

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-15-12
Baltimore, Maryland 21244-1850



Medicare Shared Savings Program Application

2012 APPLICATION

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Medicare Shared Savings Program Application

I. Instructions for Completing Your Application

A. OVERVIEW

The Shared Savings Program created under the Affordable Care Act is a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures. The Shared Savings Program promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under the program, groups of provider and suppliers that meet the criteria in the statute and implementing regulations may work together as Accountable Care Organizations (ACOs) and agree to become accountable for the quality, cost, and overall care delivered to the Medicare fee for service beneficiaries for which they will be held responsible. In return Medicare will share resulting savings with eligible ACOs. Beneficiaries will continue to have the freedom to choose any provider and supplier that participates in the Medicare program.

Organizations interested in participating in the Medicare Shared Savings Program must complete the 2012 ACO application as instructed. Please note that throughout this document the applicant may be referred to as “APPLICANT”, “YOU”, and “ACO”. The Centers for Medicare & Medicaid Services may be referred to as “CMS”, “US” and “WE”.

All documents must clearly identify you as the ACO applicant with your identification number (ACO ID) received with your Notice of Intent to Apply (NOI) acknowledgement letter. To answer questions in this application, indicate YES, NO, or N/A in sections organized with this format. By responding YES, you are attesting that you will be compliant as of the date of the agreement, unless the attestation or application requires an earlier compliance date.

Throughout this application, you are asked to submit various narratives and/or documents to support your response. Once you have completed your application, you will be ready to submit your supporting documentation. Please refer to the ACO Application Reference Guide for instructions on how to submit your supporting documentation. (see **Appendix D**)

We may verify your readiness and compliance with Medicare requirements through on-site visits at your ACO facilities as well as through other program monitoring techniques throughout the application process, as well as at any time both prior to and after the start of the agreement period. Failure to meet the requirements in this application or to operate the ACO consistent with the applicable statutes, regulations, or the terms of the ACO agreement could result in termination from the ACO program.

We strongly recommend and encourage you to refer to the regulations at 42 C.F.R. part 425 for further information regarding the nature of the ACO requirements and to assist you in providing appropriate responses. Nothing in this application is intended to supersede either the statute or the regulations. Failure to reference a statutory or regulatory requirement in this application does not affect the applicability of such requirement, and you are required to comply with all applicable requirements of the statute and regulations.

Applicants are encouraged to visit the CMS website periodically to stay informed about new or revised guidance documents. www.cms.gov/sharedsavingsprogram/

B. HOW TO SUBMIT YOUR APPLICATION

Applications must be submitted **by 5:00 pm EST January 20, 2011** for the April 1, 2012 start date, and **by 5:00 pm EST March 30, 2012** for the July 1, 2012 start date. We will not review applications received after this date and time. If there are any processing delays, it may result in the inability to make a determination about an application for the start date requested.

Below is the current timeline for the SSP Application review process. Dates are subject to change, so check this website frequently for updates. www.cms.gov/sharedsavingsprogram/.

i. Application Key Dates

Start date	April 1, 2012	July 1, 2012
2012 applications posted on CMS website	Fall 2011	Fall 2011
NOIs accepted	Nov 1, 2011 - Jan 6, 2012	Nov 1, 2011 — Feb 17, 2012
CMS User ID forms accepted	Nov 9, 2011 - Jan 12, 2012	Nov 9, 2011 - Feb 23, 2012
2012 applications accepted	Dec 1, 2011 - Jan 20, 2012	March 1- 30, 2012
2012 application approval or denial decision	March 16, 2012	May 31, 2012
Reconsideration review deadline*	March 23, 2012	June 15, 2012

*Date an organization must receive a favorable reconsideration review determination in order to qualify for the start date indicated on the application.

ii. Automated Submissions

In order to submit an application electronically, you must first obtain both your ACO ID and CMS User ID following the NOI instructions at http://www.cms.gov/sharedsavingsprogram/37_Application.asp Once you have received your ACO ID and CMS User ID, go to the link provided in your CMS User ID notice to begin completing the application.

You will notice your application is pre-populated with the information you provided to us on your NOI. If you need to correct any of this pre-populated information, you must submit a request in writing through the ACO application email box: SSPACO_Applications@cms.hhs.gov.

