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(B) Any particular geographic area.

(b) *Duration of moratoria.* A moratorium under this section may be imposed for a period of 6 months and, if deemed necessary by CMS, may be extended in 6-month increments. CMS will publish a document in the FEDERAL REGISTER when it extends a moratorium.

(c) *Denial of enrollment: Moratoria.* A Medicare contractor denies the enrollment application of a provider or supplier if the provider or supplier is subject to a moratorium as specified in paragraph (a) of this section.

(d) *Lifting moratoria.* CMS will publish a document in the FEDERAL REGISTER when a moratorium is lifted. CMS may lift a temporary moratorium at any time after imposition of the moratorium if one of the following occur:

(1) The President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act).

(2) Circumstances warranting the imposition of a moratorium have abated or CMS has implemented program safeguards to address the program vulnerability.

(3) The Secretary has declared a public health emergency under section 319 of the Public Health Service Act in the area subject to a temporary moratorium.

(4) In the judgment of the Secretary, the moratorium is no longer needed.

[76 FR 5965, Feb. 2, 2011]

**PART 425—MEDICARE SHARED SAVINGS PROGRAM**

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AUTHORITY: Secs. 1102, 1106, 1871, and 1899 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

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### Subpart A—General Provisions

#### § 425.10 Basis and scope.

(a) *Basis.* This part implements section 1899 of the Act by establishing a shared savings program that 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 services. The regulations under this part must not be construed to affect the payment, coverage, program integrity, and other requirements that apply to providers and suppliers under FFS Medicare.

(b) *Scope.* This part sets forth the following:

(1) The eligibility requirements for an ACO to participate in the Medicare Shared Savings Program (Shared Savings Program).

(2) Application procedures and provisions of the participation agreement.

(3) Program requirements and beneficiary protections.

(4) The method for assigning Medicare fee-for-service beneficiaries to ACOs.

(5) Quality performance standards, reporting requirements, and data sharing.

(6) Payment criteria and methodologies (one-sided model and two-sided model).

(7) Compliance monitoring and sanctions for noncompliance.

(8) Reconsideration review process.

#### § 425.20 Definitions.

As used in this part, unless otherwise indicated—

*Accountable care organization (ACO)* means a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one or more ACO participants(s) that is(are) defined at § 425.102(a) and may also include any other ACO participants described at § 425.102(b).

*ACO participant* means an individual or group of ACO provider(s)/supplier(s), that is identified by a Medicare-enrolled TIN, that alone or together with one or more other ACO participants comprise(s) an ACO, and that is included on the list of ACO participants that is required under § 425.204(c)(5).

*ACO professional* means an ACO provider/supplier who is either of the following:

(1) A physician legally authorized to practice medicine and surgery by the State in which he performs such function or action.

(2) A practitioner who is one of the following:

(i) A physician assistant (as defined at § 410.74(a)(2) of this chapter).

(ii) A nurse practitioner (as defined at § 410.75(b) of this chapter).

(iii) A clinical nurse specialist (as defined at § 410.76(b) of this chapter).

*ACO provider/supplier* means an individual or entity that—

(1) Is a provider (as defined at § 400.202 of this chapter) or a supplier (as defined at § 400.202 of this chapter);

(2) Is enrolled in Medicare;

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(3) Bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations; and

(4) Is included on the list of ACO providers/suppliers that is required under § 425.204(c)(5).

*Agreement period* means the term of the participation agreement which begins at the start of the first performance year and concludes at the end of the final performance year.

*Antitrust Agency* means the Department of Justice or Federal Trade Commission.

*Assignment* means the operational process by which CMS determines whether a beneficiary has chosen to receive a sufficient level of the requisite primary care services from a physician who is an ACO provider/supplier so that the ACO may be appropriately designated as exercising basic responsibility for that beneficiary's care.

*At-risk beneficiary* means, but is not limited to, a beneficiary who—

(1) Has a high risk score on the CMS-HCC risk adjustment model;

(2) Is considered high cost due to having two or more hospitalizations or emergency room visits each year;

(3) Is dually eligible for Medicare and Medicaid;

(4) Has a high utilization pattern;

(5) Has one or more chronic conditions.

(6) Has had a recent diagnosis that is expected to result in increased cost.

(7) Is entitled to Medicaid because of disability; or

(8) Is diagnosed with a mental health or substance abuse disorder.

*Continuously assigned beneficiary* means a beneficiary assigned to the ACO in the current performance year who was either assigned to or received a primary care service from any of the ACO's participant during the most recent prior calendar year.

*Covered professional services* has the same meaning given these terms under section 1848(k)(3)(A) of the Act.

*Critical access hospital (CAH)* has the same meaning given this term under § 400.202 of this chapter.

*Eligible professional* has the meanings given this term under section 1848(k)(3)(B) of the Act.

*Federally qualified health center (FQHC)* has the same meaning given to this term under § 405.2401(b) of this chapter.

*Hospital* means a hospital subject to the prospective payment system specified in § 412.1(a)(1) of this chapter.

