MEDICARE SHARED SAVINGS PROGRAM 2015 APPLICATION

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

Some information in this section is pre-populated in HPMS. Complete any fields that are blank online.

SECTION 1 – Give us your contact information

ACO ADDRESS

Legal Entity Name

Trade Name/DBA (If Applicable)

Mailing Address

ORGANIZATION CONTACTS

ACO EXECUTIVE (AUTHORIZED OFFICIAL) REQUIRED, ESM DESIGNEE

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

CMS LIAISON (PRIMARY CONTACT) REQUIRED

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

APPLICATION CONTACT (PRIMARY) REQUIRED

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

APPLICATION CONTACT (SECONDARY) OPTIONAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

INFORMATION (IT) CONTACT (PRIMARY) REQUIRED

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

ORGANIZATION CONTACTS (CONT.)

INFORMATION (IT) CONTACT (SECONDARY) OPTIONAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

FINANCIAL CONTACT REQUIRED

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

COMPLIANCE CONTACT REQUIRED

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

AUTHORIZED TO SIGN (PRIMARY) REQUIRED, ESM DESIGNEE

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

AUTHORIZED TO SIGN (SECONDARY) REQUIRED, ESM DESIGNEE

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

QUALITY CONTACT (PRIMARY) OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

QUALITY CONTACT (SECONDARY) OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

MARKETING CONTACT (PRIMARY) OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

ORGANIZATION CONTACTS (CONT.)

MARKETING CONTACT (SECONDARY) OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

PUBLIC CONTACT OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

DUA REQUESTOR OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL, ESM DESIGNEE

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

DUA CUSTODIAN OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL, ESM DESIGNEE

Last Name, First Name

Title

Mailing Address

Phone Number (including area code) | *E-mail Address*

ACO WEBPAGE OPTIONAL AT TIME OF APPLICATION; REQUIRED UPON CMS APPROVAL

URL: _____

SECTION 2 – Tell us some general information about your ACO

I AM A:

- ☐ New Applicant (including previously withdrawn or denied applicants)
- ☐ Re-Applicant (If you have previously been terminated from Medicare Shared Savings Program (voluntarily or involuntarily) and are re-applying)
- ☐ Physician Group Practice (PGP) Transition Demonstration Participant
- ☐ Pioneer Accountable Care Organization Model (prior to January 1, 2015)

COMPOSITION OF ACO PARTICIPANTS ELIGIBLE TO FORM THE ACO: (Select All that Apply)

- ☐ 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
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Rural Health Clinic (RHC)

MEDICARE SHARED SAVINGS PROGRAM TRACK: (Select One)

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

ACO TAXPAYER IDENTIFICATION NUMBER (TIN): _____

DATE OF FORMATION

The date on the ACO Certificate of Incorporation or other formation documentation: _____
(DD/MM/YYYY)

YOUR BUSINESS STRUCTURE: (Select One)

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Publicly-Traded Corporation
- ☐ Privately-Held Corporation
- ☐ Limited Liability Company
- ☐ Other (specify) _____

YOUR TAX STATUS: (Select One)

- ☐ Not-for-profit
- ☐ For profit

REPAYMENT MECHANISM:

** For Track 2 (Two-Sided Model: Shared Savings/Losses) Only.*

The repayment mechanism must be capable of repaying an amount of shared losses equivalent to at least one (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.

What repayment mechanism will you use to repay CMS for any losses, or other monies owed to CMS?
Ways you may repay CMS are: (Check All That Apply)

- ☐ Reinsurance
- ☐ Funds placed in escrow
- ☐ Surety bonds
- ☐ A line of credit the Medicare program could draw upon, as evidenced by a letter of credit

Alternatively, the ACO may establish an appropriate alternative repayment mechanism that will ensure your ACO's ability to repay the Medicare Program. If you select an 'Alternative repayment mechanism,' submit a narrative describing your proposed alternative repayment mechanism for CMS' evaluation and approval.

- ☐ Alternative repayment mechanism

SECTION 3 – Tell us if your ACO meets the Antitrust Agencies' definition of "newly formed"

JOINTLY NEGOTIATED CONTRACTS WITH A PRIVATE PAYOR(S)

1. Is the ACO "newly formed"? An ACO is not "newly formed" if it is comprised solely of providers who jointly negotiated or jointly signed any contracts with a private payor(s), on or before March 23, 2010. If the ACO includes any providers who were not part of the prior joint negotiation or joint contracting, it is newly formed.

   ☐ YES ☐ NO

   If you answer **YES**, you understand and agree that we will share a copy of your 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)

SECTION 4 – Tell us about your ACO's legal entity

2. Submit a narrative giving us a brief overview of your ACO's history, mission and organization, including your ACO's affiliations.