To facilitate timely application submission and tracking, we strongly recommend you consider submitting your application through the automated application system. For additional information questions about automated submissions, please contact CMS via e-mail at SSPACO_Applications@cms.hhs.gov.

iii. Paper Submissions

In order to submit an application on paper, you must first obtain your ACO ID following the NOI instructions at http://www.cms.gov/sharedsavingsprogram/37_Application.asp Once you have received your ACO ID, download and complete the application which can be found on the Shared Savings Program website (www.cms.gov/sharedsavingsprogram). All documents should include the file name in the header of each document.

Paper submission information must be typed and follow the instructions included in the Application Reference Guide (see Appendix D). Hand written applications will not be processed. If a question indicates that it is pre-populated based on the information you submitted in your NOI, enter the same information you submitted on your NOI on the application. If you need to correct any of the information you previously provided in your NOI, you must submit a request in writing through the ACO application email box: SSPACO_Applications@cms.hhs.gov. Differences in the information submitted in your NOI and application will result in processing delays.

Paper applications must be submitted via tracked mail (FedEx, UPS, etc.). We must receive your application by the due date indicated in the Application Key Dates table above. The date of submission is the actual date of receipt of by CMS and not the postmarked date on the submission. Send the completed application with the **ORIGINAL** signature to:

Centers for Medicare & Medicaid Services
Attn: SSP ACO Applications
Mail Stop: C5-15-12
7500 Security Blvd.
Desk Location: C4-07-01
Baltimore, MD 21244

iv. **Submission of Additional Information**

During the review of your application or anytime during your agreement period, you may be required to submit additional information to CMS upon request to support the statements you have made on this application. The requested information must be received by CMS by the date specified on the CMS notice. The date of submission is the actual date of receipt by CMS, and not the postmarked date on the submission. Please reference the Application Reference Guide (**see Appendix D**) for submission requirements.

v. **Information for PGP Transition Demonstration Participants**

PGP Transition Demonstration Participants have the opportunity to complete a condensed application. After completing the NOI process by following the instructions at http://www.cms.gov/sharedsavingsprogram/37_Application.asp, contact the PGP Project Director, Heather Grimsley to obtain instructions on how to complete the application.

II. Application

MEDICARE SHARED SAVINGS PROGRAM APPLICATION 2012

A. ORGANIZATION OVERVIEW

1. ACO Structure

Application Type

- NEW Medicare Shared Savings Program ACO
- Re-Applicant
- Physician Group Practice (PGP) Transition Demo

Note: Only select **Re-Applicant**, if you have previously applied to the Medicare Shared Savings Program

Start Date

This field is either pre-populated in the electronic application or must be filled in on the paper application based on the response you provided in your Notice of Intent to Apply. If you wish to change this information, you must contact CMS prior to submitting your application (*requirement for all applicants*).

- April 1, 2012
- July 1, 2012

Note: Program start dates have varying agreement periods.
April 1, 2012 (3 year and 9 month agreement period)
July 1, 2012 (3 year and 6 month agreement period)

ACO Entity *(Select all that apply)*

This field is either pre-populated in the electronic application or must be filled in on the paper application based on the response you provided in your Notice of Intent to Apply. If you wish to change this information, you must contact CMS prior to submitting your application (*requirement for all applicants*).

- ACO professionals in a group practice arrangement
- Network of individual practices of ACO professionals
- Partnership or joint venture arrangements between hospitals and ACO professionals
- Hospital employing ACO professionals
- Critical Access Hospital (CAH) billing under Method II
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)

Medicare Shared Savings Program Track

This field is either pre-populated in the electronic application or must be filled in on the paper application based on the response you provided in your Notice of Intent to Apply. If you wish to change this information, you must contact CMS prior to submitting your application (*requirement for all applicants*).

- Track 1 (one-sided model: shared savings)
- Track 2 (two-sided model: shared savings/losses)

Applicant Legal Entity:

Legal Entity Name Click here to enter text.

Trade Name/DBA (if applicable): Click here to enter text.

Mailing Address: Click here to enter text.

Street Address

Click here to enter text.