*Marketing materials and activities* include, but are not limited to, general audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, Web pages, data sharing opt out letters, mailings, social media, or other activities conducted by or on behalf of the ACO, or by ACO participants, or ACO providers/suppliers participating in the ACO, when used to educate, solicit, notify, or contact Medicare beneficiaries or providers and suppliers regarding the Shared Savings Program. The following beneficiary communications are not marketing materials and activities: Certain informational materials customized or limited to a subset of beneficiaries; materials that do not include information about the ACO, its ACO participants, or its ACO providers/suppliers; materials that cover beneficiary-specific billing and claims issues or other specific individual health related issues; educational information on specific medical conditions (for example, flu shot reminders), written referrals for health care items and services, and materials or activities that do not constitute "marketing" under 45 CFR 164.501 and 164.508(a)(3)(i).

*Medicare fee-for-service beneficiary* means an individual who is—

(1) Enrolled in the original Medicare fee-for-service program under both parts A and B; and

(2) Not enrolled in any of the following:

(i) A MA plan under part C.

(ii) An eligible organization under section 1876 of the Act.

(iii) A PACE program under section 1894 of the Act.

*Medicare Shared Savings Program (Shared Savings Program)* means the program, established under section 1899 of the Act and implemented in this part.

*Newly assigned beneficiary* means a beneficiary that is assigned in the current performance year who was neither assigned to nor receives a primary care service from any of the ACO's participants during the most recent prior calendar year.

*One-sided model* means a model under which the ACO may share savings with the Medicare program, if it meets the requirements for doing so, but is not liable for sharing any losses incurred under subpart G of this part.

*Performance year* means the 12-month period beginning on January 1 of each year during the agreement period, unless otherwise noted in the ACO's agreement. For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO's first performance year is defined as 21 months and 18 months, respectively.

*Physician* means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

*Physician Quality Reporting System (PQRS)* means the quality reporting system established under section 1848(k) of the Act.

*Primary care physician* means a physician who has a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, a physician included in an attestation by the ACO as provided under § 425.404.

*Primary care services* mean the set of services identified by the following HCPCS codes:

- (1) 99201 through 99215.
- (2) 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits);
- (3) Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

*Quality measures* means the measures defined by the Secretary, under section 1899 of the Act, to assess the quality of care furnished by an ACO, such as measures of clinical processes and outcomes, patient and, where practicable, caregiver experience of care and utilization.

*Reporting period*, for purposes of subpart F of this part, means the calendar year from January 1 to December 31.

*Rural health center (RHC)* has the same meaning given to this term under § 405.2401(b).

*Shared losses* means a portion of the ACO's performance year Medicare fee-for-service Parts A and B expenditures, above the applicable benchmark, it must repay to CMS. An ACO's eligibility for shared losses will be determined for each performance year. For an ACO requesting interim payment, shared losses may result from the interim payment calculation.

*Shared savings* means a portion of the ACO's performance year Medicare fee-for-service Parts A and B expenditures, below the applicable benchmark, it is eligible to receive payment for from CMS. An ACO's eligibility for shared savings will be determined for each performance year. For an ACO requesting interim payment, shared savings may result from the interim payment system calculation.

*Taxpayer Identification Number (TIN)* means a Federal taxpayer identification number or employer identification number as defined by the IRS in 26 CFR 301.6109-1.

*Two-sided model* means a model under which the ACO may share savings with the Medicare program, if it meets the requirements for doing so, and is also liable for sharing any losses incurred under subpart G of this part.

### Subpart B—Shared Savings Program Eligibility Requirements

#### § 425.100 General.

(a) Under the Shared Savings Program, ACO participants may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO that meets the criteria specified in this part. The ACO must become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

(b) ACOs that meet or exceed a minimum savings rate established under § 425.604 or § 425.606, meet the minimum quality performance standards established under § 425.500, and otherwise

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maintain their eligibility to participate in the Shared Savings Program under this part are eligible to receive payments for shared savings under subpart G.

(c) ACOs that operate under the two-sided model and meet or exceed a minimum loss rate established under § 425.606 must share losses with the Medicare program under subpart G of the part.

### § 425.102 Eligible providers and suppliers.

(a) The following ACO participants or combinations of ACO participants are eligible to form an ACO that may apply to participate in the Shared Savings Program:

(1) ACO professionals in group practice arrangements.

(2) Networks of individual practices of ACO professionals.

(3) Partnerships or joint venture arrangements between hospitals and ACO professionals.

(4) Hospitals employing ACO professionals.

(5) CAHs that bill under Method II (as described in § 413.70(b)(3) of this chapter).

(6) RHCs.

(7) FQHCs.

(b) Other ACO participants that are not identified in paragraph (a) of this section are eligible to participate through an ACO formed by one or more of the ACO participants identified in paragraph (a) of this section.

### § 425.104 Legal entity.

(a) 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 purposes of the following:

(1) Receiving and distributing shared savings.

(2) Repaying shared losses or other monies determined to be owed to CMS.

(3) Establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards.

(4) Fulfilling other ACO functions identified in this part.

(b) An ACO formed by two or more otherwise independent ACO partici-

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pants must be a legal entity separate from any of its ACO participants.

### § 425.106 Shared governance.

(a) *General rule.* An ACO must maintain an identifiable governing body with authority to execute the functions of an ACO as defined under this part, including but not limited to, the processes defined under § 425.112 to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.

(b) *Responsibilities of the governing body and its members.* (1) The governing body must have responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities as described in this part.

(2) The governing body must have a transparent governing process.

