreement ending December 1, 2016 and your renewal application for the January 1, 2017 program start date.</i></p>		<p><i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i></p>
	I Am A (Application Type): You are renewing your agreement (or is scheduled to) for an additional 3-year agreement period.	N/A	N/A
	ACO Legal Entity: Verify your ACO Legal Entity Name	N/A	N/A
	<p>Medicare Shared Savings Program Track: Make your selection to participate in:</p> <ul style="list-style-type: none"> • Track 1 (one-sided model: shared savings), • Track 2 (two-sided model: shared savings/losses) or • Track 3 (two-sided model: shared savings/losses) on the Basic Agreement Data page in HPMS. This question will only appear on this page. • 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 <p>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.</p> <ul style="list-style-type: none"> • You may only make this selection in HPMS at the time of your application submission. 	§425.204 (e)(1), 425.600	N/A

Section 2 – General information about your ACO			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p><i>* Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p> <p><i>*Any changes to your Basic Agreement Data page will affect your current agreement ending December 1, 2016 and your renewal application for the January 1, 2017 program start date.</i></p>		<p>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</p>
	<ul style="list-style-type: none"> Once you make the selection, you will not be able to change it in HPMS. If you identify an error, you must notify CMS at SSPACO_Applications@cms.hhs.gov to make the correction. See Section 3.4 How to Request Changes to Pre-Populated Information. <p>ACOs participating under the two-sided model accept liability for losses and have the chance for greater reward (savings). Track 3, in comparison to Track 2, offers greater risk and greater opportunity for reward.</p> <p>If you select Track 2 or Track 3, you must indicate your Repayment Mechanism selection on the Basic Agreement Data page once you make your selection. The Repayment Mechanism section will not appear for ACOs who select Track 1.</p>		
	<p>Skilled Nursing Facility (SNF) 3-Day Waiver (For Track 3 only)</p> <p>If you are applying as a Track 3 ACO and would also like to apply for the SNF 3-Day Rule Waiver, you must complete a separate SNF 3-Day Rule Waiver application in addition to this application.</p> <p>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 starting January 1, 2018, you do not need to submit the SNF 3-Day Rule Waiver Application at this time. You should submit it in next year’s application cycle.</p>	§425.612	N/A
	<p>ACO Tax Payer Identification Number (TIN): Confirm your ACO’s TIN used to establish the ACO as a legal entity. This is the TIN that will receive and distribute shared savings to your ACO participants. This TIN will be responsible for paying shared losses (ACOs who selected Track 2 or Track 3). This TIN will also be responsible for regulatory requirements.</p>	§425.104 & §425.204	N/A

Section 2 – General information about your ACO			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p><i>* Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p> <p><i>*Any changes to your Basic Agreement Data page will affect your current agreement ending December 1, 2016 and your renewal application for the January 1, 2017 program start date.</i></p>		<p>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</p>
	<p>Date of Formation: Confirm your ACO’s legal date of formation. This date should match the information on your entity formation documentation (e.g. Certificate of Incorporation).</p>	§425.104 & §425.204	N/A
	<p>Your Business Structure: Confirm your ACO’s Legal Entity type: sole proprietorship, partnership, publicly-traded corporation, privately-held corporation, limited liability company or Other. * If you select “Other”, indicate the type of Legal Entity in the text box provided in HPMS.</p>	§425.104 & §425.204	N/A
	<p>Your Tax Status: Select the ACO’s tax status. Please select only one: Not-for-profit, or For profit.</p>	§425.104 & §425.204	N/A
	<p>Repayment Mechanism: Complete this section on the Basic Agreement Data page once you select your Medicare Shared Savings Program Track. You will ONLY see this selection if you are applying for Track 2 or Track 3. Indicate which repayment mechanism(s) you will use. Select all that apply from the following options:</p> <ul style="list-style-type: none"> • Funds placed in escrow • Surety bonds • A line of credit the Medicare program can draw upon, as evidenced by a letter of credit <p>You may only make this selection in HPMS at the time of your application submission. Once you make the selection, you will not be able to change it in HPMS. If you identify an error, you must notify CMS at SSPACO_Applications@cms.hhs.gov to make the correction.</p> <p>See Section 3.4 How to Request Changes to Pre-Populated Information.</p> <p>Your ACO is not required to submit repayment mechanism documentation with the initial/renewal application submission. However, you should begin discussions with a financial institution or insurance company of your choice as soon as your ACO decides to</p>	§425.204 (f)	N/A

Section 2 – General information about your ACO			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p><i>* Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p> <p><i>*Any changes to your Basic Agreement Data page will affect your current agreement ending December 1, 2016 and your renewal application for the January 1, 2017 program start date.</i></p>		<p>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</p>
	<p>apply for a two-sided risk model. After you submit your application and during the application review process, you will receive a letter from CMS outlining the process for the submission and review of your repayment mechanism and key deadlines. The letter will also include the estimated dollar amount for your repayment mechanism. A fully funded repayment mechanism must be in place and approved by CMS before CMS will approve your Shared Savings Program application.</p> <p>Refer to the Repayment Mechanism Guidance for additional information.</p>		

Section 3 – Tell us if your ACO meets the Antitrust Agencies’ definition of “newly formed”			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
1.	<p>Jointly negotiated contracts with a private payor(s)– Confirm whether your ACO has entered into any contracts with private payors prior to March 23, 2010. ACOs who HAVE signed or jointly negotiated any contracts with private payors on or after March 23, 2010, must agree to permit CMS to share a copy of this application with the Antitrust Agencies.</p> <p>An ACO is not newly formed if it is comprised solely of providers that signed or jointly negotiated contracts with private payors on or before March 23, 2010.</p> <p>Read the Federal Trade Commission (FTC) and Department of Justice’s (DOJ) Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program Antitrust Policy Statement.</p>	<p>§425.202 (a)(3) & the Antitrust Policy Statement</p>	<p>N/A</p>

Section 4 – Your ACO legal entity			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
2a.	<p>Certify that your ACO is a legal entity that meets the requirements of 42 CFR 425.104</p> <p>Note: If your currently approved legal entity status has changed, you may not be able to apply as a renewal Medicare Shared Savings Program ACO. For example, you must apply as a new Medicare Shared Savings applicant entering under a new agreement period for the January 1, 2017 start date, 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. In this instance, we consider your ACO a new entity and you must submit a NOIA as a new applicant per the instructions in the NOIA Memo.</p>	<p>§425.104 §425.204</p>	N/A
2b	Submit a narrative describing any substantive changes to your organization and/or affiliations since the approval of your initial application.	N/A	Yes, if applicable. Name your file: Axxxx_S4_Q2b_Hist_mmddyyyy.pdf
3.	<p>Certify that your ACO meets the governing body requirements and your ACO has an identifiable governing body with authority to execute the functions of your ACO as defined in regulations at 42 CFR §425.106.</p> <p>The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises two or more ACO participants.</p> <p>If you answer YES, you are certifying that your ACO meets the requirements:</p> <p>If you answer NO, describe why you seek to differ from this requirement and explain with supporting documentation how your ACO meets the governing body requirements as described in the regulations at 42 CFR §425.106.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program. 	§425.106	Yes, if applicable. Name your file: Axxxx_S4_Q3_GovBodDiff_mmddyyyy.pdf
4.	Certify that you ACO's leadership and management meets the requirements of 42 CFR 425.108.	§425.108	N/A

Section 4 – Your ACO legal entity			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
5.	<p>Upload your ACO's organizational charts 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. You must use the organizational chart that is established by your ACO.</p> <p>See Appendix A for samples Organizational Chart</p> <ul style="list-style-type: none"> • Section C Organizational Chart-Acceptable Sample • Section D. Organizational Chart – Unacceptable Sample 	<p>§425.204 (c)(1)(iii) & §425.108</p>	<p>Yes, required. Name your file: Axxxx_S4_Q5_OrgChart_mmddyyyy.pdf</p>
6.	<p>Upload your ACO's governing body template – Upload the names, titles (e.g. Chair, Vice-Chair), and responsibilities for all members of the governing body.</p> <p>See the Governing Body Governing Body FAQs for more information.</p> <p>Please use the Governing Body Instructions to submit the Governing Body Template to identify:</p> <ol style="list-style-type: none"> All governing body members Position each member holds on the governing body Voting power of each governing body member Indicate which ACO participant the governing body member represents; or indicate if the governing body member is a Medicare beneficiary representative, community stakeholder representative, or other. <p>NOTE: The Governing Body Template completes this requirement.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program. 	<p>§425.308 (c)(3) & §425.106</p>	<p>Yes, required. Name your file: Axxxx_S4_Q6_GovBod_mmddyyyy.pdf</p>