City

State

Zip Code

ACO Taxpayer Identification Number (TIN)

This field is either pre-populated in the electronic application or must be filled in on the paper application based on the response you provided in your Notice of Intent to Apply. If you wish to change this information, you must contact CMS prior to submitting your application (*requirement for all applicants*).

Provide a designated TIN to receive Shared Savings.

[Click here to enter text.](#)

Note: This is the TIN established for the ACO, as a legal entity. Shared savings payments are made to this TIN.

Date of Formation

This field is either pre-populated in the electronic application or must be filled in on the paper application based on the response you provided in your Notice of Intent to Apply. If you wish to change this information, you must contact CMS prior to submitting your application (*requirement for all applicants*).

Enter the date on the ACO Certificate of Incorporation or other formation documentation)

[Click here to enter text.](#)

(DD/MM/YYYY)

Jointly Negotiated Contracts

Has the ACO signed or jointly negotiated any contracts with a private payor(s) or does the ACO comprise only the same; or a subset of the same providers that signed or jointly negotiated any contracts with a private payor(s), on or before March 23, 2010?

Yes No

Note: If you answered NO, we will share your application with the Antitrust Agencies. By submitting this application, the ACO agrees to permit CMS to share a copy of its application, including all information and documents submitted with the application, with the Federal Trade Commission (FTC) and the Antitrust Division of the Department of Justice (DOJ) you have met this criterion. All ACOs should review the FTC/DOJ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Antitrust Policy Statement).

Type of Entity *(Select One)*

- Sole Proprietorship
- Partnership
- Publicly-Traded Corporation
- Privately-Held Corporation
- Limited Liability Company
- Other

2. Organization Contacts

ACO Executive (Authorized Official)

Name: Click here to enter text. **Title:** Click here to enter text.

Mailing Address: Click here to enter text.
(If different than above) **Street Address:** Click here to enter text.

City: Click here to enter text. **State:** Click here to enter text. **ZIP Code:** Click here to enter text.

Email: Click here to enter text.

Phone: Click here to enter text. **Fax:** Click here to enter text.

CMS Liaison (Primary Contact)

Name: Click here to enter text. **Title:** Click here to enter text.

Mailing Address: Click here to enter text.
(If different than above) **Street Address:** Click here to enter text.

City: Click here to enter text. **State:** Click here to enter text. **ZIP Code:** Click here to enter text.

Email: Click here to enter text.

Phone: Click here to enter text. **Fax:** Click here to enter text.

Application Contact (If different from Primary Contact)

Name: Click here to enter text. **Title:** Click here to enter text.

Mailing Address: Click here to enter text.
(If different than above) **Street Address:** Click here to enter text.

City: Click here to enter text. **State:** Click here to enter text. **ZIP Code:** Click here to enter text.

Email: Click here to enter text.

Phone: Click here to enter text. **Fax:** Click here to enter text.

This field either is pre-populated in the electronic application or must be filled in on the paper application based on the response you provided in your NOI. If you wish to change this information, update the electronic application or provide the correction on you paper application

IT Contact

Name: Click here to enter text. **Title:** Click here to enter text.

Mailing Address: Click here to enter text.
(If different than above) **Street Address:** Click here to enter text.

City: Click here to enter text. **State:** Click here to enter text. **ZIP Code:** Click here to enter text.

Email: Click here to enter text.

Phone: Click here to enter text. **Fax:** Click here to enter text.

B. LEGAL REQUIREMENTS

1. Legal Entity Formation

Is the ACO a recognized legal entity formed under applicable State, Federal, or Tribal law and authorized to conduct business in each State in which it operates?

Yes No

Is the ACO formed among multiple, independent ACO participants?

Yes No

If you answered **YES** to the previous question, do you certify that the ACO's legal entity is separate from any of the ACO participant TINs?

Yes No

Do you have available all documents that effectuate the formation and operation of the ACO?

Yes No

You are not required to submit these documents with your application; however you must provide copies of all documents effectuating the ACO's formation and operation to CMS upon request. Such documentation may include, but is not limited to:

- 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

C. GOVERNANCE / LEADERSHIP

2. Organization Structure

Submit the leadership and organizational chart for the ACO, including relevant committees.

