



# Renewal Application Agreement Period Beginning on January 1, 2026

Please refer to the [Application Toolkit](#) for instructions and eligibility requirements for completing this application.

**PAPER APPLICATIONS ARE NOT ACCEPTED.** USE THIS DOCUMENT TO PREPARE YOUR RESPONSES. SUBMIT YOUR APPLICATION ONLINE VIA THE [ACO MANAGEMENT SYSTEM](#) (ACO-MS).

Information submitted in your Renewal Application is effective for your subsequent agreement period with the Centers for Medicare & Medicaid Services (CMS).

## PHASE 1

### SECTION 1 – ACO INFORMATION

Review your ACO information in ACO-MS. Note: The information in this section of ACO-MS has been pre-populated and will not be editable after initial submission of your application.

1. Review ACO legal entity information:
  - Legal entity name
  - Trade name/doing business as (DBA) name
  - Mailing address
  - Taxpayer identification number (TIN)

### SECTION 2 – PROGRAM PARTICIPATION

2. Select a Medicare Shared Savings Program (Shared Savings Program) track and, if applicable, level. Note that CMS will verify the ACO's eligibility to participate in the track and, if applicable, level selected:

BASIC track:

- Level A of the BASIC track (one-sided model)
- Level B of the BASIC track (one-sided model)
- Level C of the BASIC track (two-sided model)
- Level D of the BASIC track (two-sided model)
- Level E of the BASIC track (two-sided model)

ENHANCED track:

- ENHANCED track (two-sided model)

*Disclaimers: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.*

*This communication material was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain 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 its contents.*

3. Indicate your ACO's symmetrical minimum savings rate (MSR)/minimum loss rate (MLR):

Selecting a symmetrical MSR/MLR is only applicable to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track). ACOs applying to participate in Level B of the BASIC track will receive an MSR based on the number of beneficiaries assigned to the ACO.

- 0.0% MSR/MLR
- 0.5% MSR/MLR
- 1.0% MSR/MLR
- 1.5% MSR/MLR
- 2.0% MSR/MLR
- Symmetrical MSR/MLR (based on the number of beneficiaries assigned to your ACO)

4. Select a beneficiary assignment methodology:

- Prospective assignment
- Preliminary prospective assignment with retrospective reconciliation

ACOs may elect to change their beneficiary assignment methodology selection prior to the start of each performance year.

### ACO Participant List

5. Your ACO must submit a list of ACO participants in ACO-MS. An ACO participant is an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together with one or more other ACO participants, composes the ACO, and that is included on the list of ACO participants that is required under 42 CFR § 425.118. Do not submit any ACO participants that have not signed an ACO Participant Agreement with the ACO. Submit evidence of a signed ACO Participant Agreement for each ACO participant TIN entered on your ACO Participant List. The agreement must comply with the requirements of 42 CFR § 425.116(a) and must be signed on behalf of the ACO and the ACO participant by individuals who are authorized to bind the ACO and the ACO participant, respectively. Evidence of a signed ACO Participant Agreement means the first and signature page of the agreement.

6. I certify to the best of my knowledge, information, and belief that my ACO has executed ACO Participant Agreements that comply with the requirements of 42 CFR § 425.204(c) and the criteria listed in 42 CFR § 425.116(a).

I understand, acknowledge, and agree that 42 CFR § 425.314(a) authorizes CMS to audit, inspect, investigate, and evaluate any and/or all ACO Participant Agreements submitted at any time to determine compliance with the Shared Savings Program requirements set forth at 42 CFR § 425.116.

Finally, I understand, acknowledge, and agree that if my ACO's executed ACO Participant Agreements do not satisfy all of the requirements set forth in 42 CFR § 425.116, CMS may take one or more of the compliance actions listed under 42 CFR §§ 425.216 and 425.218 against my ACO.

- Yes

7. If your ACO providers/suppliers are employed by the ACO legal entity, are they required to participate in the Shared Savings Program as a condition of employment?

- Yes
- No
- N/A

7.1 I attest that if accepted into the program, my ACO will notify each of the employed ACO provider(s)/supplier(s) of their participation in the Shared Savings Program.

Yes

## Skilled Nursing Facility (SNF) 3-Day Rule Waiver

The SNF 3-Day Rule Waiver is only applicable to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track).

8. Is your ACO electing to apply for a SNF 3-Day Rule Waiver? (Only applicable to ACOs without a SNF 3-Day Rule Waiver.)

Yes

No

By selecting "Yes," your ACO must complete the SNF 3-Day Rule Waiver application in addition to this application and submit all proposed SNF affiliates during Phase 1 of the application process. By selecting "Yes," a separate SNF 3-Day Rule Waiver application task is created on your dashboard in ACO-MS.

8.1 I am electing to apply for a SNF 3-Day Rule Waiver for use during my next agreement period. (Only applicable to ACOs with an existing SNF 3-Day Rule Waiver.)