Section 5 – Managing your ACO’s shared savings			
	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
7.	<p>Select your symmetrical Minimum Loss Rate (MLR)/ Minimum Savings Rate (MSR) for your 3-year agreement period.</p> <p>ACOs applying under Track 1 must select N/A.</p> <p>ACOs applying under Track 2 or Track 3 must select any other option:</p> <ul style="list-style-type: none"> 0.0% MLR/MSR 0.5% MLR/MSR 1.0% MLR/MSR 1.5% MLR/MSR 2.0% MLR/MSR <p>Symmetrical Variable MLR/MSR (based on the size of your ACO’s assigned population)</p> <p>For more information regarding MLR/MSR, go to the Shared Savings and Losses and Assignment Methodology Specifications, applicable beginning Performance Year 2016 (version 4, Dec 2015).</p>	<p>42 CFR 425.604(b)</p>	<p>N/A</p>
8.	<p>Banking Information: Certify the banking information you have on file is current.</p> <p>If you need to update your banking information, read the Shared Savings Program ACO Banking Form Guidance and FAQs. Download and complete the Form CMS 588 ACO Cover Sheet and the Form CMS-588. Mail the completed form with the ORIGINAL signature (neither digital nor photocopied) using overnight mail that can be tracked (like FedEx or UPS) to:</p> <p>Centers for Medicare & Medicaid Services Attention: Jonnice McQuay 7500 Security Blvd, Mail Stop C5-15-12, Location C4-02-02 Baltimore, MD 21244-1850</p>	<p>Treasury Reg. Secs 1.408- 2(e)(2)-(e)5</p>	<p>Send your Form CMS-588 by a traceable delivery method such as FedEx or UPS, if applicable.</p>

Section 6 – Your ACO Participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
9.	<p>Enter your ACO Participant List and ACO provider/suppliers by confirming through the “SSP ACO Participant List Management” module in HPMS. Confirm that your ACO Participants have agreed to continue participating in your next agreement period. You can also submit changes to your ACO Participant List including additions, deletions, and modifications to your currently approved ACO Participant List.</p> <p>Follow the guidance at ACO Participant List and ACO Participant Agreement Guidance. For additional information about submitting your ACO Participants in HPMS in the “SSP ACO Participant List Management” module refer to the HPMS “SSP ACO Participant List Management Module User Guide” found in HPMS under the User Manual section of the “SPP ACO Participant List Management Module”.</p>	§425.204 (c)(5) & §425.214 (a)	Yes, required but, you will upload your TINS in HPMS in the “SSP ACO Participant List Management” module.
10.	<p>Meaningful Commitment: 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.</p> <p>If you select NO, you cannot participate in the Shared Savings Program.</p>	§425.108 (d)	N/A
11.	<p>Employment Agreements: Certify that you’re a single entity ACO (Scenario 2) and that the ACO participant TIN and the ACO legal entity are the same number. If you answered YES:</p> <ul style="list-style-type: none"> You are attesting that if your participation agreement is renewed, you will notify each ACO provider/supplier of their participation in the 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 Shared Savings Program. You must submit a sample ACO provider/supplier agreement you have in place for your ACO provider/suppliers that are not required as a condition of employment to participate in the Shared Savings Program. 	§425.116 §425.204 (c)(1)(i) §425.104 & §425.204 & §425.210	Yes, if applicable. Name your file: Axxxx_S6_Q11_EmplAgmt_mmddyyyy.pdf

Section 6 – Your ACO Participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<ul style="list-style-type: none"> Do not complete questions 12 and 13. <p>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.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program. 		
12a.	<p>ACO Participant Agreement: 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.</p> <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program, and <p>NOTE: If your ACO is a single entity ACO (Scenario 2) where the sole participant in the ACO has the same TIN as the ACO, upload the required document in the upload section of the “SSP ACO Application Submission” module in HPMS:</p> <ul style="list-style-type: none"> Scenario 2a – upload your sample Employment agreement (if all the practitioners billing through the ACO TIN are employed), Scenario 2B – upload your sample ACO provider/supplier agreement (if all the practitioners billing through the ACO TIN are contracted), or Scenario 2C – upload your sample Employment and/or ACO provider/supplier agreement (if all the practitioners billing through the ACO TIN are employed or contracted). 	§425.116; §425.204 (c)(1)(i); §425.104; §425.204; §425.210	Yes, required. Name your file: Axxxx_S6_Q12a_AgmtSamp_mmddyyyy.pdf

Section 6 – Your ACO Participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
12b.	Submit the ACO Participant Agreement Template to identify the location of the program requirements in your ACO Participant Agreement.	§425.304 & §425.204 (c)(1)(i)	Yes, required. Name your file: Axxxx_S6_Q12b_AgmtTemp_mmdyyyy.pdf
13.	<p>Executed ACO Participant Agreements: Upload your ACO Participants 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.</p> <p>You must upload your agreements with each Change Request you submit in the SSP ACO Participant List Management” module in HPMS. 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. The ACO Participant Agreements must have an original signature (ink on paper), not an electronic signature. 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 also must attest that it complies with the requirements of the program found at 42 CFR Part 425.</p> <p>For additional guidance about ACO participants, see ACO Participant List and ACO Participant Agreement Guidance and the HPMS ACO Participant List User Guide for step-by-step instructions on submitting your ACO Participants in HPMS in the “SSP ACO Participant List Management” module.</p> <p>NOTE: If your ACO contains FQHC(s) and/or RHC(s), these ACO participants are also required to supply the National Provider Identifier (NPI) and other identifying information for each physician that directly provides primary care services on behalf of the participating FQHC and RHC.</p>	§425.204 (c)(5) & §425.214 (a)	<p>Yes, required. Upload your executed ACO Participant Agreement with each CR you enter individually in the “SSP ACO Participant List Management” module in HPMS. Name your file: Axxxx_ParAgmExec[TINName]_List_mmd dyy.pdf.</p> <p>If your ACO is a single entity, name your file: Axxxx_ParAgmtExec_SingleTIN_mmd dyy.pdf</p> <p>Note: Do not upload your executed ACO Participant Agreements in the upload section of the Online Application in HPMS.</p>

Section 6 – Your ACO Participants			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p>NOTE: If your ACO is a single entity ACO (Scenario 2) where the sole participant in the ACO has the same TIN as the ACO, no executed Participant Agreement is required. However, an upload is required in the Participant List Management module in HPMS for each ACO participant. To satisfy this requirement, please do the following:</p> <ol style="list-style-type: none"> 1. Create a separate document that includes the following information: <ul style="list-style-type: none"> • ACO ID and ACO LBN • TIN LBN and TIN (digit) • Sentence stating that your ACO is a Single Entity ACO, therefore no executed agreement is required. 2. Compress (zip) the file. File name: Axxxx_ParAgmtExec_SingleTIN_mmddyy.pdf 3. Upload this document in lieu of an executed Participant Agreement in the “SSP ACO Participant List Management” module in HPMS. <p>Additionally, in response to Question 11, upload your sample employment and or ACO provider/supplier agreement for your single ACO Participant. Upload the required document in the upload section of the “SSP ACO Application Submission” module in HPMS:</p> <ul style="list-style-type: none"> • Scenario 2a – upload your sample Employment agreement (if all the practitioners billing through the ACO TIN are employed), • Scenario 2B – upload your sample ACO provider/supplier agreement (if all the practitioners billing through the ACO TIN are contracted), or • Scenario 2C – upload your sample Employment and/or ACO provider/supplier agreement (if all the practitioners billing through the ACO TIN are employed or contracted) <p>Confirm that your response is consistent with the guidance in Appendix A:</p> <ul style="list-style-type: none"> • Section A. Organization Structure Description for definitions on the most common types of organization structures for the Medicare Shared Savings Program. 		