Submit a list for each committee including names/roles of committee members, and structure.

Submit job descriptions for the ACO's senior administrative and clinical leaders.

3. Governing Body

Submit the names, titles, and responsibilities for all members of the ACO's governing body.

Is your governing body controlled by at least 75% of ACO participants?

Yes No

If **NO**, describe why you seek to differ from this requirement and explain, with supporting documentation, if appropriate, how the ACO will involve ACO participants in ACO governance.

Does your governing body include one or more Medicare beneficiaries who are served by the ACO, who do not have a conflict of interest with the ACO, and who have no immediate family with a conflict of interest?

Yes No

If **NO**, describe why you seek to differ from this requirement and explain with supporting documentation, if appropriate, how the ACO will ensure meaningful participation in ACO governance by Medicare beneficiaries.

Does your governing body have a conflict of interest policy that applies to members of the governing body?

Yes No

Note: by selecting **YES**, you certify that the conflict of interest policy states the following:

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

4. Leadership and Management

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

Yes No

If **NO**, describe how you intend to manage the operations of the ACO, and how this alternate leadership and management structure will be capable of accomplishing the ACO's mission.

Are your clinical management and oversight managed by a senior-level medical director who is a physician and one of the ACO providers/suppliers, who is physically present on a regular basis at any clinic, office, or other location participating in the ACO, and who is a board-certified physician and licensed in a State in which the ACO operates?

Yes No

If **NO**, describe the ACO's clinical management and oversight, including how this structure will be capable of accomplishing the ACO's mission.

Has each ACO participant and each ACO provider/supplier agreed to demonstrate a meaningful commitment to the mission of the ACO to ensure the ACO's likely success?

Yes No

Does the ACO have a compliance plan that includes at least the following elements:

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

Yes No

D. PARTICIPATION IN OTHER MEDICARE INITIATIVES INVOLVING SHARED SAVINGS

1. Current Participation

Does the ACO or any of the ACO participants, under the same or different name, **CURRENTLY** participate in any Medicare initiative involving a shared savings arrangement?

Yes No

Note: By selecting **NO**, you are certifying that neither the ACO nor any of the ACOs participants are currently participating in any other Medicare initiative involving shared savings.

If **YES**, indicate all program(s) that apply:

- Independence at Home Medical Practice Demonstration
- Medicare Health Care Quality Demonstration Programs (including Indiana Health Information Exchange and North Carolina Community Care Network)
- Multipayer Advanced Primary Care Practice Demonstration with a shared savings arrangement
- Care Management for High-Cost Beneficiaries Demonstration
- Physician Group Practice Transition Demonstration
- Pioneer Accountable Care Organization Model Demonstration
- Other (please specify) [Click here to enter text.](#)

Will participation in this/these program(s) be complete by the start date for which you are applying?

Yes No

Note: By selecting **YES**, you are certifying that neither the ACO nor any of the ACO participants will concurrently participate in any other Medicare initiative involving shared savings.

E. FINANCIAL

1. Shared Savings

Please describe in a narrative how you plan to use shared savings payments, including whether you intend to share savings with ACO participants and ACO providers/suppliers, or to use the shared savings to re-invest in the ACO's infrastructure, redesigning care processes, etc. You should include 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. Additionally, 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.

2. Interim Payment Election

ACOs beginning program participation on April 1, 2012 and July 1, 2012 have the option to elect an interim payment calculation for shared savings (or losses for ACOs in Track 2) after the completion of the first 12 months of program participation.

Are you electing to receive interim payment calculation?

Yes No

If **YES**, you must complete the repayment mechanism question below, regardless of the Track you indicated.

3. Repayment Mechanism

What repayment mechanism will you use to repay CMS for any losses, or other monies owed to CMS?

The repayment mechanism must be capable of repaying an amount of shared losses equivalent to at least 1 percent of total per capita Medicare Parts A and B fee-for-service expenditures for your assigned beneficiaries based on expenditures for the most recent performance year or expenditures used to establish the benchmark. bases for which recoupment may be considered adequate are (check all that apply):

- Reinsurance
- Funds placed in escrow
- Surety bonds
- A line of credit as evidenced by a letter of credit that the Medicare program could draw upon.
- Alternative repayment mechanism

If you selected 'alternative repayment mechanism', attach a narrative describing the alternative repayment mechanism you are proposing to use and submit for CMS approval. Prior to the start of each performance year, you must submit documentation to support the adequacy of the repayment mechanism you selected.