(3) The governing body members must have a fiduciary duty to the ACO and must act consistent with that fiduciary duty.

(4) The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises multiple, otherwise independent ACO participants.

(5) 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 requirements of this section.

(c) *Composition and control of the governing body.* (1) 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.

(2) 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 conflict of interest with the ACO.

(3) At least 75 percent control of the ACO's governing body must be held by ACO participants.

(4) The governing body members may serve in a similar or complementary manner for an ACO participant.

(5) In cases in which the composition of the ACO's governing body does not meet the requirements of paragraphs

(c)(2) and (c)(3) of this section, 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.

(d) *Conflict of interest.* 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—

(1) Require each member of the governing body to disclose relevant financial interests; and

(2) Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.

(3) The conflict of interest policy must address remedial action for members of the governing body that fail to comply with the policy.

**§ 425.108 Leadership and management.**

(a) 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 aims of better care for individuals, better health for populations, and lower growth in expenditures.

(b) 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.

(c) 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.

(d) 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.

(1) 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.

(2) A meaningful commitment can be shown when an ACO participant or ACO provider/supplier agrees to comply with and implement the ACO's processes required by § 425.112 and is held accountable for meeting the ACO's performance standards for each required process.

(e) CMS retains the right to give consideration to an innovative ACO with a management structure not meeting paragraphs (b) through (c) of this section.

**§ 425.110 Number of ACO professionals and beneficiaries.**

(a)(1) The ACO must include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subpart E of this part. The ACO must have at least 5,000 assigned beneficiaries.

(2) CMS deems an ACO to have initially satisfied the requirement to have at least 5,000 assigned beneficiaries specified in paragraph (a)(1) of this section if the number of beneficiaries historically assigned to the ACO participants in each of the three years before the start of the agreement period, using the assignment methodology in subpart E of this part, is 5,000 or more.

(b) 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 CAP.

(1) While under the CAP, the ACO remains eligible for shared savings and losses during that performance year and its MSR will be set at a level consistent with the number of assigned beneficiaries.

(2) If the ACO's assigned population is not returned to at least 5,000 or more by the end of next performance year, the ACO's agreement will be terminated and the ACO will not be eligible

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to share in savings for that performance year.

**§ 425.112 Required processes and patient-centeredness criteria.**

(a) *General.* (1) An ACO must—

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

(ii) 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

(iii) Have defined processes to fulfill these requirements.

(2) An ACO must have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program, which must include the defined processes included in paragraphs (b)(1) through (4) of this section.

(3) For each process specified in paragraphs (b)(1) through (4) of this section, the ACO must—

(i) Explain how it will require ACO participants and ACO providers/suppliers to comply with and implement each process (and subelement thereof), 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

(ii) Explain how it will employ its internal assessments of cost and quality of care to improve continuously the ACO's care practices.

(b) *Required processes.* The ACO must define, establish, implement, evaluate, and periodically update processes to accomplish the following:

(1) 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.

(2) Promote patient engagement. These processes must address the following areas:

(i) Compliance with patient experience of care survey requirements in § 425.500.

(ii) Compliance with beneficiary representative requirements in § 425.106.

(iii) 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.

(A) 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.

(B) 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.

(iv) Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them.

(v) Beneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities;

(vi) Written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record.

(3) 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.

(4) Coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers. The ACO must—

(i) 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

(ii) As part of its application, the ACO must:

(A) 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.

(B) 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.

**§ 425.114 Participation in other shared savings initiatives.**

(a) 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 under section 1866E of the Act, a model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings.

(b) CMS will review and deny an ACO's application if any ACO participants are participating in another Medicare initiative that involves shared savings payments.

(c) CMS will determine an appropriate method to ensure no duplication in payments for beneficiaries assigned to other shared savings programs or initiatives, including initiatives involving dually eligible beneficiaries, when such other shared savings programs have an assignment methodology that is different from the Shared Savings Program.

**Subpart C—Application Procedures and Participation Agreement**

**§ 425.200 Agreement with CMS.**

(a) *General.* In order to participate in the Shared Savings Program, an ACO must enter into a participation agreement with CMS for a period of not less than three years.

(b) *Term of agreement.* (1) *For 2012.* For applications that are approved to participate in the Shared Savings Program for 2012, the start date for the agreement will be one of the following:

(i) April 1, 2012 (term of the agreement is 3 years and 9 months).

(ii) July 1, 2012 (term of the agreement is 3 years and 6 months).

(2) For 2013 and all subsequent years—

(i) The start date is January 1 of that year; and

(ii) The term of the agreement is 3 years.

(c) *Performance year.* (1) Except as specified in paragraphs (b)(1)(i) and (ii) of this section, the ACO's performance year under the agreement is the 12 month period beginning on January 1 of each year during the term of the agreement unless otherwise noted in its agreement.

(2) For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO's first performance year is defined as 21 months or 18 months, respectively.

(d) During each calendar year of the agreement period, including the partial year associated with start dates specified in paragraph (b)(1)(i) and (ii) of this section, ACOs must submit measures in the form and manner required by CMS.

**§ 425.202 Application procedures.**

(a) *General rules.* (1) In order to obtain a determination regarding whether it meets the requirements to participate in the Shared Savings Program, a prospective ACO must submit a complete application in the form and manner required by CMS by the deadline established by CMS.