3. Your ACO is 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

   By selecting **YES**, you certify that your ACO legal entity can:

   a. Receive and distribute shared savings
   b. Repay shared losses or other monies determined to be owed to CMS
   c. Establish, report, and ensure provider compliance with health care quality criteria, including quality performance standards
   d. Fulfill other ACO functions identified in 42 CFR Part 425

4. Is your ACO formed among multiple, otherwise independent ACO participants?

   ☐ YES ☐ NO

   Note: 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.

5. If you answered **YES** to question 4, do you certify that your ACO is a legal entity separate from any of the ACO participants and comprised only of ACO participants? If you answered **NO** to question 4, select **N/A**.

☐ YES ☐ NO ☐ N/A

6. If you answered **NO** to question 4, your ACO is not required to have a separate legal entity. However, please indicate whether your ACO has chosen to have a legal entity separate from the single ACO participant to allow the addition of ACO participants in the future.

   If you answered **YES** to question 4, select **N/A**.

   ☐ YES ☐ NO ☐ N/A

7. You have available all documents (e.g., charters, by-laws, articles of incorporation, etc.) that effectuate the formation and operation of the ACO.

   ☐ YES

8. Submit your ACO's organizational chart showing the flow of responsibility. Include committees and key leadership personnel on each committee.

SECTION 5 – Tell us about your ACO's governing body

9. Your ACO has an identifiable governing body with authority to execute the functions of your ACO as defined in the Medicare Shared Savings Program regulations at 42 CFR Part 425.

   ☐ YES

   By selecting Y**ES**, you certify that:

   a. The governing body has responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities as described in 42 CFR Part 425;
   b. The governing body has a transparent governing process;
   c. The governing body members have a fiduciary duty to the ACO and will act consistent with that fiduciary duty; and
   d. The governing body of the ACO is separate and unique to the ACO in cases where the ACO comprises multiple, otherwise independent ACO participants, or if the ACO is an existing entity, the ACO governing body may be the same as the governing body of that existing entity, provided it satisfies the other governing body requirements in a, b and c.

10. Your ACO provides for meaningful participation in the composition and control of the ACO's governing body for ACO participants or their designated representatives.

    ☐ YES

11. Your ACO participants have at least 75% control of your ACO's governing body.

    ☐ YES ☐ NO

    If you answered **NO**, submit a narrative explaining why you seek to differ from this requirement. Include supporting documentation showing how the ACO will involve ACO participants in innovative ways in ACO governance.

12. Your governing body includes one or more Medicare fee-for-service beneficiaries who are served by the ACO, who do not have a conflict of interest with your ACO, and who have no immediate family with a conflict of interest with your ACO.

    ☐ YES ☐ NO

    If you answered **NO**, submit a narrative explaining why you seek to differ from this requirement. You should also provide supporting documentation showing how your ACO provides for meaningful participation in ACO governance by Medicare fee-for-service beneficiaries.

13. Your governing body has a conflict of interest policy that applies to members of the governing body.

☐ YES

By selecting **YES**, you certify that your conflict of interest policy:

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

14. Use the Governing Body Template to identify the following:

a. All governing body members
b. Position each member holds on the governing body
c. Voting power of each governing body member
d. 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.

SECTION 6 – Tell us about your ACO's leadership and management

15. Your operations are managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of your 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 you answered **NO**, describe how you manage the operations of your ACO, and how this alternate leadership and management structure is capable of accomplishing the ACO's mission.

16. Your clinical management and oversight are managed by a senior-level medical director who is a physician and one of your 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 your ACO operates.

☐ YES ☐ NO

If you answered **NO**, describe your ACO's clinical management and oversight, including how this structure is capable of accomplishing the ACO's mission.

17. Your ACO has a compliance plan that includes at least the following elements:

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

By selecting **YES**, you confirm that your Compliance Plan meets program requirements.

☐ YES

Note: Your Compliance Plan is not required to be submitted with your application, however it must be made available to CMS upon request at any time.

SECTION 7 – Tell us about your participation in other Medicare initiatives involving shared savings

PAST PARTICIPATION

18. Has your ACO, ACO participants, or ACO provider/suppliers ever been voluntarily or involuntarily terminated from the Shared Savings Program? §425.204(b)(3)

☐ YES ☐ NO

If you answered **YES** to question 18, provide a narrative that identifies the cause of termination and what safeguards are now in place to enable your ACO, ACO participant, and/or ACO provider/supplier to participate in the program for the full term of the agreement.

CURRENT PARTICIPATION

19. Does your ACO or any of your ACO participants, under the same or different name currently participate in any Medicare initiative involving a shared savings arrangement?

☐ YES ☐ NO

If you answered NO, you certify that neither your ACO nor any of your ACO participants currently are participating in any other Medicare initiative involving shared savings.