Note: Answer this question only if you are applying for Track 2 or an interim payment calculation under either Track 1 or 2.

4. Banking Information

You must establish a relationship with a banking partner that meets the Internal Revenue Service (IRS) requirements (a bank, insurance company or other entity as set out in the Treasury Reg. Secs. 1.408-2(e)(2) through (e)(5).

- Complete the Electronic Funds Transfer (EFT) Authorization Agreement (CMS 588) (see **Appendix A**).
- For further guidance on completing the CMS 588, please reference a tutorial at this link: <https://www.highmarkmedicareservices.com/enrollment/tutorial/588.html>.
- Send the completed CMS 588 with the ORIGINAL signature and voided check to CMS using tracked mail (FedEx, UPS, etc.) to:

Centers for Medicare & Medicaid Services
7500 Security Blvd
OFM/FSG/DFSE Mail Stop N3 04 07
Baltimore, MD 21244-1850
Attention: Ed Berends

Note: The signed CMS 588 for the ACO is due at the same time as the application. Shared savings will be deposited directly to this account. Please refer to the Application Key Dates table in the application instructions. Applications are not considered complete until this form is received.

F. PROVIDER INFORMATION

1. Participation Agreements

Please provide sample agreements between the ACO and the ACO Participants (TINs) and other entities furnishing services related to ACO activities. These sample agreements must describe the ACO participants' and ACO providers'/suppliers' rights and obligations in and representation by the ACO, including how the opportunity to receive shared savings or other financial arrangements will encourage ACO participants and ACO providers/suppliers to adhere to the quality assurance and improvement program and evidence-based clinical guidelines. These agreements must require compliance with the requirements and conditions of the program, including, but not limited to, those specified in the participation agreement with CMS.

Note: You are not required to submit copies of the executed agreements with your application; however the executed agreements must be available to CMS upon request.

2. ACO Participants

You must submit a list of ACO participant TINs. These are the ACO participants that have joined together to form the ACO. Please follow the instructions included the ACO Participant list provided for you to complete this request. (see **Appendix B**)

If your ACO includes FQHCs and/or RHCs: Note each FQHC/RHC participant TIN and also indicate the NPI and other identifying information for each physician that directly provides primary care services on behalf of the participating FQHC or RHC.

G. DATA SHARING

Will you request the name, DOB, sex, and HICN of beneficiaries used to generate the ACO's benchmark?

Yes No

Will you request beneficiary identifiable Part A, B and/or D claims data?

Yes No

If you selected **YES** to either question above, do you certify that you are requesting this information as a HIPAA-covered entity or as a business associate of a HIPAA-covered entity?

Yes No

If you selected **YES** to any of the questions in this section, describe in a narrative the following:

- How you will ensure privacy and security of data,
- How you intend to use this data
 - to evaluate the performance of ACO participants, and ACO providers/suppliers,
 - to conduct quality assessment and improvement activities, and
 - to conduct population-based activities to improve the health of your assigned beneficiary population.

If you selected **YES** to any of the questions in this section, and you are approved to participate in the Medicare Shared Savings Program, you will be instructed to sign and return a Data Use Agreement (DUA) in your approval letter. (see **Appendix C**)

H. REQUIRED CLINICAL PROCESSES AND PATIENT CENTEREDNESS

1. Quality Assurance and Improvement Program

Do you have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program that encompasses all of the four following processes:

- (a) Promoting evidence-based medicine
- (b) Promoting beneficiary engagement
- (c) Reporting internally on quality and cost metrics
- (d) Coordinating care.

Yes No

Instructions for answering each of the four required processes below (2) – (5):

Submit a narrative and/or supporting documentation for each of the following four required processes. Describe in your narrative how the ACO will implement each required process, including each sub element. Also, describe your remedial process and penalties that will apply to ACO participants and/or ACO provider/suppliers who fail to comply with these required processes. You must also explain how you intend to use the internal assessments of these processes to continuously improve the ACO's care practices.