(2) An ACO executive who has the authority to legally bind the ACO must certify to the best of his or her knowledge, information, and belief that the information contained in the application is accurate, complete, and truthful.

(3) An ACO that seeks to participate in the Shared Savings Program and was newly formed after March 23, 2010, as defined in the Antitrust Policy Statement, must agree that CMS can share a copy of their application with the Antitrust Agencies.

(b) *Condensed application form.* PGP demonstration sites applying to participate in the Shared Savings Program will have an opportunity to complete a condensed application form.

(c) *Application review.* (1) CMS determines whether an applicant satisfies the requirements of this part and is qualified to participate in the Shared Savings Program.

(2) CMS approves or denies applications accordingly.

**§ 425.204 Content of the application.**

(a) *Accountability for beneficiaries.* As part of its application and participation agreement, the ACO must certify that the ACO, its ACO participants, and its ACO providers/suppliers have agreed to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

(b) *Disclosure of prior participation.* (1) The ACO must disclose to CMS whether the ACO, its ACO participants, or its ACO providers/suppliers have participated in the Medicare Shared Savings Program under the same or a different name, or is related to or has an affiliation with another Shared Savings Program ACO.

(2) The ACO must specify whether the related ACO agreement is currently active or has been terminated. If it has been terminated, the ACO must specify whether the termination was voluntary or involuntary.

(3) If the ACO, ACO participant, or ACO provider/supplier was previously terminated from the Shared Savings Program, the ACO must identify the cause of termination and what safeguards are now in place to enable the ACO, ACO participant, or ACO provider/supplier to participate in the program for the full term of the agreement.

(c) *Eligibility.* (1) As part of its application, an ACO must submit to CMS the following supporting materials to demonstrate that the ACO satisfies the eligibility requirements set forth in subpart B of this part:

(i) Documents (for example, participation agreements, employment contracts, and operating policies) sufficient to 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 evidenced-based clinical guidelines.

(ii) A description, or documents sufficient to describe, how the ACO will implement the required processes and patient-centeredness criteria under

§ 425.112, including descriptions of the remedial processes and penalties (including the potential for expulsion) that will apply if an ACO participant or an ACO provider/supplier fails to comply with and implement these processes.

(iii) Materials documenting the ACO's organization and management structure, including an organizational chart, a list of committees (including names of committee members) and their structures, and job descriptions for senior administrative and clinical leaders including administrative and clinical leaders specifically noted in § 425.108.

(iv) Evidence that the governing body is an identifiable body, that the governing body is comprised of representatives of the ACO's participants, and that the ACO participants have at least 75 percent control of the ACO's governing body.

(v) Evidence that the governing body includes 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 conflict of interest with the ACO.

(vi) A copy of the ACO's compliance plan or documentation describing the plan that will be put in place at the time the ACO's agreement with CMS becomes effective.

(2) Upon request, the ACO must provide copies of all documents effectuating the ACO's formation and operation, including, without limitation the following:

- (i) Charters.
- (ii) By-laws.
- (iii) Articles of incorporation.
- (iv) Partnership agreement.
- (v) Joint venture agreement.
- (vi) Management or asset purchase agreements.
- (vii) Financial statements and records.
- (viii) Resumes and other documentation required for leaders of the ACO.

(3) If an ACO requests an exception to the—

(i) Governing body requirements in § 425.106, 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 or both; or

(ii) Leadership and management requirements in § 425.108, the ACO must describe how its alternative leadership and management structure will be capable of accomplishing the ACO's mission.

(4)(i) An ACO must certify that it is recognized as a legal entity in the State, Federal or Tribal area in which it was established and that it is authorized to conduct business in each State or Tribal area in which it operates.

(ii) An ACO formed among multiple, independent ACO participants must provide evidence in its application that it is a legal entity separate from any of the ACO participants.

(5) The ACO must provide CMS with such information regarding its ACO participants and its ACO providers/suppliers participating in the program as is necessary to implement the program.

(i) The ACO must submit a list of all ACO participants and their Medicare-enrolled TINs.

(A) For each ACO participant, the ACO must submit a list of the ACO providers/suppliers and their provider identifier (for example, NPI) and indicate whether the ACO provider/supplier is a primary care physician as defined in § 425.20.

(B) The list specified in paragraph (c)(5)(i)(A) of this section must be updated in accordance with § 425.302(d).

(ii) ACOs must also submit any other specific identifying information as required by CMS in the application process.

(iii) If the ACO includes an FQHC or RHC as an ACO participant, it must also do the following:

(A) Indicate the TINs, organizational NPIs, and other identifying information for its participant FQHCs or RHCs or both, as well as NPIs and other identifying information for the physicians that directly provide primary care services in the participant FQHCs or RHCs or both.

(B) Submit any other specific identifying information for its participant FQHCs or RHCs or both as required by CMS in the application process.

(iv) The ACO must certify the accuracy of this information.

(d) *Distribution of savings.* As part of its application to participate in the Shared Savings Program, an ACO must describe the following:

(1) How it plans to use shared savings payments, including the criteria it plans to employ for distributing shared savings among its ACO participants and ACO providers/suppliers.

(2) How the proposed plan will achieve the specific goals of the Shared Savings Program.

(3) How the proposed plan will achieve the general aims of better care for individuals, better health for populations, and lower growth in expenditures.