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

- ☐ Comprehensive Primary Care Initiative (CPCI)
- ☐ Coordinated ESRD Care (CEC) Program
- ☐ Independence at Home Medical Practice Demonstration
- ☐ Medicare Health Care Quality Demonstration Programs (including Indiana Health Information Exchange and North Carolina Community Care Network)
- ☐ Multi-payer Advanced Primary Care Practice Demonstration with a shared savings arrangement
- ☐ Pioneer Accountable Care Organization Model
- ☐ Other (please specify)

FUTURE PARTICIPATION

20. You certify that participation in the program(s) in question 19 will be completed by the start date for which you are applying.

☐ YES ☐ N/A

By selecting **YES**, you certify that neither your ACO nor any of your ACO participants will participate concurrently in any other Medicare initiative involving shared savings.

SECTION 8 – Tell us how you plan to manage shared savings

SHARED SAVINGS

21. Describe in a narrative how you plan to use shared savings payments, including:

    a. 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.
    b. 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.
    c. 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.

BANKING INFORMATION

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

    This checking account is associated with the TIN designated for the ACO. Shared savings will be deposited directly to the account you indicate.

    a. Complete the Electronic Funds Transfer (EFT) Authorization Agreement Form CMS 588. Use this Form CMS 588 tutorial for further guidance.

    b. We will not consider your application complete until we get this form. Send your completed Form CMS 588, with your original signature and a voided check using tracked mail, such as certified mail, Federal Express or United Parcel Service, to:

    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

SECTION 9 – Tell us about your ACO participants

ACO PARTICIPANTS

23. You must submit a list of ACO participant Taxpayer Identification Numbers (TINs). If your ACO contains FQHC or RHC participants, you are required to submit additional ACO provider/supplier information. The ACO participant TINs submitted on this list are the ACO participants that have joined together to form the ACO and have agreed to become accountable for the quality, cost, and overall care of beneficiaries assigned to the ACO and to comply with all requirements of the program under 42 CFR Part 425. DO NOT submit any ACO participant TINs that have not signed an ACO Participant Agreement with the ACO.

MEANINGFUL COMMITMENT

24. You 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.

☐ YES

MERGED OR ACQUIRED TINS

25. Does your ACO include any TINs that have been subsumed into an ACO Participant TIN through a merger or acquisition within the three (3) benchmarking years?

☐ YES ☐ NO

If you answered YES, you must:

a. Indicate the merged or acquired TIN(s) on your ACO Participant List following the instructions in the Toolkit
b. Submit an attestation indicating the following:
   - Which ACO Participant merged with or acquired the TIN
   - All ACO providers/suppliers that previously billed under the acquired TIN have reassigned their billings to the TIN of the identified ACO Participant, and
   - The acquired TIN is no longer in use.
c. Submit supporting documentation demonstrating that the TIN was acquired by an ACO participant through a sale or merger.

EMPLOYMENT AGREEMENTS

26. If you answered **NO** to both questions 4 and 6, choose **YES** or **NO.** If you answered **YES** to either question 4 or 6, choose **N/A**.

Your ACO providers/suppliers are employed by the ACO legal entity, and as a condition of employment, are they required to participate in the Medicare Shared Savings Program?

☐ YES ☐ NO ☐ N/A

If you answered **YES**:

- You are attesting that if you are accepted into the program, you will notify each ACO provider/supplier of their participation in the Medicare Shared Savings Program.
- You must submit a copy of the employment agreement you have in place with your ACO providers/suppliers.
- DO NOT complete questions 27 and 29. Answer N/A for question 28.

If you answered **NO** or **N/A**, you must complete questions 27 and 28 and submit all required documentation associated with these questions.

ACO PARTICIPANT AGREEMENT

27a. Submit a sample of the agreements you are currently using between the ACO and ACO participants, Taxpayer Identification Number (TINs), ACO providers/suppliers, other individuals and other entities performing functions or services related to ACO activities. All ACO providers/suppliers (NPIs) that have reassigned their billings to the TIN of an ACO participant must also agree to participate in the ACO and to comply with all applicable laws and regulations, including the regulations in 42 CFR Part 425.

27b. Submit the ACO Participant Agreement Template to identify the location of the following in your agreements:

a. An explicit requirement that the ACO's participant and the ACO providers/suppliers that bill through the TIN of the ACO participant will comply with the requirements and conditions of the Medicare Shared Savings Program (42 CFR Part 425), including, but not limited to, those specified in the participation agreement with CMS. For example, agreements must show that the ACO participant and ACO providers/suppliers agree to be accountable for the quality, cost, and overall care of Medicare fee-for-service beneficiaries under their care.
b. The ACO participants' and ACO providers'/suppliers' rights and obligations in and representation by the ACO.
c. How the opportunity to get shared savings or other financial arrangements will encourage ACO participants and ACO providers/suppliers to follow the quality assurance and improvement program and evidence-based clinical guidelines.
d. Remedial measures that will apply to ACO participants and ACO providers/suppliers that don't follow the requirements of their agreement with the ACO.
e. An explicit requirement that the ACO participant and ACO provider/supplier will comply with all applicable laws including, but not limited to, federal criminal law, False Claims Act, anti-kickback statute, civil monetary penalties law, and physician self-referral law.
f. An explicit requirement that all NPIs that bill through the TIN of the ACO participant have also agreed to participate and follow program regulations.