2. Promoting Evidence-Based Medicine

Submit a narrative describing how the ACO will define, establish, implement, evaluate, and periodically update its process to promote evidence-based medicine. This process should cover diagnoses with significant potential for the ACO to achieve quality improvements, taking into account the circumstances of individual beneficiaries.

3. Promoting Beneficiary Engagement

Submit a narrative describing how the ACO will define, establish, implement, evaluate, and periodically update its process to promote patient engagement. Also, describe how the applicant intends to address the following areas:

1. Evaluating the health needs of the ACO's assigned population including consideration of diversity in its patient population and a plan to address the needs of its population. This plan should include a description of how the ACO intends to partner with community stakeholders to improve the health of its population;
2. Communicating clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them;
3. Beneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities; and
4. Written standards for beneficiary access and communication, and a process for beneficiaries to access their medical records.

4. Internally Reporting on Quality and Cost Metrics

Submit a narrative describing how the ACO will define, establish, implement, evaluate, and periodically update its process and infrastructure to support internal reporting on quality and cost metrics to enable the ACO to monitor, provide feedback, and evaluate ACO participant and ACO provider/supplier performance and to use these results to continually improve care and service over time.

5. Promoting Coordination of Care

Submit a narrative describing how the ACO will define, establish, implement, evaluate, and periodically update its care coordination processes. Narrative must include a description of:

1. The ACO's methods to coordinate care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO).
2. The ACO's individualized care program, along with a sample individual care plan, and explain how this program is used to promote improved outcomes for, at a minimum, its high-risk and multiple chronic condition patients.
3. Additional target populations that would benefit from individualized care plans.
4. How individual care plans will take into account the community resources available to beneficiaries.

I. APPLICATION CERTIFICATION

I have read the contents of this application. My signature (or electronic signature) legally and financially binds this ACO to the applicable laws and regulations of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Centers for Medicare and Medicaid Services (CMS) to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify CMS of this fact immediately and provide the correct and/or complete information. If my ACO is newly formed according to the definition in the Antitrust Policy Statement, I understand and agree that CMS will share the content of this application, including all information and documents submitted with this application, with the FTC and DOJ.

[Click here to enter text.](#)

Signature CEO/ Executive Director

[Click here to enter text.](#)

(MM/DD/YYYY)

Electronic submissions: This page will appear at the end of your application. Select **I agree**, or **I disagree**. Once you select **I agree**, you are certifying the application.

Note: We will not process your application if this certification is not complete.

III. Request to Withdraw a Pending Application

If you wish to withdraw an entire pending application, you must submit a written request to such effect on your organization's letterhead and signed by the authorized official prior to the date on which approved ACO agreements are due back to CMS. The following information must be included:

- Your organization's legal entity name
- ACO ID
- Full and correct address
- Point of contact information for follow-up, if necessary
- Exact description of the nature of the withdrawal

To submit a request to withdraw your application via email, send the request in PDF format as an attachment to the email message to: SSPACO_Applications@cms.hhs.gov.

To submit a request to withdraw your application via tracked mail, (e.g. Fed Ex, UPS, certified) address your request to:

Centers for Medicare and Medicaid Services
Attn: SSP ACO Applications
Mail Stop: C5-15-12
Desk Location: C4-07-01
7500 Security Blvd.
Baltimore, MD 21244

IV. Application Determination Reconsideration Review Process

If CMS determines that the Applicant does not meet the requirements to enter into an agreement with CMS and denies this application, the applicant has the right to request a reconsideration review of the initial determination. Details on how to request a reconsideration review will be included in the application denial letter. Administrative reconsiderations of an ACO application denial are governed by the regulations at 42 C.F.R. part 425, subpart I.

You must receive a favorable determination from the reconsideration review or the on-the-record review by the date noted in the Application Key Dates table in order to be eligible to begin participation on the requested start date.

V. Appendix

**Appendix A: Electronic Funds Transfer (EFT) Authorization Agreement
(CMS 588)**

Appendix B: ACO Participant List Template

Appendix C: Data Use Agreement (DUA)

Appendix D: Application Reference Guide