(e) *Selection of track and option for interim payment calculation.*

(1) As part of its application, an ACO must specify whether it is applying to participate in Track 1 or Track 2 (as described in § 425.600).

(2)(i) An ACO applying to participate in the program with a start date of April 1, 2012 or July 1, 2012, has the option of requesting an interim payment calculation based on the financial performance for its first 12 months of program participation and quality performance for CY 2012.

(ii) An ACO must request interim payment calculation as part of its application to participate in the Shared Savings Program.

(f) *Assurance of ability to repay.* (1) An ACO must have the ability to repay losses for which it may be liable, and any other monies determined to be owed upon first performance year reconciliation.

(i) As part of its application, an ACO that is applying to participate under the two-sided model of the Shared Savings Program or requesting an interim payment calculation under the one-sided model must submit for CMS approval documentation that it is capable of repaying losses or other monies determined to be owed upon first year reconciliation.

(ii) The documentation specified in paragraph (f)(1)(i) of this section must include details supporting the adequacy of the mechanism for repaying losses, or other monies determined to be owed upon first year reconciliation,

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equal to at least 1 percent of the ACO's total per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiaries based either on expenditures for the most recent performance year or expenditures used to establish the benchmark.

(2) An ACO may demonstrate its ability to repay losses, or other monies determined to be owed upon first year reconciliation, by obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit (as evidenced by a letter of credit that the Medicare program can draw upon), or establishing another appropriate repayment mechanism that will ensure its ability to repay the Medicare program.

(3) An ACO participating under the two-sided model must demonstrate the adequacy of this repayment mechanism annually, prior to the start of each performance year in which it takes risk.

**§ 425.206 Evaluation procedures for applications.**

(a) *Basis for evaluation and determination.* (1) CMS evaluates an ACO's application on the basis of the information contained in and submitted with the application.

(2) CMS notifies applicant ACOs when the application is incomplete and provide an opportunity to submit information to complete the application. Applications remaining incomplete by the application due date will be denied.

(b) *Notice of determination.* (1) CMS notifies in writing each applicant ACO of its determination to approve or deny the ACO's application to participate in the Shared Savings Program.

(2) If CMS denies the application, the notice will indicate that the ACO is not qualified to participate in the Shared Savings Program, specify the reasons why the ACO is not so qualified, and inform the ACO of its right to request reconsideration review in accordance with the procedures specified in subpart I of this part.

**§ 425.208 Provisions of participation agreement.**

(a) *General rules.* (1) Upon being notified by CMS of its approval to participate in the Shared Savings Program,

an executive of that ACO who has the ability to legally bind the ACO must sign and submit to CMS a participation agreement.

(2) Under the participation agreement the ACO must agree to comply with the provisions of this part in order to participate in the Shared Savings Program.

(b) *Compliance with laws.* The ACO must agree, and must require its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to the ACO's activities to agree, or to comply with all applicable laws including, but not limited to, the following:

(1) Federal criminal law.

(2) The False Claims Act (31 U.S.C. 3729 *et seq.*).

(3) The anti-kickback statute (42 U.S.C. 1320a-7b(b)).

(4) The civil monetary penalties law (42 U.S.C. 1320a-7a).

(5) The physician self-referral law (42 U.S.C. 1395nn).

(c) *Certifications.* (1) The ACO must agree, as a condition of participating in the program and receiving any shared savings payment, that an individual with the authority to legally bind the ACO will certify the accuracy, completeness, and truthfulness of any data or information requested by or submitted to CMS, including, but not limited to, the application form, participation agreement, and any quality data or other information on which CMS bases its calculation of shared savings payments and shared losses.

(2) Certifications must meet the requirements at § 425.302.

**§ 425.210 Application of agreement to ACO participants, ACO providers/suppliers, and others.**

(a) The ACO must provide a copy of its participation agreement with CMS to all ACO participants, ACO providers/suppliers, and other individuals and entities involved in ACO governance.

(b) All contracts or arrangements between or among the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities must require compliance with the requirements and conditions of this part, including, but not

limited to, those specified in the participation agreement with CMS.

**§ 425.212 Changes to program requirements during the agreement term.**

(a)(1) ACOs are subject to all statutory changes that become effective during the term of their participation agreement.

(2) ACOs are subject to all regulatory changes with the exception of the following program areas:

(i) Eligibility requirements concerning the structure and governance of ACOs.

(ii) Calculation of sharing rate.

(iii) Beneficiary assignment.

(b) In those instances where there are changes in law or regulations, the ACO will be required to submit to CMS for review and approval, as a supplement to its original application, an explanation detailing how it will modify its processes to address these changes in law or regulations.

(c) If an ACO does not modify its processes to address a change in law or regulations, it will be placed on a CAP. If the ACO fails to effectuate the necessary modifications while under the CAP, the ACO will be terminated from the Shared Savings Program using the procedures in § 425.218.

(d) An ACO will be permitted to terminate its agreement, in those instances where Shared Savings Program statutory and regulatory standards are established during the agreement period which the ACO believes will impact its ability to continue to participate in the Shared Savings Program.

**§ 425.214 Managing changes to the ACO during the agreement.**

(a)(1) During the term of the participation agreement, an ACO may add or remove ACO participants or ACO providers/suppliers (identified by TINs and NPIs).