Section 7 – Tell us about data sharing			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
14a.	<p>Indicate if you are requesting the following minimum necessary data based on the Medicare Shared Savings Track you select:</p> <ul style="list-style-type: none"> • 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. • For Track 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 categories below for Track 1 and 2- beneficiaries that are preliminarily prospectively assigned; for Track 3- beneficiaries that are prospectively assigned: <ul style="list-style-type: none"> ▪ demographic data ▪ health status information ▪ utilization rates ▪ expenditure information <p>* The specific information provided in these categories will (1) be derived from Medicare Fee-for-Service claims and beneficiary eligibility data, and (2) be available as part of the quarterly and annual aggregate program reports. The type of information included in the quarterly and annual aggregate program reports are updated on an annual basis by the first quarter of any given program year.</p> <p>If you indicate YES to requesting the minimum necessary data, the CMS data files listed below (and subject to change) are covered in the Data Use Agreement (DUA) you will sign upon application approval (the DUA is not required at the time of your application submission).</p>	<p>§425.700; §425.702; §425.710</p>	<p>N/A</p>

Section 7 – Tell us about data sharing																					
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention																		
	<table border="0"> <tr> <td>Files</td> <td>System of Record</td> </tr> <tr> <td>HIGLAS - Payment Data</td> <td>N/A</td> </tr> <tr> <td>NLR - Meaningful Use</td> <td>NCH</td> </tr> <tr> <td>RAS - Risk Adjustment Data</td> <td>IDR</td> </tr> <tr> <td>CAHPS - Beneficiary Survey Data</td> <td>IDR</td> </tr> <tr> <td>GPRO - Quality Measurement Data</td> <td>NCH</td> </tr> <tr> <td>NPIXW - NPI Crosswalk</td> <td>NPESS</td> </tr> <tr> <td>PECOS - Provider Enrollment Data</td> <td>PECOS</td> </tr> <tr> <td>EDB - Beneficiary Enrollment Data</td> <td>CMS</td> </tr> </table>	Files	System of Record	HIGLAS - Payment Data	N/A	NLR - Meaningful Use	NCH	RAS - Risk Adjustment Data	IDR	CAHPS - Beneficiary Survey Data	IDR	GPRO - Quality Measurement Data	NCH	NPIXW - NPI Crosswalk	NPESS	PECOS - Provider Enrollment Data	PECOS	EDB - Beneficiary Enrollment Data	CMS		
Files	System of Record																				
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PECOS - Provider Enrollment Data	PECOS																				
EDB - Beneficiary Enrollment Data	CMS																				
14b.	<p>Indicate if you are requesting beneficiary identifiable Part A, B and D claims data.</p> <p>The minimum necessary Parts A, B, and D data elements are listed in appendix D of this reference guide and are subject to change.</p> <p>If you want to receive data on a beneficiary-identifiable level, you must select YES. If you select YES, you may receive beneficiary-identifiable data AND aggregate data. If you select NO, you will receive aggregate data ONLY.</p>	§425.700; §425.704; §425.706; §425.708; §425.710	N/A																		
14c.	<p>If you answered YES to either Question 14a or 14b, you must 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.</p>	§425.700; §425.702; §425.704; §425.706; §425.708; §425.710	N/A																		
14d.	<p>Indicate if you will maintain the same methods 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.</p> <p>If you answered No, you must submit a new narrative describing the following requirements in both a and b:</p> <ol style="list-style-type: none"> How you will ensure privacy and security of data How you intend to use this data: 	§425.700; §425.702; §425.704; §425.706; §425.708; §425.710	Yes, if applicable. Axxx_S7_Q14d_DataShare_mmddyyy.pdf																		

Section 7 – Tell us about data sharing			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<ul style="list-style-type: none"> 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. <p>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.</p>		

Section 8 – Required clinical processes and patient centeredness			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
15.	Accountability for Beneficiaries: Certify that your ACO has agreed to be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.	§425.204 (a)	N/A
16.	Required Clinical Processes: Certify that your 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 that would apply for non-compliance.	§425.112& §425.204	N/A

Section 9 – Certify your application			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	You must select I agree to certify your application. Your application is complete and submitted once you select I agree .	§425.202 (a)(2) & §425.202 (a)(3)	N/A

Appendix D. Application Reference Table – For SNF 3-Day Waiver Applicants

Purpose: This SNF 3-Day Rule Waiver Application Reference Table guides you through each application question, one-by-one providing additional guidance to assist you in answering questions accurately and completely. All documents you submit must include your ACO legal entity name and ACO ID per the instructions in this appendix.

Use the zip file naming conventions below for each upload section of the application. All documents included in the zip file must follow file naming conventions provided in the table below.

- [Section 1](#): n/a
- [Section 2](#): Axxxx_S2_mmddyyyy.zip
- [Section 3](#): n/a
- [Section 4](#): Axxxx_S4_mmddyyyy.zip
- [Section 5](#): Axxxx_S5_mmddyyyy.zip
- [Section 6](#): Axxxx_S6_mmddyyyy.zip
- [Section 7](#): Axxxx_S7_mmddyyyy.zip

Application Reference Table Layout:

- Column 1: Application Question Number (Q#). You may also use this column to check-off completed items
- Column 2: Instructions to aide you in answering applciation questions and the type of document requested
- Column 3: Regulation reference
- Column 4: Indicator for determining if supporting documentation and or a narrative is required with the File naming convention

You must complete your SNF 3-Day Rule Waiver application in HPMS. Where applicable, your application has been pre-populated with information from your NOIA. The submission of your NOIA does not bind your ACO to submit an application. You can change the pre-populated information by notifying CMS with an email to SharedSavingsProgram@cms.hhs.gov following the normal procedure.

Section 1 – General			
Q#	Description/Instructions <i>*Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i>	Regulation Reference	Support Documents/Narrative Required/File Naming convention
1.	Certification to Identify and Manage Beneficiaries – the ability to identify and manage those beneficiaries who are either directly administered to a SNF or admitted to a SNF after and inpatient hospitalization of fewer than 3 days is a pre-requisite to being able to apply for this waiver. If you select NO , you are not eligible for the SNF 3-Day Rule Waiver		N/A

Section 2 – Communication Plan			
Q#	Description/Instructions <i>* Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information. *Any changes to your Basic Agreement Data page will affect your current agreement ending December 1, 2016 and your renewal application for the January 1, 2017 program start date.</i>	Regulation Reference	Support Documents/Narrative Required/File Naming convention <i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i>
2.	Certification of Required Communication Plan: Communication Plan includes the following: <ul style="list-style-type: none"> • The process the ACO will use to evaluate and periodically update its Communication Plan with its SNF affiliates; • How your ACO will identify and designate person(s) at the ACO with whom SNF affiliates will communicate and coordinate admissions; • 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; • 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; 	§425.612(a)(1)(i)(A)(1)	N/A

Section 2 – Communication Plan			
Q#	Description/Instructions	Regulation Reference	Support Documents/Narrative Required/File Naming convention
	<p><i>* Information in this section is pre-populated with information on file for your ACO. If you wish to change this information, follow the instructions in Section 3.4 How to Request Changes to Pre-Populated Information.</i></p> <p><i>*Any changes to your Basic Agreement Data page will affect your current agreement ending December 1, 2016 and your renewal application for the January 1, 2017 program start date.</i></p>		<p><i>Section 2 does not require an upload at the time you submit your application. However you may be required to upload supporting documents during the application review process.</i></p>
	<ul style="list-style-type: none"> • How frequently communications will take place between the ACO and its SNF affiliates; • 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. • How the ACO will respond to questions and complaints related to the ACO’s use of the SNF 3-Day Rule Waiver from SNF affiliates, ACO participants, ACO providers/suppliers, beneficiaries, acute care hospitals, and other stakeholders. <p>If you select NO, you are not eligible for the SNF 3-Day Rule Waiver</p>		
3.	Submit your Communication Plan: Plan must address each of the requirements listed in Question 2.	§425.612(a) (1)(i)(A)(1)	Yes, if applicable. Name your file: Axxx_S2_Q3_CommPlan_mmdyyy.pdf