MEDICARE REFERRALS

28. Your ACO Participant Agreement(s) do not include language requiring Medicare referrals to ACO participants or their associated ACO provider/suppliers or to any other provider or supplier, except under the specific and limited circumstances expressly permitted by the regulations.

☐ YES ☐ N/A

You certify that your ACO Participant Agreements comply with the requirements in 42 CFR 425.304(c)(2).

EXECUTED ACO PARTICIPANT AGREEMENTS

29. Submit a signed ACO Participant Agreement for each ACO participant (TIN) entered on your ACO Participant List. 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.

SECTION 10 – Tell us about data sharing

30. You certify that you are requesting the name, date of birth, sex and Health Insurance Claim Number (HICN) of beneficiaries used to generate the ACO's benchmark.

☐ YES ☐ NO

31. You intend to request beneficiary-identifiable Part A, B and/or D claims data.

☐ YES ☐ NO

32. If you answered **YES** in response to question 30 or 31, you 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.

☐ YES ☐ N/A

33. If you answered **YES** in response to question 30 or 31, describe in a narrative the following:

a. How you will ensure privacy and security of data
b. 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.

You certify that if you are approved to participate in the Medicare Shared Savings Program, you will submit a Data Use Agreement (DUA) prior to receiving any data.

SECTION 11 – Tell us about your clinical processes and patient centeredness

ACCOUNTABILITY FOR BENEFICIARIES

34. You certify that your ACO, your ACO participants, and your ACO providers/suppliers agree to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

☐ YES

PROVIDING A QUALITY ASSURANCE AND IMPROVEMENT PROGRAM

35. You have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program that encompasses all four (4) of the following processes:

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

☐ YES

36. Submit a narrative describing how your ACO will require ACO participants and ACO providers/suppliers to comply with and implement a quality assurance and improvement program including, but not limited to, your ACO's processes to promote evidence-based medicine, beneficiary engagement, coordination of care, and internal reporting on cost and quality. Please include a description of remedial processes and penalties (including the potential for expulsion) that would apply for non-compliance.

PROMOTING EVIDENCE-BASED MEDICINE

37. Submit a narrative describing how your ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine. Also, describe how your ACO will:

a. Use evidence-based medicine to cover diagnoses with significant potential for the ACO to achieve quality improvements, while taking into account the circumstances of individual beneficiaries.
b. Use the internal assessments of this process to continuously improve your ACO's care practices.

PROMOTING BENEFICIARY ENGAGEMENT

38. Submit a narrative describing how your ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement. Also, describe how your ACO will:

    a. Evaluate the health needs of its assigned beneficiary population (including consideration of diversity in its patient population) and develop a plan to address the needs of its population. This plan should include a description of how your ACO partners with community stakeholders to improve the health of its population.
    b. Communicate clinical knowledge/evidence-based medicine to beneficiaries in a way they can understand.
    c. Engage beneficiaries in shared decision-making in ways that consider beneficiaries' unique needs, preferences, values and priorities.
    d. Establish written standards for beneficiary access and communication as well as a process for beneficiaries to access their medical records.
    e. Use the internal assessments of this process to continuously improve the ACO's care practices.

INTERNALLY REPORTING ON QUALITY AND COST METRICS

39. Submit a narrative describing how your ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics that lets the ACO monitor, give feedback, and evaluate ACO participant and ACO provider/supplier performance. Also, describe how you use these results to improve care and service over time. In addition, describe how your ACO will use the internal assessments of this process to continuously improve your ACO's care practices.

PROMOTING COORDINATION OF CARE

40. Submit a narrative describing how your ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. Also describe:

    a. Your ACO's methods and processes 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).
    b. Your ACO's individualized care program, along with a sample individual care plan, and explain how you use this program to promote improved outcomes for, at a minimum, high-risk and multiple chronic-condition patients.
    c. How individual care plans take into account the community resources available to beneficiaries.
    d. Additional target populations that would benefit from individualized care plans.
    e. How your ACO will use the internal assessments of this process to continuously improve the ACO's care practices.

SECTION 12 – Certify your application

** We will not process your application if you do not complete this certification in HPMS. This page will appear at the end of your application. Select "I agree", or "I disagree." You certify your application when you select "I agree".*

I have read the contents of this application. I certify that I am legally authorized to execute this document and to bind my ACO to comply with 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 & 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 to 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 Federal Trade Commission and the Department of Justice.