(2) An ACO must notify CMS within 30 days of such an addition or removal.

(3) The ACO's benchmark, risk scores, and preliminary prospective assignment may be adjusted for this change at CMS' discretion.

(b) ACOs must notify CMS within 30 days of any significant change. A "significant change" occurs when an ACO

is no longer able to meet the eligibility or program requirements of this Part.

(c) Upon receiving an ACO's notice of a significant change described in paragraph (b) of this section, CMS reevaluates the ACO's eligibility to continue to participate in the Shared Savings Program and may request additional documentation. CMS may make a determination that includes one of the following:

(1) The ACO may continue to operate under the new structure.

(2) The ACO structure is so different from the initially approved ACO that it must terminate its agreement and submit a new application for participation.

(3) The ACO no longer meets the eligibility criteria for the program and its participation agreement must be terminated.

(4) CMS and the ACO may mutually decide to terminate the agreement.

**§ 425.216 Actions prior to termination.**

(a) *Pre-termination actions.* (1) If CMS concludes that termination of an ACO from the Shared Savings Program is warranted, CMS may take one or more of the following actions prior to termination of the ACO from the Shared Savings Program.

(i) Provide a warning notice to the ACO regarding noncompliance with one or more program requirements.

(ii) Request a CAP from the ACO.

(iii) Place the ACO on a special monitoring plan.

(2) Nothing in this part, including the actions set forth in paragraph (a)(1) of this section, negates, diminishes, or otherwise alters the applicability of other laws, rules, or regulations, including, but not limited to, the Sherman Act (15 U.S.C. 1 *et seq.*), the Clayton Act (15 U.S.C. 12), and the Federal Trade Commission Act (15 U.S.C. 45 *et seq.*).

(b) *Corrective action plans.* (1) The ACO must submit a CAP for CMS approval by the deadline indicated on the notice of violation.

(i) The CAP must address what actions the ACO will take to ensure that the ACO, ACO participants, ACO providers/suppliers or other individuals or entities performing functions or services related to the ACO's activities or

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both correct any deficiencies and comply with all applicable Shared Savings Program requirements.

(ii) The ACO's performance will be monitored and evaluated during and after the CAP process.

(2) CMS may terminate the ACO's agreement if the ACO fails to submit, obtain approval for, or implement a CAP, or fails to demonstrate improved performance upon completion of the CAP.

### § 425.218 Termination of the agreement by CMS.

(a) *General.* CMS may terminate the participation agreement with an ACO when an ACO, the ACO participants, ACO providers/suppliers or other individuals or entities performing functions or services related to ACO activities fail to comply with any of the requirements of the Shared Savings Program under this part.

(b) *Grounds for termination by CMS.* CMS may terminate the participation agreement for reasons including, but not limited to the following:

(1) Non-compliance with eligibility and other requirements described in this part.

(2) The imposition of sanctions or other actions taken against the ACO by an accrediting organization, State, Federal or local government agency leading to inability of the ACO to comply with the requirements under this part.

(3) Violations of the physician self-referral prohibition, civil monetary penalties (CMP) law, Federal anti-kickback statute, antitrust laws, or any other applicable Medicare laws, rules, or regulations that are relevant to ACO operations.

(c) CMS may immediately terminate a participation agreement without taking any of the pre-termination actions set forth in § 425.216.

(d) *Notice of termination by CMS.* CMS notifies an ACO in writing of its decision to terminate the participation agreement.

### § 425.220 Termination of an agreement by the ACO.

(a) *Notice of termination.* An ACO must provide at least 60 days advance written notice to CMS and its ACO par-

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ticipants of its decision to terminate the participation agreement and the effective date of its termination.

(b) *Payment consequences of early termination.* The ACO will not share in any savings for the performance year during which it notifies CMS of its decision to terminate the participation agreement.

### § 425.222 Re-application after termination.

(a) An ACO that has been terminated from the Shared Savings Program under § 425.218 or § 425.220 may participate in the Shared Savings Program again only after the date on which the term of the original participation agreement would have expired if the ACO had not been terminated.

(b) To be eligible to participate in the Shared Savings Program after a previous termination, the ACO must demonstrate in its application that it has corrected the deficiencies that caused it to be terminated from the Shared Savings Program and has processes in place to ensure that it will remain in compliance with the terms of the new participation agreement.

(c) An ACO under the one-sided model whose agreement was previously terminated may reenter the program only under the two-sided model unless it was terminated less than half way through its agreement under the one-sided model in which case it will be allowed to re-enter the one-sided model. An ACO under the two-sided model whose agreement was terminated may only re-apply for participation in the two-sided model.

## Subpart D—Program Requirements and Beneficiary Protections

### § 425.300 Compliance plan.

(a) The ACO must have a compliance plan that includes at least the following elements:

(1) A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body.

(2) Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance.

(3) 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.

(4) Compliance training for the ACO, the ACO participants, and the ACO providers/suppliers.

(5) A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

(b)(1) ACOs that are existing entities may use the current compliance officer if the compliance officer meets the requirements set forth in paragraph (a)(1) of this section.

(2) An ACO's compliance plan must be in compliance with and be updated periodically to reflect changes in law and regulations.