Section 3 – Beneficiary Evaluation & Admission Plan			
Q#	Description/Instructions	Regulation Reference	Support Documents/Narrative Required/File Naming convention
4.	Certification that your ACO has established, and will evaluate and periodically update a Beneficiary Evaluation and Admission Plan for beneficiaries	§425.112	N/A

Section 3 – Beneficiary Evaluation & Admission Plan			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
5.	<p>Certify that the Beneficiary Evaluation and Admission Plan includes at least the following:</p> <ul style="list-style-type: none"> • 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); • 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 Rule Waiver; • A protocol for admitting beneficiaries to a SNF directly from home or an outpatient setting under the waiver; • 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; • A protocol for informing beneficiaries about the waiver and their options for care settings; <p>If you select NO, you are not eligible for the SNF 3-Day Rule Waiver</p>	§425.612 (a)(1)(ii)	N/A
6.	<p>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:</p> <ul style="list-style-type: none"> • Is prospectively assigned to my ACO for the performance year in which the beneficiary is admitted to the SNF affiliate; • Does not reside in a SNF or other long-term care facility; • Is medically stable; • Does not require inpatient or further inpatient hospital evaluation or treatment; • Has a certain and confirmed diagnosis; • Has an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient; 	§425.612	N/A

Section 3 – Beneficiary Evaluation & Admission Plan			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p>*Review, update, and confirm your ACO legal entity information. If you need to change any pre-populated information, notify CMS by sending an email to SharedSavingsProgram@cms.hhs.gov following the normal procedure.</p> <ul style="list-style-type: none"> 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. <p>If you select NO, you are not eligible for the SNF 3-Day Rule Waiver</p>		
7.	<p>Certify that you ACO’s leadership and management meets the requirements and will be responsible for the quality assurance and improvement program.</p> <p>If you select NO, you are not eligible for the SNF 3-Day Rule Waiver</p>		N/A
8.	<p>Upload 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.</p>	<p>§425.612(a)(1)(i)(A)(3); §425.612(a)(1)(ii); §425.112</p>	<p>Yes, required. Name your file: Axxxx_S3_Q8_BeneEval_mmddyyyy.pdf</p>

Section 4 – Care Management Plan			
	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
9.	<p>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:</p> <ul style="list-style-type: none"> Designate the ACO provider/supplier responsible for initiating the admission and Care Management Plan; Designate a person from the SNF affiliate responsible for accepting the beneficiary and implementing the Care Management Plan; 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); 	<p>§425.612</p>	N/A

Section 4 – Care Management Plan			
	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<ul style="list-style-type: none"> 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; Ensure the provision of high quality and efficient care delivery (including facilitating optimum length of stay) 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. 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. <p>If you select NO, you are not eligible for the SNF 3-Day Rule Waiver</p>		
10.	Upload 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.	§425.612(a)(1)(i) (A)(2)	Yes, required. Name your file: Axxx_S4_Q10_CareMgmt_mmdyyy.pdf

Section 5 – Financial Relationships			
	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
11.	<p>Upload a brief description of any financial relationships between your ACO, SNF affiliates, and any acute care hospitals.</p> <p>Please only provide the legal business name of the entities that have a financial relationship for purposes of the ACO’s implementation of the SNF 3-day rule waiver. You do not need to provide a detailed description of the financial arrangement itself. If you do provide a description of the financial arrangement, it should be brief.</p>	§425.612(a)(1)(i) (A)(4)	Yes, required. Name your file: Axxx_S5_Q11_FinRel_mmdyyy.pdf

Section 5 – Financial Relationships			
	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	<p>Examples of the types of responses we are looking for include:</p> <ul style="list-style-type: none"> • The ACO and ABC Nursing Home have a financial relationship. ----or---- • ABC Hospital and ABC Nursing Home have a financial relationship for outpatient imaging services. <p>If you submit additional information than what we just described, it will not be reviewed. Finally, it is important to note that if your application is approved, that does not mean the financial or other arrangements between or among ACOs, ACO participants, ACO providers/suppliers and/or other individuals or entities providing services to ACO patients are protected from liability under the fraud and abuse laws or any other applicable laws.</p>		

Section 6 – SNF Affiliates			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
12.	<p>Upload a list of SNF affiliates with whom the ACO will partner. Please make sure to include the following:</p> <ul style="list-style-type: none"> • SNF Tax Identification Number (TIN) • SNF Legal Business Name • SNF CCN • SNF CCN Legal Business Name • Identify SNF’s current star rating reported on CMS’ Nursing Home Compare Website 	§425.612	Yes, required. Name your file: Axxx_S6_Q12_SNFAffiliate_mmddyyyy.pdf
13a.	<p>Upload 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.</p>	§425.612	Yes, if applicable. Name your file: Axxx_S6_Q13a_QualityRating_mmddyyy.pdf
13b.	<p>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.</p>	§425.612	N/A

Section 6 – SNF Affiliates			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
14.	Upload a sample of the SNF Affiliate Agreement your ACO uses.	§425.612 (a)(1)(iii)	Yes, required. Name your file: Axxx_S6_Q14_AffAgree_mmddyyyy.pdf
15.	Upload the SNF Affiliate Agreement Template to identify where in your SNF affiliate agreement the required elements can be found including, but not limited to, the following: <ul style="list-style-type: none"> • 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. 	§425.612 (a)(1)(iii) (B)	Yes, required. Name your file: Axxx_S6_Q15_AFFTEMP_mmddyyyy.pdf
16.	Upload 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.	§425.612	Yes, required. Name your file: Axxx_S6_Q16_SNFAGmt_mmddyyyy.pdf

Section 7 – Certify your application			
Q#	Description /Instructions	Regulation Reference	Support Documents / Narrative Required / File Naming convention
	You must select I agree to certify your application. Your application is complete and submitted once you select I agree .	§425.612	N/A

Appendix E. Data Elements – Claims and Claims Line Feed Files

Purpose: The following is the list of data elements present on the Claims and Claim Line Feed (CCLF) Files as referred to in the Data Sharing section of the Initial and Renewal applications. Please note that these are subject to change. These tables are included as part of an appendix in the NGC ACO-OS CCLF IP.DOCX file that can be found on the SSP ACO Portlet. Upon approval, we will provide an overview of the NGC ACO-OS CCLF IP.DOCX file.

The records in the text file are fixed width. The File Name Convention for CCLFs sent to ACO mailbox is listed prior to each table.

NOTE: Where applicable in the file layouts, a minus “-” in the beginning of the format description indicates that if the value is negative, the first character will display as “-”. For all other values, a blank will display as the first character.

The File Name Convention for the Medicare Shared Savings Program in [Table 4](#) is P.A****.ACO.CCLF1.Dyymmdd.Thhmmss.

