CMS Eligibility Requirements Checklist for MSSP ACO Participation

1. General Eligibility Requirements

☐ ACO participants work together to manage and coordinate care for Medicare fee-for-service beneficiaries. The ACO must become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

☐ ACOs must meet or exceed a minimum savings rate established by CMS, meet minimum quality performance standards, and otherwise maintain their eligibility to participate in the MSSP in order to receive shared savings payments.

☐ ACOs operating under the two-sided model that meet or exceed a minimum loss rate must share losses with the Medicare program.

2. Eligible Providers and Suppliers

☐ ACO participants or combinations of ACO participants must qualify as one, or more, of the following providers or suppliers or participate through an ACO formed by one or more of the following:

- ☐ Professionals in group practice arrangements.
- ☐ Networks of individual professional practices.
- ☐ Partnerships or joint venture arrangements between hospitals and ACO professionals.
- ☐ Hospitals employing ACO professionals.
- ☐ CAHs that bill under Method II.
- ☐ RHCs.
- ☐ FQHCs.

3. Organizational and Management Requirements

☐ An ACO must be a legal entity, formed under applicable State, Federal, or Tribal law, and authorized to conduct business in each State in which it operates for the following purposes :

- ☐ Receiving and distributing shared savings.
- ☐ Repaying shared losses or other monies determined to be owed to CMS.
- ☐ Establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards.
- ☐ Fulfilling other ACO functions identified in this part.

☐ An ACO must maintain an identifiable governing body with authority to execute the functions of an ACO, including but not limited to, promoting evidence-based medicine and patient engagement, reporting on quality and cost measures, and coordination of care.

- ☐ The governing body must have responsibility for the oversight and strategic direction of the ACO and holding ACO management accountable for the ACO's activities.
- ☐ The governing body must have a transparent governing process.
- ☐ The governing body members must have a fiduciary duty to the ACO and must act consistent with that fiduciary duty.
- ☐ The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises multiple independent ACO participants.
- ☐ 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 all other ACO governing body requirements.

☐ The ACO must provide for meaningful participation in the composition and control of the ACO's governing body for ACO participants or their designated representatives.

- ☐ The ACO governing body must include a Medicare beneficiary representative(s) served by the ACO who does not have a conflict of interest with the ACO, and who has no immediate family member with a conflict of interest with the ACO.
- ☐ At least 75 percent control of the ACO's governing body must be held by ACO participants.
- ☐ The governing body members may serve in a similar or complementary manner for an ACO participant.
- ☐ In cases in which the composition of the ACO's governing body does not meet the requirements above, the ACO must describe why it seeks to differ from these requirements and how the ACO will involve ACO participants in innovative ways in ACO governance or provide meaningful representation in ACO governance by Medicare beneficiaries.

☐ The ACO governing body must have a conflict of interest policy that applies to members of the governing body. The conflict of interest policy must—

- ☐ Require each member of the governing body to disclose relevant financial interests; and
- ☐ Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.
- ☐ The conflict of interest policy must address remedial action for members of the governing body that fail to comply with the policy.

☐ An ACO must have a leadership and management structure that includes clinical and administrative systems that align with and support the goals of the Shared Savings Program and the three aims of **better care for individuals**, **better health for populations**, and **lower growth in expenditures**.

- ☐ The ACO's operations must be 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.

☐ Clinical management and oversight must be managed by a senior-level medical director who is a physician and one of its 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.

☐ Each ACO participant and each ACO provider/supplier must demonstrate a meaningful commitment to the mission of the ACO to ensure the ACO's likely success.

- 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.
- A meaningful commitment can be shown when an ACO participant or ACO provider/supplier agrees to comply with and implement the ACO's processes and is held accountable for meeting the ACO's performance standards for each required process.

☐ The ACO must include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO.

☐ The ACO must have at least 5,000 assigned beneficiaries.

- CMS deems an ACO to have initially satisfied the requirement to have at least 5,000 assigned beneficiaries if the number of beneficiaries historically assigned to the ACO participants in each of the three years before the start of the agreement period, is 5,000 or more.
- If at any time during the performance year, an ACO's assigned population falls below 5,000, the ACO will be issued a warning and placed on a Corrective Action Plan.

4. Required ACO Processes and Functions

☐ An ACO must—

☐ Promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care;

☐ Adopt a focus on patient centeredness that is promoted by the governing body and integrated into practice by leadership and management working with the organization's health care teams; and

☐ Have defined processes to fulfill these requirements.

☐ Have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program, which must include the defined processes below.

☐ For each process below, the ACO must—

- Explain how it will require ACO participants and ACO providers/suppliers to comply with and implement each process, including the remedial processes and penalties (including the potential for expulsion) applicable to ACO participants and ACO providers/suppliers for failure to comply with and implement the required process; and
- Explain how it will employ its internal assessments of cost and quality of care to improve continuously the ACO's care practices.

☐ The ACO must define, establish, implement, evaluate, and periodically update processes to accomplish the following:

☐ Promote evidence-based medicine.
- These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements taking into account the circumstances of individual beneficiaries.

☐ Promote patient engagement.
- These processes must address the following areas:
  - Compliance with patient experience of care survey requirements;
  - Compliance with beneficiary representative requirements; and
  - A process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient populations, and a plan to address the needs of its population.
    - In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population.
    - An ACO that has a stakeholder organization serving on its governing body will be deemed to have satisfied the requirement to partner with community stakeholders.
  - Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them.
  - Beneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities;
  - Written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record.

☐ Develop an infrastructure for its ACO participants and ACO providers/suppliers to internally report on quality and cost metrics that enables the ACO to monitor, provide feedback, and evaluate its ACO participants and ACO provider(s)/supplier(s) performance and to use these results to improve care over time.

☐ Coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers. The ACO must—
- Define its methods and processes established to coordinate care throughout an episode of care and during its 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); and
- As part of its application, the ACO must:
  - Submit a description of its 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.
  - Describe additional target populations that would benefit from individualized care plans. Individual care plans must take into account the community resources available to the individual.

5. Prohibition from Participation in Other Shared Savings Initiatives

☐ ACOs may not participate in the Shared Savings Program if they include an ACO participant that participates in the independence at home medical practice pilot program, a model tested or expanded that involves shared savings, or any other Medicare initiative that involves shared savings.

6. Mandatory Compliance Plan

☐ The ACO must develop a Compliance Plan that contains at least the following elements

- ☐ A designated compliance official or individual that 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, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer.
- ☐ Compliance training for ACO, ACO participants and the ACO providers/suppliers.
- ☐ A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.