**§ 425.302 Program requirements for data submission and certifications.**

(a) *Requirements for data submission and certification.* (1) The ACO, its ACO participants, its ACO providers/suppliers or individuals or other entities performing functions or services related to ACO activities must submit all data and information, including data on measures designated by CMS under § 425.500, in a form and manner specified by CMS.

(2) *Certification of data upon submission.* With respect to data and information that are generated or submitted by the ACO, ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, an individual with the authority to legally bind the individual or entity submitting such data or information must certify the accuracy, completeness, and truthfulness of the data and information to the best of his or her knowledge information and belief.

(3) *Annual certification.* At the end of each performance year, an individual with the legal authority to bind the ACO must certify to the best of his or her knowledge, information, and belief—

(i) That the ACO, its ACO participants, its ACO providers/suppliers, and other individuals or entities per-

forming functions or services related to ACO activities are in compliance with program requirements; and

(ii) The accuracy, completeness, and truthfulness of all data and information that are generated or submitted by the ACO, ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, including any quality data or other information or data relied upon by CMS in determining the ACO's eligibility for, and the amount of a shared savings payment or the amount of shared losses or other monies owed to CMS.

(b) [Reserved]

**§ 425.304 Other program requirements.**

(a) *Beneficiary inducements.* (1) ACOs, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities are prohibited from providing gifts or other remuneration to beneficiaries as inducements for receiving items or services from or remaining in, an ACO or with ACO providers/suppliers in a particular ACO or receiving items or services from ACO participants or ACO providers/suppliers.

(2) Consistent with the provisions of paragraph (a)(1) of this section and subject to compliance with all other applicable laws and regulations, ACO, ACO participants and ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities may provide in-kind items or services to beneficiaries if there is a reasonable connection between the items and services and the medical care of the beneficiary and the items or services are preventive care items or services or advance a clinical goal for the beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition.

(b) *Screening of ACO applicants.* (1) ACOs, ACO participants, and ACO providers/suppliers will be reviewed during the Shared Savings Program application process and periodically thereafter with regard to their program integrity

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history, including any history of Medicare program exclusions or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.

(2) ACOs, ACO participants, or ACO providers/suppliers whose screening reveals a history of program integrity issues or affiliations with individuals or entities that have a history of program integrity issues may be subject to denial of their Shared Savings Program applications or the imposition of additional safeguards or assurances against program integrity risks.

(c) *Prohibition on certain required referrals and cost shifting.* ACOs, ACO participants, and ACO providers/suppliers are prohibited from:

(1) Conditioning the participation of ACO participants, ACO providers/suppliers, other individuals or entities performing functions or services related to ACO activities in the ACO on referrals of Federal health care program business that the ACO, its ACO participants, or ACO providers/suppliers or other individuals or entities performing functions or services related to ACO activities know or should know is being (or would be) provided to beneficiaries who are not assigned to the ACO.

(2) Requiring that beneficiaries be referred only to ACO participants or ACO providers/suppliers within the ACO or to any other provider or supplier, except that the prohibition does not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement to the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if the beneficiary expresses a preference for a different provider, practitioner, or supplier; the beneficiary's insurer determines the provider, practitioner, or supplier; or the referral is not in the beneficiary's best medical interests in the judgment of the referring party.

(d) *Required reporting of NPIs and TINs.* (1) The ACO must maintain, update, and annually furnish to CMS at the beginning of each performance year and at other such times as specified by CMS the list of each ACO participant's

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TIN and ACO providers/supplier's NPI that is required to be submitted under § 425.204(c)(5)(i).

(2) The ACO must notify CMS within 30 days of any changes to the list of NPIs and TINs.

### § 425.306 Participation agreement and exclusivity of ACO participant TINs.

(a) For purposes of the Shared Savings Program, each ACO participant TIN is required to commit to a participation agreement with CMS.

(b) Each ACO participant TIN upon which beneficiary assignment is dependent must be exclusive to one Medicare Shared Savings Program ACO for purposes of Medicare beneficiary assignment. ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive to one Medicare Shared Savings Program ACO.

### § 425.308 Public reporting and transparency.

For purposes of the Shared Savings Program, each ACO must publicly report the following information regarding the ACO in a standardized format as specified by CMS:

- (a) Name and location.
- (b) Primary contact.
- (c) Organizational information including all of the following:
  - (1) Identification of ACO participants.
  - (2) Identification of participants in joint ventures between ACO professionals and hospitals.
  - (3) Identification of the members of its governing body.
  - (4) Identification of associated committees and committee leadership.
- (d) Shared savings and losses information, including:

(1) Amount of any shared savings performance payment received by the ACO or shared losses owed to CMS.

(2) Total proportion of shared savings invested in infrastructure, redesigned care processes and other resources required to support the three-part aim goals of better health for populations, better care for individuals and lower growth in expenditures, including the proportion distributed among ACO participants.

(e) *Results of claims based measures.* Quality measures reported using the GPRO web interface and patient experience of care survey measures will be reported on Physician Compare in the same way as for the group practices that report under the Physician Quality Reporting System.

[76 FR 67973, Nov. 2, 2011, as amended at 77 FR 69372, Nov. 16, 2012]

**§ 425.310 Marketing requirements.**

(a) *File and use.* Marketing materials and activities, as defined in § 425.20, may be used or conducted five business days following their submission to CMS if—

(1) The ACO certifies compliance with all the marketing requirements under this section; and

(2) CMS does not disapprove the marketing materials or activities.