Table 4: Part A Claims Header File (CCLF1)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2.	PRVDR_OSCAR_NUM	Provider OSCAR Number	14	19	6	X(06)	A facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
3.	BENE_HIC_NUM	Beneficiary HIC Number	20	30	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary’s current HICN, not necessarily the HICN that was used to process the claim.
4.	CLM_TYPE_CD	Claim Type Code	31	32	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
5.	CLM_FROM_DT	Claim From Date	33	42	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as "Statement Covers From Date."
6.	CLM_THRU_DT	Claim Thru Date	43	52	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
7.	CLM_BILL_FAC_TY E_CD	Claim Bill Facility Type Code	53	53	1	X(01)	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved
8.	CLM_BILL_CLSFACTN _CD	Claim Bill Classification Code	54	54	1	X(01)	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							hospital). Find Claim Service Classification Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
9.	PRNCPL_DGNS_CD	Principal Diagnosis Code	55	61	7	X(07)	The ICD-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
10.	ADMTG_DGNS_CD	Admitting Diagnosis Code	62	68	7	X(07)	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted.
11.	CLM_MDCR_NPMT_RSN_CD	Claim Medicare Non-Payment Reason Code	69	70	2	X(02)	Indicates the reason payment on an institutional claim is denied. Find Medicare Non-Payment Reason Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/claim-medicare-non-payment-reason-code).
12.	CLM_PMT_AMT	Claim Payment Amount	71	87	17	-9(13).99	Amount that Medicare paid on the claim.
13.	CLM_NCH_PRMRY_PYR_CD	Claim NCH Primary Payer Code	88	88	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer. If this field is blank, Medicare is the primary payer for the beneficiary. Find NCH Primary Payer Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/NCH-Primary-Payer-Code).
14.	PRVDR_FAC_FIPS_ST_CD	Federal Information	89	90	2	X(02)	Identifies the state where the facility providing services is located.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
		Processing Standards (FIPS) State Code					
15.	BENE_PTNT_STUS_CD	Beneficiary Patient Status Code	91	92	2	X(02)	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death). Find Patient Discharge Status Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/patient-discharge-status-code).
16.	DGNS_DRG_CD	Diagnosis Related Group Code	93	96	4	X(04)	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
17.	CLM_OP_SRVC_TY PE_CD	Claim Outpatient Service Type Code	97	97	1	X(01)	Indicates the type and priority of outpatient service. Claim Outpatient Service Type Codes are: 0=Blank 1=Emergency 2=Urgent 3=Elective 5-8=Reserved 9=Unknown
18.	FAC_PRVDR_NPI_NUM	Facility Provider NPI Number	98	107	10	X(10)	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
19.	OPRTG_PRVDR_NPI_NUM	Operating Provider NPI Number	108	117	10	X(10)	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
20.	ATNDG_PRVDR_NP	Attending	118	127	10	X(10)	Identifies the attending provider associated with

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
	I_NUM	Provider NPI Number					the claim. Each provider is assigned its own unique NPI.
21.	OTHR_PRVDR_NPI_NUM	Other Provider NPI Number	128	137	10	X(10)	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
22.	CLM_ADJSMT_TYPE_CD	Claim Adjustment Type Code	138	139	2	X(02)	Indicates whether the claim is an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
23.	CLM_EFCTV_DT	Claim Effective Date	140	149	10	YYYY-MM-DD	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
24.	CLM_IDR_LD_DT	Claim IDR Load Date	150	159	10	YYYY-MM-DD	When the claim was loaded into the IDR.
25.	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	160	170	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key.
26.	CLM_ADMSN_TYPE_CD	Claim Admission Type Code	171	172	2	X(2)	Indicates the type and priority of inpatient services. Claim Admission Type Codes are: 0=Blank 1=Emergency 2=Urgent 3=Elective

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							4=Newborn 5=Trauma Center 6-8=Reserved 9=Unknown
27.	CLM_ADMSN_SRC_CD	Claim Admission Source Code	173	174	2	X(2)	Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Find Admission Source Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code).
28.	CLM_BILL_FREQ_CD	Claim Bill Frequency Code	175	175	1	X(1)	The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Find Claim Frequency Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
29.	CLM_QUERY_CD	Claim Query Code	176	176	1	X(1)	Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator). Claim Query Codes are: 0=Credit adjustment 1=Interim bill 2=HHA benefits exhausted 3=Final bill 4=Discharge notice 5=Debit adjustment
30.	DGNS_PRCDR_ICD_IND	ICD Version Indicator	177	177	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

The File Name Convention for the Medicare Shared Savings Program in [Table 5](#) is P.A****.ACO.CCLF2.Dyymmdd.Thhmmss.

Table 5: Part A Claims Revenue Center Detail File (CCLF2)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim
2.	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line
3.	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
4.	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
5.	CLM_LINE_FROM_DT	Claim Line From Date	37	46	10	YYYY-MM-DD	The date the service associated with the line item began.
6.	CLM_LINE_THRU_DT	Claim Line Thru Date	47	56	10	YYYY-MM-DD	The date the service associated with the line item ended.
7.	CLM_LINE_PROD_REV_CTR_CD	Product Revenue Center Code	57	60	4	X(04)	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							<p>A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Find Revenue Center Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/Line-HCFA-Type-Service-Code). Revenue center code 0001 represents the total of all revenue centers included on the claim.</p>
8.	CLM_LINE_INSTN L_REV_CTR_DT	Claim Line Institutional Revenue Center Date	61	70	10	YYYY-MM-DD	The date that applies to the service associated with the Revenue Center code.
9.	CLM_LINE_HCPC S_CD	HCPCS Code	71	75	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
10.	BENE_EQTBL_BIC _HICN_NUM	Beneficiary Equitable BIC HICN Number	76	86	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
11.	PRVDR_OSCAR_ NUM	Provider OSCAR Number	87	92	6	X(6)	A facility’s Medicare/Medicaid identification number, also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12.	CLM_FROM_DT	Claim From Date	93	102	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
13.	CLM_THRU_DT	Claim Thru Date	103	112	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
14.	CLM_LINE_SRVC_UNIT_QTY	Claim Line Service Unit Quantity	113	136	24	-9(18).9999	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).
15.	CLM_LINE_CVRD_PD_AMT	Claim Line Covered Paid Amount	137	153	17	-9(13).99	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
16.	HCPCS_1_MDFR_CD	HCPCS First Modifier Code	154	155	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
17.	HCPCS_2_MDFR_CD	HCPCS Second Modifier Code	156	157	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
18.	HCPCS_3_MDFR_CD	HCPCS Third Modifier Code	158	159	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
19.	HCPCS_4_MDFR_CD	HCPCS Fourth Modifier Code	160	161	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
20.	HCPCS_5_MDFR_CD	HCPCS Fifth	162	163	2	X(2)	The fifth code to modify the HCPCS

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
	CD	Modifier Code					procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

The File Name Convention for the Medicare Shared Savings Program in [Table 6](#) is P.A****.ACO.CCLF3.Dyymmdd.Thhmmst.

Table 6: Part A Procedure Code File (CCLF3)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2.	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
3.	CLM_TYPE_CD	Claim Type Code	25	26	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
4.	CLM_VAL_SQNC_NUM	Claim Value Sequence Number	27	28	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
5.	CLM_PRCDR	Procedure Code	29	35	7	X(07)	The ICD-9/10 code that indicates the procedure

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
	_CD						performed during the period covered by the claim.
6.	CLM_PRCDR_PRFRM_DT	Procedure Performed Date	36	45	10	YYYY-MM-DD	The date the indicated procedure was performed.
7.	BENE_EQTB L_BIC_HICN _NUM	Beneficiary Equitable BIC HICN Number	46	56	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
8.	PRVDR_OSCAR_NUM	Provider OSCAR Number	57	62	6	X(6)	A facility’s Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.
9.	CLM_FROM_DT	Claim From Date	63	72	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as “Statement Covers From Date.”
10.	CLM_THRU_DT	Claim Thru Date	73	82	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the “Statement Covers Through Date.”
11.	DGNS_PRCDR_ICD_IND	ICD Version Indicator	83	83	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than “9” or “0” in the source data.

The File Name Convention for the Medicare Shared Savings Program in [Table 7](#) is P.A****.ACO.CCLF4.Dyymmdd.Thhmmst.

Table 7: Part A Diagnoses Code File (CCLF4)

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2.	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
3.	CLM_TYPE_CD	Claim Type Code	25	26	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
4.	CLM_PROD_TYPE_CD	Claim Product Type Code	27	27	1	X(01)	Codes classifying the diagnosis category: E=Accident diagnosis code 1=First diagnosis E code D=Other diagnosis codes
5.	CLM_VAL_S_QNC_NUM	Claim Value Sequence Number	28	29	2	9(2)	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
6.	CLM_DGNS_CD	Diagnosis Code	30	36	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability.
7.	BENE_EQTB_L_BIC_HICN	Beneficiary Equitable BIC	37	47	11	X(11)	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.