Yes

No

By selecting "Yes," your ACO must complete the SNF 3-Day Rule Waiver application in addition to this application and submit all proposed SNF affiliates during Phase 1 of the application process. By selecting "Yes," a separate SNF 3-Day Rule Waiver application task is created on your dashboard in ACO-MS.

## Repayment Mechanism

A repayment mechanism is only applicable to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track).

9. Select and upload the DRAFT repayment mechanism(s) your ACO intends to submit demonstrating the ACO is capable of repaying shared losses that it may incur during its agreement period under a two-sided model (Only applicable to ACOs without an existing repayment mechanism.):

Escrow Agreement: An escrow account established with an insured institution

Surety Bond: A surety bond issued by a company included on the U.S. Department of the Treasury's List of Certified (Surety Bond) Companies

Letter of Credit: A line of credit as evidenced by a letter of credit that the Medicare program could draw upon, established at an insured institution

9.1 Does your ACO intend to use its existing repayment mechanism(s) for its next agreement period? (Only applicable to ACOs with an existing repayment mechanism.)

Yes

No

If "Yes," select and upload a DRAFT of the following:

If your ACO is using an escrow agreement, upload a letter stating an updated confirmation of deposit will be provided after final amounts are released, if necessary.

If your ACO is using a surety bond, upload a draft of a rider to the previously approved surety bond.

- If your ACO is using a letter of credit, upload a draft of an amendment to the previously approved letter of credit.

If No, select and upload the DRAFT repayment mechanism(s) your ACO intends to submit demonstrating the ACO is capable of repaying shared losses that it may incur during its agreement period under a two-sided model:

- Escrow Agreement: An escrow account established with an insured institution
- Surety Bond: A surety bond issued by a company included on the U.S. Department of the Treasury's List of Certified (Surety Bond) Companies
- Letter of Credit: A line of credit as evidenced by a letter of credit that the Medicare program could draw upon, established at an insured institution

## Banking Information

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

- Yes
- No

Select "No" if any of your ACO's information below has changed:

- Legal entity name
- Address
- TIN
- Financial institution/account information
- Authorized/delegated official
- Form contact

If your ACO selected "No," upload an updated [Electronic Funds Transfer Authorization Agreement \(Form CMS-588\)](#), [Banking Information Cover Sheet](#), and supporting financial documentation (e.g., a voided, pre-printed check or a signed letter from the financial institution) to ACO-MS. All three documents must be submitted for processing. Please refer to the [ACO Banking Form Instructions](#) for additional information.

## SECTION 3 – CERTIFY YOUR APPLICATION

\*CMS will not process your application if you do not complete this certification in ACO-MS. This page will appear at the end of your application. You certify your application when you select "I agree."

I certify that I am legally authorized to execute this document on behalf of the ACO. By my signature, I certify that the information contained herein is true, accurate, and complete, and I authorize CMS to verify this information. If I become aware that any information in this application is not true, accurate, or complete, I agree to notify CMS of this fact immediately and to provide the relevant complete and corrected information.

- I agree

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## PHASE 2

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### SECTION 1 – ACO INFORMATION

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1. Review your information in ACO-MS:
  - Date of formation
  - Legal entity type (i.e., sole proprietorship, partnership, publicly traded corporation, privately held corporation, limited liability company, or other)
  - Tax status (i.e., for-profit or not-for-profit)
  - Public reporting webpage
2. An ACO that seeks to participate in the Shared Savings Program must agree that CMS can share a copy of their application with the Antitrust Agencies.
  - I agree
3. CMS will identify whether your ACO has a history of noncompliance with the requirements of the Shared Savings Program. This includes, but is not limited to:
  - Pattern of failure to meet the quality performance standard
  - Failed to repay shared losses in a timely manner
  - Generated losses outside its negative corridor for two or more years
  - Voluntarily or involuntarily terminated from the Shared Savings Program

If CMS has identified your ACO as having a history of noncompliance, upload a narrative that demonstrates your ACO has corrected the deficiencies that caused any noncompliance and how it will remain in compliance with the terms of the new participation agreement as specified in 42 CFR § 425.224.

#### Organization Contacts

4. Review and update information on your ACO's contacts in ACO-MS: name, title, mailing address, phone number, and email address. Note that some contact information in this section of ACO-MS has been pre-populated.

#### Required Contacts:

- ACO Executive
- CMS Liaison
- Application Contact (primary)
- Information Technology (IT) Contact (primary)
- Financial Contact
- Compliance Contact
- Authorized to Sign (primary)
- Data Use Agreement (DUA) Requestor
- DUA Custodian

- Medical Director
- Primary Contact (Public Usage)

#### Additional Required Contacts:

- Authorized to Sign (secondary)
- Quality Contact (primary and secondary)
- Marketing Contact (primary and secondary)

#### Optional Contacts:

- Application Contact (secondary)
- IT Contact (secondary)

## SECTION 2 – PROGRAM PARTICIPATION

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### Beneficiary Incentive Program (BIP)

The BIP is applicable only to ACOs applying to a two-sided model (Levels C, D, or E of the BASIC track or the ENHANCED track).