Element #	Element Name	Data Description	Start Position	End Position	Data Length	Format	Comments
	_NUM	HICN Number					For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
8.	PRVDR_OSCAR_NUM	Provider OSCAR Number	48	53	6	X(6)	The OSCAR is a facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of services.
9.	CLM_FROM_DT	Claim From Date	54	63	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
10.	CLM_THRU_DT	Claim Thru Date	64	73	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
11.	CLM_POA_IND	Claim Present-on-Admission Indicator	74	80	7	X(7)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-Admission values at the ResDAC website (http://www.resdac.org/cms-data/variables/claim-diagnosis-code-i-diagnosis-present-admission-indicator-code).
12.	DGNS_PRCDR_ICD_IND	ICD Version Indicator	81	81	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

The File Name Convention for the Medicare Shared Savings Program in [Table 8](#) is P.A****.ACO.CCLF5.Dyymmdd.Thhmsst.

Table 8: Part B Physicians File (CCLF5)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2.	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line within a given claim.
3.	BENE_HIC_NUM	Beneficiary HICNumber	24	34	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim
4.	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs Claim type codes are: 71=RICO local carrier non-DMEPOS claim 72=RICO local carrier DMEPOS claim
5.	CLM_FROM_DT	Claim From Date	37	46	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
6.	CLM_THRU_DT	Claim Thru Date	47	56	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
7.	RNDRG_PRVDR_TYPE_CD	Rendering Provider Type Code	57	59	3	X(03)	Indicates the type of provider who provided the service associated with this line item on the claim. Provider Type Codes are: 0=Clinics, groups, associations, partnerships, or other entities

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							1=Physicians or suppliers reporting as solo practitioners 2=Suppliers (other than sole proprietorship) 3=Institutional provider 4=Independent laboratories 5=Clinics (multiple specialties) 6=Groups (single specialty) 7=Other entities UI= UPIN Identification N2= National Council for Prescription Drug Programs D= National Supplier Clearinghouse BP= PIN Individual BG= PIN Group A= Online Survey, Certification and Reporting
8.	RNDRG_PRVDR_FIPS_ST_CD	Rendering Provider FIPS State Code	60	61	2	X(02)	Identifies the state that the provider providing the service is located in.
9.	CLM_PRVDR_S_PCLTY_CD	Claim-Line Provider Specialty Code	62	63	2	X(02)	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item. Find Provider Specialty Codes at the Medicare website (http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf)
10.	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service	64	64	1	X(01)	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
		Code					Service Codes are defined in the Medicare Carrier Manual. Find Types of Service Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/Line-HCFA-Type-Service-Code).
11.	CLM_POS_CD	Claim Place of Service Code	65	66	2	X(02)	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual. Find Place of Service Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/line-place-service-code).
12.	CLM_LINE_FROM_DT	Claim Line From Date	67	76	10	YYYY-MM-DD	The date the service associated with the line item began.
13.	CLM_LINE_THRU_DT	Claim Line Thru Date	77	86	10	YYYY-MM-DD	The date the service associated with the line item ended.
14.	CLM_LINE_HCPCS_CD	HCPCS Code	87	91	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
15.	CLM_LINE_NCH_PMT_AMT	Claim Line NCH Payment Amount	92	106	15	X(15)	The amount of payment made by Medicare on behalf of the beneficiary for the indicated service after deductible and coinsurance amounts have been paid.
16.	CLM_LINE_PRIMARY_PAYER_CD	Claim Primary Payer Code	107	107	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							Find Primary Payer Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code).
17.	CLM_LINE_DG NS_CD	Diagnosis Code	108	114	7	X(07)	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
18.	CLM_RNDRG_P RVDR_TAX_NUM	Claim Provider Tax Number	115	124	10	X(10)	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.
19.	RNDRG_PRVDR _NPI_NUM	Rendering Provider NPI Number	125	134	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
20.	CLM_CARR_P M_T_DNL_CD	Claim Carrier Payment Denial Code	135	136	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied. Find Carrier Payment Denial Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/Carrier-Claim-Payment-Denial-Code).
21.	CLM_PRCG_I ND_CD	Claim-Line Processing Indicator Code	137	138	2	X(02)	Indicates whether the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/Line-Processing-Indicator-Code).
22.	CLM_ADJSMT_ TYPE_CD	Claim Adjustment Type Code	139	140	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							1=Cancelation Claim 2=Adjustment claim
23.	CLM_EFCTV_DT	Claim Effective Date	141	150	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
24.	CLM_IDR_LD_DT	Claim IDR Load Date	151	160	10	YYYY-MM-DD	When the claim was loaded into the IDR.
25.	CLM_CNTL_NUM	Claim Control Number	161	200	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.
26.	BENE_EQTBL_BIC_HICN_NUM	Beneficiary Equitable BIC HICN Number	201	211	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
27.	CLM_LINE_ALLOWED_CHRG_AMT	Claim Line Allowed Charges Amount	212	228	17	X(17)	The amount Medicare approved for payment to the provider.
28.	CLM_LINE_SERVICE_UNIT_QTY	Claim Line Service Unit Quantity	229	252	24	-9(18).9999	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29.	HCPCS_1_MDF R_CD	HCPCS First Modifier Code	253	254	2	X(2)	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
30.	HCPCS_2_MDF R_CD	HCPCS Second Modifier Code	255	256	2	X(2)	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
31.	HCPCS_3_MDF R_CD	HCPCS Third Modifier Code	257	258	2	X(2)	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
32.	HCPCS_4_MDF R_CD	HCPCS Fourth Modifier Code	259	260	2	X(2)	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
33.	HCPCS_5_MDF R_CD	HCPCS Fifth Modifier Code	261	262	2	X(2)	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
34.	CLM_DISP_CD	Claim Disposition Code	263	264	2	X(2)	Information regarding payment actions on the claim. Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted
35.	CLM_DGNS_1_CD	Claim Diagnosis First Code	265	271	7	X(7)	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
36.	CLM_DGNS_2_CD	Claim Diagnosis Second Code	272	278	7	X(7)	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
37.	CLM_DGNS_3_CD	Claim Diagnosis Third Code	279	285	7	X(7)	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
38.	CLM_DGNS_4_CD	Claim Diagnosis Fourth Code	286	292	7	X(7)	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
39.	CLM_DGNS_5_CD	Claim Diagnosis Fifth Code	293	299	7	X(7)	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
40.	CLM_DGNS_6_CD	Claim Diagnosis Sixth Code	300	306	7	X(7)	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
41.	CLM_DGNS_7_CD	Claim Diagnosis Seventh Code	307	313	7	X(7)	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
42.	CLM_DGNS_8_CD	Claim Diagnosis Eighth Code	314	320	7	X(7)	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability.
43.	DGNS_PRCR_CD_IND	ICD Version Indicator	321	321	1	X(1)	9 = ICD-9 0 = ICD-10 U = any value other than "9" or "0" in the source data.

The File Name Convention for the Medicare Shared Savings Program in [Table 9](#) is P.A****.ACO.CCLF6.Dyymmdd.Thhmmst.

Table 9: Part B DME File (CCLF6)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2.	CLM_LINE_NUM	Claim Line Number	14	23	10	9(10)	A sequential number that identifies a specific claim line.
3.	BENE_HIC_NUM	Beneficiary HIC Number	24	34	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
4.	CLM_TYPE_CD	Claim Type Code	35	36	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are:

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							81=RICM DMERC non-DMEPOS claim 82=RICM DMERC DMEPOS claim
5.	CLM_FROM_DT	Claim From Date	37	46	10	YYYY-MM-DD	The first day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers From Date."
6.	CLM_THRU_DT	Claim Thru Date	47	56	10	YYYY-MM-DD	The last day on the billing statement that covers services rendered to the beneficiary. Also known as the "Statement Covers Through Date."
7.	CLM_FED_TYPE_SRVC_CD	Claim Federal Type Service Code	57	57	1	X(01)	Indicates the type of service (e.g., consultation, surgery), provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual. Find Types of Service Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/Line-HCFA-Type-Service-Code).
8.	CLM_POS_CD	Claim Place of Service Code	58	59	2	X(02)	Indicates place where the indicated service was provided (e.g., ambulance, school). Find Place of Service Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/place-service).
9.	CLM_LINE_FROM_DT	Claim Line From Date	60	69	10	YYYY-MM-DD	The date the service associated with the line item began.
10.	CLM_LINE_THRU_DT	Claim Line Thru Date	70	79	10	YYYY-MM-DD	The date the service associated with the line item ended.
11.	CLM_LINE_HCPCS_CD	HCPCS Code	80	84	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
12.	CLM_LINE_PRFNL_NCH_P	Claim Line NCH Payment	85	99	15	-9(11).99	The amount of payment made by Medicare on behalf of the beneficiary for the indicated

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
	PMT_AMT	Amount					service after deductible and coinsurance amounts have been paid.
13.	CLM_PRMR Y_PYR_CD	Claim Primary Payer Code	100	100	1	X(01)	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code. If this field is blank, Medicare is the primary payer for the beneficiary. Find Primary Payer Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Line-Beneficiary-Primary-Payer-Code).
14.	PAYTO_PRV DR_NPI_NUM	Pay-to Provider NPI Number	101	110	10	X(10)	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.
15.	ORDRG_PRV DR_NPI_NUM	Ordering Provider NPI Number	111	120	10	X(10)	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.
16.	CLM_CARR_PMT_DNL_CD	Claim Carrier Payment Denial Code	121	122	2	X(02)	Indicates to whom payment was made (e.g., physician, beneficiary) or if the claim was denied Find Carrier Payment Denial Codes at the ResDAC website (https://www.resdac.org/cms-data/variables/Carrier-Claim-Payment-Denial-Code).
17.	CLM_PRCSG_IND_CD	Claim Processing Indicator Code	123	124	2	X(02)	Indicates whether the service indicated on the claim line was allowed or the reason it was denied. Find Processing Indicator Codes at the ResDAC website

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							(https://www.resdac.org/cms-data/variables/Line-Processing-Indicator-Code).
18.	CLM_ADJSM T_TYPE_CD	Claim Adjustment Type Code	125	126	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
19.	CLM_EFCTV _DT	Claim Effective Date	127	136	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
20.	CLM_IDR_L D_DT	Claim IDR Load Date	137	146	10	YYYY-MM-DD	When the claim was loaded into the IDR.
21.	CLM_CNTL_ NUM	Claim Control Number	147	186	40	X(40)	A unique number assigned to a claim by the Medicare carrier. This number allows CMS to associate each line item with its respective claim.
22.	BENE_EQTB L_BIC_HICN _NUM	Beneficiary Equitable BIC HICN Number	187	197	11	X(11)	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary’s spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event using the natural key.
23.	CLM_LINE_ ALLOWD_CH RG_AMT	Claim Line Allowed Charges Amount	198	214	17	-9(14)V99	The amount Medicare approved for payment to the provider.
24.	CLM_DISP_ CD	Claim Disposition	215	216	2	X(2)	Contains information regarding payment actions on the claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
		Code					Claim Disposition Codes are: 01=Debit accepted 02=Debit accepted (automatic adjustment) 03=Cancel accepted

The File Name Convention for the Medicare Shared Savings Program in [Table 10](#) is P.A****.ACO.CCLF7.Dyymmdd.Thhmmst.

Table 10: Part D File (CCLF7)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1.	CUR_CLM_UNIQ_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2.	BENE_HIC_NUM	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
3.	CLM_LINE_NDC_CD	NDC Code	25	35	11	X(11)	A universal unique product identifier for human drugs.
4.	CLM_TYPE_CD	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 01=Part D - Original without resubmitted PDE 02=Part D - Adjusted PDE 03=Part D - Deleted Claims 04=Part D - Resubmitted PDE

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5.	CLM_LINE_F ROM_DT	Claim Line From Date	38	47	10	YYYY-MM-DD	The date the service associated with the line item began (i.e., the date upon which the prescription was filled).
6.	PRVDR_SRV C_ID_QLFYR _CD	Provider Service Identifier Qualifier Code	48	49	2	X(02)	Indicates the type of number used to identify the pharmacy providing the services: 01= NPI Number 06=Unique Physician Identification Number (UPIN) 07=National Council for Prescription Drug Programs (NCPDP) Number 08=State License Number 11=TIN 99=Other mandatory for Standard Data Format
7.	CLM_SRVC_ PRVDR_GNR C_ID_NUM	Claim Service Provider Generic ID Number	50	69	20	X(20)	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
8.	CLM_DSPNS NG_STUS_C D	Claim Dispensing Status Code	70	70	1	X(01)	Indicates the status of prescription fulfillment. Dispensing Codes are: P=Partially filled C=Completely filled
9.	CLM_DAW_ PROD_SLCT N_CD	Claim Dispense as Written (DAW) Product Selection Code	71	71	1	X(01)	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed. DAW Product Selection Codes are: 0=No product selection indicated 1=Substitution not allowed by prescriber 2=Substitution allowed – Patient requested that brand be dispensed

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
							<p>3=Substitution allowed – Pharmacist selected product dispensed</p> <p>4=Substitution allowed – Generic not in stock</p> <p>5=Substitution allowed – Brand drug dispensed as generic</p> <p>6=Override</p> <p>7=Substitution not allowed – Brand drug mandated by law</p> <p>8=Substitution allowed – Generic drug not available in marketplace</p> <p>9=Other</p>
10.	CLM_LINE_S RVC_UNIT_ QTY	Claim Line Service Unit Quantity	72	95	24	-9(18).9999	Count of total units, at the line-item level, associated with services needing unit reporting (e.g., anesthesia time units and blood units).
11.	CLM_LINE_ DAYS_SUPL Y_QTY	Claim Line Days' Supply Quantity	96	104	9	9(09)	The number of days the supply of medication dispensed by the pharmacy will cover.
12.	PRVDR_PRS BNG_ID_QL FYR_CD	Provider Prescribing ID Qualifier Code	105	106	2	X(02)	<p>Indicates the type of number used to identify the prescribing provider:</p> <p>01= NPI Number</p> <p>06= UPIN</p> <p>07= NCPDP Number</p> <p>08=State License Number</p> <p>11=TIN</p> <p>12=DEA</p> <p>99=Other mandatory for Standard Data Format</p>
13.	CLM_PRSBN G_PRVDR_G NRC_ID_NU M	Claim Prescribing Provider Generic ID Number	107	126	20	X(20)	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14.	CLM_LINE_BENE_PMT_AMT	Claim Line Beneficiary Payment Amount	127	139	13	-9(9).99	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
15.	CLM_ADJUST_TYPE_CD	Claim Adjustment Type Code	140	141	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
16.	CLM_EFFECTIVE_DT	Claim Effective Date	142	151	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
17.	CLM_IDR_LOAD_DT	Claim IDR Load Date	152	161	10	YYYY-MM-DD	When the claim was loaded into the IDR.
18.	CLM_LINE_RX_SRVC_REF_RNC_NUM	Claim Line Prescription Service Reference Number	162	173	12	9(12)	Identifies a prescription dispensed by a particular service provider on a particular service date.
19.	CLM_LINE_RX_FILL_NUM	Claim Line Prescription Fill Number	174	182	9	X(09)	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CUR_CLM_UNIQUE_ID	Current Claim Unique Identifier	1	13	13	9(13)	A unique identification number assigned to the claim.
2	BENE_HIC_NUMBER	Beneficiary HIC Number	14	24	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's <i>current</i> HICN, not necessarily the HICN that was used to process the claim.
3	CLM_LINE_NDC_CD	NDC Code	25	35	11	X(11)	A universal unique product identifier for human drugs.
4	CLM_TYPE_CODE	Claim Type Code	36	37	2	9(02)	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 01=Part D - Original without resubmitted PDE 02=Part D - Adjusted PDE 03=Part D - Deleted Claims 04=Part D - Resubmitted PDE
5	CLM_LINE_FROM_DATE	Claim Line From Date	38	47	10	YYYY-MM-DD	The date the service associated with the line item began (i.e., the date upon which the prescription was filled).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
6	PRVDR_SRVC_ID_QLFYR_CD	Provider Service Identifier Qualifier Code	48	49	2	X(02)	Indicates the type of number used to identify the pharmacy providing the services: 01=NPI Number 06=Unique Physician Identification Number (UPIN) 07=National Council for Prescription Drug Programs (NCPDP) Number 08=State License Number 11=TIN 99=Other mandatory for Standard Data Format
7	CLM_SRVC_PRVDR_GNRC_ID_NUM	Claim Service Provider Generic ID Number	50	69	20	X(20)	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
8	CLM_DSPNSNG_STUS_CD	Claim Dispensing Status Code	70	70	1	X(01)	Indicates the status of prescription fulfillment. Dispensing Codes are: P=Partially filled C=Completely filled