5. Select Yes to apply to establish and operate a BIP as described in 42 CFR § 425.304(c).

Yes

If you select “Yes,” your ACO must complete a separate BIP application in addition to this application.

### Prepaid Shared Savings (PSS)

Prepaid shared savings are only applicable to ACOs who meet PSS eligibility requirements as described in 42 CFR § 425.640(b).

6. If your ACO would like to receive PSS, select “Yes.” Select “No” if you do not wish to receive PSS.

Yes

No

If you select “Yes,” your ACO must submit PSS supplemental information as part of this application.

## SECTION 3 – LEADERSHIP AND GOVERNANCE

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### Organizational Chart

7. Submit an organizational chart for your ACO.

### ACO Governing Body

8. Enter your ACO’s governing body members in ACO-MS. At least 75 percent control of your ACO’s governing body must be held by ACO participants. Additionally, your ACO’s governing body must include at least one Medicare beneficiary who is served by the ACO. Include:

a. All governing body members (include first and last name)

b. Title/position

c. Voting power (Enter voting power as a percentage, enter “0” for non-voting members.)

- d. Membership type (i.e., ACO Participant Representative, Medicare Beneficiary Representative, Community Stakeholder Representative, Other)
- e. ACO participant TIN legal business name (for ACO participant representatives, type the ACO participant TIN legal business name exactly as it appears on the ACO Participant List, including any name extensions (e.g., LLC, Incorporated, M.D., P.A.). For Medicare Beneficiary and Community Stakeholder Representatives, type N/A.)
- If desired, include the applicable ACO participant TIN's DBA name.
9. Does your governing body include at least one Medicare beneficiary who is served by the ACO, is not an ACO provider/supplier, does not have a conflict of interest with your ACO, and has no immediate family members with a conflict of interest with your ACO as specified in 42 CFR § 425.106(c)(2)?
- Yes
- No
- If "No" is selected, submit a narrative explaining why you seek to differ from this requirement and how your ACO will provide for meaningful representation of Medicare fee-for-service beneficiaries in ACO governance.

## SECTION 4 – CERTIFICATIONS

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10. I certify to the best of my knowledge, information, and belief that my ACO agrees to meet all applicable Shared Savings Program requirements in 42 CFR part 425, including but not limited to the following:

- 42 CFR § 425.104 (Legal entity)
- 42 CFR § 425.106 (Shared governance)
- 42 CFR § 425.108 (Leadership and management)
- 42 CFR § 425.112 (Required processes and patient-centeredness criteria)
- 42 CFR §§ 425.116(a) and (b) (Agreements with ACO participants and ACO providers/suppliers)
- 42 CFR §§ 425.204(a), (c)(1), (d), and (f) (Content of the application)
- 42 CFR § 425.300 (Compliance plan)

Yes

11. I certify that I am requesting the following minimum necessary data per 42 CFR § 425 Subpart H:

- a. The name, date of birth, sex, and Health Insurance Claim Number of beneficiaries
- b. Demographic data
- c. Health status information
- d. Utilization rates
- e. Expenditure information

For ACOs participating under prospective assignment as specified under 42 CFR § 425.400(a)(3), such data is limited to the ACO's prospectively assigned beneficiaries. For ACOs participating under preliminary prospective assignment with retrospective reconciliation under 42 CFR § 425.400(a)(2), such data is limited to beneficiaries who 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 under 42 CFR § 425 Subpart E.

I further certify my ACO is requesting the minimum necessary data as a HIPAA-covered entity, as the business associate of my ACO participants and ACO providers/suppliers, or as an organized health care arrangement in order to conduct health care operations per 45 CFR § 164.501. Such minimum necessary data may include, but are not limited to, the data elements as defined in 42 CFR § 425.706.

I certify that my ACO is requesting the data per 42 CFR § 425.704 to:

- a. Evaluate the performance of ACO participants and ACO providers/suppliers;
- b. Conduct quality assessment and improvement activities; and
- c. Conduct population-based activities to improve the health of the ACO's assigned beneficiary population.

I acknowledge and accept that if my ACO is approved to participate in the Shared Savings Program, my ACO will be required to submit a DUA prior to receiving any data.

Yes

## **SECTION 5 – CERTIFY YOUR APPLICATION**

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\*CMS will not process your application if you do not complete this certification in ACO-MS. This page will appear at the end of your application. You certify your application when you select "I agree."

I certify that I am legally authorized to execute this document on behalf of the ACO. By my signature, I certify that the information contained herein is true, accurate, and complete to the best of my knowledge, information, and belief, and I authorize CMS to verify this information. If I become aware that any information in this application is not true, accurate, or complete, I agree to notify CMS of this fact immediately and to provide the relevant complete and corrected information. I understand and agree that CMS may share the content of this application, including all information and documents submitted with this application, with the Antitrust Agencies.

I agree