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLM_DAW_P ROD_SLCTN_ CD	Claim Dispense as Written (DAW) Product Selection Code	71	71	1	X(01)	Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed. DAW Product Selection Codes are: 0=No product selection indicated 1=Substitution not allowed by prescriber 2=Substitution allowed – Patient requested that brand be dispensed 3=Substitution allowed – Pharmacist selected product dispensed 4=Substitution allowed – Generic not in stock 5=Substitution allowed – Brand drug dispensed as generic 6=Override 7=Substitution not allowed – Brand drug mandated by law 8=Substitution allowed – Generic drug not available in marketplace 9=Other
10	CLM_LINE_S RVC_UNIT_Q TY	Claim Line Service Unit Quantity	72	95	24	-9(18).9999	The number of dosage units of medication that were dispensed in this fill.
11	CLM_LINE_D AYS_SUPLY_ QTY	Claim Line Days' Supply Quantity	96	104	9	9(09)	The number of days the supply of medication dispensed by the pharmacy will cover.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12	PRVDR_PRSB NG_ID_QLFY R_CD	Provider Prescribing ID Qualifier Code	105	106	2	X(02)	Indicates the type of number used to identify the prescribing provider: 01= NPI Number 06= UPIN 07= NCPDP Number 08=State License Number 11=TIN 12=DEA 99=Other mandatory for Standard Data Format
13	CLM_PRSBN G_PRVDR_G NRC_ID_NUM	Claim Prescribing Provider Generic ID Number	107	126	20	X(20)	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.
14	CLM_LINE_B ENE_PMT_A MT	Claim Line Beneficiary Payment Amount	127	139	13	-9(9).99	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
15	CLM_ADJSM T_TYPE_CD	Claim Adjustment Type Code	140	141	2	X(02)	Indicates whether the claim an original, cancelation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Cancelation Claim 2=Adjustment claim
16	CLM_EFCTV_ DT	Claim Effective Date	142	151	10	YYYY-MM-DD	The date the claim was processed and added to the NCH. This is also referred to as the NCH Weekly Processing Date.
17	CLM_IDR_LD _DT	Claim IDR Load Date	152	161	10	YYYY-MM-DD	When the claim was loaded into the IDR.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
18	CLM_LINE_R X_SRVC_RFR NC_NUM	Claim Line Prescription Service Reference Number	162	173	12	X(012)	Identifies a prescription dispensed by a particular service provider on a particular service date.
19	CLM_LINE_R X_FILL_NUM	Claim Line Prescription Fill Number	174	182	9	X(09)	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.

The File Name Convention for the Medicare Shared Savings Program in [Table 11](#) is P.A****.ACO.CCLF8.Dyymmdd.Thhmsst.

Table 11: Beneficiary Demographics File (CCLF8)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
1.	BENE_HIC_NUM	Beneficiary HIC Number	1	11	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim.
2.	BENE_FIPS_STAT E_CD	Beneficiary FIPS State Code	12	13	2	9(02)	Identifies the state where the beneficiary receiving services resides.
3.	BENE_FIPS_CNTY _CD	Beneficiary FIPS County Code	14	16	3	9(03)	Identifies the county where the beneficiary receiving services resides.
4.	BENE_ZIP_CD	Beneficiary ZIP Code	17	21	5	X(05)	The beneficiary's ZIP code as indicated in their Medicare enrollment record.
5.	BENE_DOB	Beneficiary Date of Birth	22	31	10	YYYY-MM-DD	The month, day, and year of the beneficiary's birth.
6.	BENE_SEX_CD	Beneficiary Sex Code	32	32	1	X(01)	The beneficiary's sex: 1=Male 2=Female

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
							0=Unknown
7.	BENE_RACE_CD	Beneficiary Race Code	33	33	1	X(01)	The beneficiary's race: 0=Unknown 1=White 2=Black 3=Other 4=Asian 5=Hispanic 6=North American Native
8.	BENE_AGE	Beneficiary Age	34	36	3	9(03)	The beneficiary's current age, as calculated by subtracting the beneficiary's date of birth from the current date.
9.	BENE_MDCR_ST US_CD	Beneficiary Medicare Status Code	37	38	2	X(02)	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: Old Age & Survivors Insurance (OASI), Disabled, and End Stage Renal Disease (ESRD), and by appropriate combinations of these categories: 10=Aged without ESRD 11=Aged with ESRD 20=Disabled without ESRD 21=Disabled with ESRD 31=ESRD only
10.	BENE_DUAL_STU S_CD	Beneficiary Dual Status Code	39	40	2	X(02)	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid). Find Dual Status Codes at the ResDAC website (http://www.resdac.org/cms-data/variables/Dual-Status-Code-occurs-12-times).

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
11.	BENE_DEATH_DT	Beneficiary Death Date	41	50	10	YYYY-MM-DD	The month, day, and year of a beneficiary's death.
12.	BENE_RNG_BGN_DT	Date beneficiary enrolled in Hospice	51	60	10	YYYY-MM-DD	The date the beneficiary enrolled in Hospice.
13.	BENE_RNG_END_DT	Date beneficiary ended Hospice	61	70	10	YYYY-MM-DD	The date the beneficiary is-enrolled in hospice.
14.	BENE_1ST_NAME	Beneficiary First Name	71	100	30	X(30)	The first name of the beneficiary.
15.	BENE_MIDL_NAME	Beneficiary Middle Name	101	115	15	X(15)	The middle name of the beneficiary.
16.	BENE_LAST_NAME	Beneficiary Last Name	116	155	40	X(40)	The last name of the beneficiary.
17.	BENE_ORGNL_ENTLMT_RSN_CD	Beneficiary Original Entitlement Reason Code	156	156	1	X(01)	The reason for the beneficiary's original entitlement to Medicare benefits. 0 - Old Age and Survivors Insurance (Oasi) 1 - Disability Insurance Benefits (DIB) 2 - ESRD 3 - Both DIB and ESRD 4 - Unknown
18.	BENE_ENTLMT_BUYIN_IND	Beneficiary Entitlement Buy-in Indicator	157	157	1	X(01)	Indicates for each month of the denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums. 0 Not Entitled 1 Part A Only 2 Part B Only 3 Part A and Part B

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
							A Part A, State Buy-In B Part B, State Buy-In C Parts A and B, State Buy-In

The File Name Convention for the Medicare Shared Savings Program in [Table 12](#) is P.A****.ACO.CCLF9.Dyymmdd.Thhmmst.

Table 12: Beneficiary XREF File (CCLF9)

Element #	Beneficiary Field Label	Beneficiary Field Name	Start Position	End Position	Data Length	Format	Beneficiary Field Description
19.	CRNT_HIC_NUM	Current HIC Number	1	11	11	X(11)	A beneficiary identifier. The HICN that appears in this field is the beneficiary's current HICN, not necessarily the HICN that was used to process the claim
20.	PRVS_HIC_NUM	Previous HIC Number	12	22	11	X(11)	The HICN that appears in this field is the beneficiary's previous HICN.
21.	PRVS_HICN_EFCTV_DT	Previous HICN Effective Date	23	32	10	YYYY-MM-DD	The date the previous HICN became active.
22.	PRVS_HICN_OBSLT_DT	Previous HICN Obsolete Date	33	42	10	YYYY-MM-DD	The date the previous HICN ceased to be active.
23.	BENE_RRB_NUM	Beneficiary Railroad Board Number	43	54	12	X(12)	The external (to Medicare) HICN for beneficiaries that are RRB members.