(b) *Deemed approval.* (1) Marketing materials and activities are deemed approved after expiration of the initial 5 day review period specified in paragraph (a) of this section.

(2)(i) CMS may issue written notice of disapproval of marketing materials and activities at any time, including after the expiration of the initial 5 day review period.

(ii) The ACO, ACO participant, ACO provider/supplier, or another individual or entity performing functions or services related to ACO activities as applicable, must discontinue use of any marketing materials or activities disapproved by CMS.

(c) *Marketing requirements.* Marketing materials and activities must meet all of the following:

(1) Use template language developed by CMS, if available.

(2) Not be used in a discriminatory manner or for discriminatory purposes.

(3) Comply with § 425.304(a) regarding beneficiary inducements.

(4) Not be materially inaccurate or misleading.

(d) *Sanctions.* Failure to comply with this section will subject the ACO to the penalties set forth in § 425.216, termination under § 425.218, or both.

**§ 425.312 Notification to beneficiaries of participation in shared savings program.**

(a) ACO participants must do all of the following:

(1) Notify beneficiaries at the point of care that their ACO providers/suppliers are participating in the Shared Savings Program.

(2) Post signs in their facilities to notify beneficiaries that their ACO providers/suppliers are participating in the Shared Savings Program.

(3) Make available standardized written notices regarding participation in an ACO and, if applicable, data opt-out. Such written notices must be provided by the ACO participants in settings in which beneficiaries receive primary care services.

(b)(1) ACOs have the option of notifying beneficiaries on the preliminary prospective assignment list and quarterly assignment list provided to the ACO under § 425.704(d).

(2) ACOs choosing this option must use the standardized written notice developed by CMS.

(c) The beneficiary notifications under this section meet the definition of marketing materials and activities under § 425.20 and therefore must meet all applicable marketing requirements described in § 425.310.

**§ 425.314 Audits and record retention.**

(a) *Right to audit.* The ACO must agree, and must require its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to agree, that the CMS, DHHS, the Comptroller General, the Federal Government or their designees have the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the ACO, ACO participants, and ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities that pertain to all of the following:

(1) The ACO's compliance with Shared Savings Program.

(2) The quality of services performed and determination of amount due to or from CMS under the participation agreement.

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(3) The ability of the ACO to bear the risk of potential losses and to repay any losses to CMS.

(4) If as a result of any inspection, evaluation, or audit, it is determined that the amount of shared savings due to the ACO or the amount of shared losses owed by the ACO has been calculated in error, CMS reserves the right to reopen the initial determination and issue a revised initial determination.

(b) *Maintenance of records.* An ACO must agree, and must require its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to agree to the following:

(1) To maintain and give CMS, DHHS, the Comptroller General, the Federal Government or their designees access to all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements related to ACO activities) sufficient to enable the audit, evaluation, investigation, and inspection of the ACO's compliance with program requirements, quality of services performed, right to any shared savings payment, or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS.

(2) To maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the final date of the agreement period or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless—

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the ACO at least 30 days before the normal disposition date; or

(ii) There has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its ACO participants, its ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, in which case ACOs must retain records for an additional 6 years from the date of any resulting final resolution of the termination, dis-

pute, or allegation of fraud or similar fault.

(c) *Responsibility of the ACO.* Notwithstanding any arrangements between or among an ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities, the ACO must have ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its agreement with CMS, including the requirements set forth in this section.

(d) *OIG authority.* None of the provisions of this part limit or restrict OIG's authority to audit, evaluate, investigate, or inspect the ACO, its ACO participants, its ACO providers/suppliers and other individuals or entities performing functions or services related to ACO activities.

§ 425.316 **Monitoring of ACOs.**

(a) *General rule.* (1) In order to ensure that the ACO continues to satisfy the eligibility and program requirements under this part, CMS monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers.

(2) CMS employs a range of methods to monitor and assess the performance of ACOs, ACO participants, and ACO providers/suppliers, including but not limited to any of the following, as appropriate:

(i) Analysis of specific financial and quality measurement data reported by the ACO as well as aggregate annual and quarterly reports.

(ii) Analysis of beneficiary and provider complaints.

(iii) Audits (including, for example, analysis of claims, chart review (medical record), beneficiary survey reviews, coding audits, on-site compliance reviews).

(b) *Monitoring ACO avoidance of at-risk beneficiaries.* (1) CMS may use one or more of the methods described in paragraph (a)(2) of this section (as appropriate) to identify trends and patterns suggesting that an ACO has avoided at-risk beneficiaries. The results of these analyses may subsequently require further investigation and follow-up with beneficiaries or the ACO and its ACO participants, ACO

providers/suppliers, or other individuals or entities performing functions or services related to the ACO's activities, in order to substantiate cases of beneficiary avoidance.

(2)(i) CMS, at its sole discretion, may take any of the pre-termination actions set forth in § 425.216(a)(1) or immediately terminate, if it determines that an ACO, its ACO participants, any ACO providers/suppliers, or other individuals or entities performing functions or services related to the ACO's activities avoids at-risk beneficiaries.

(ii) If CMS requires the ACO to submit a CAP, the ACO will—

(A) Submit a CAP that addresses actions the ACO will take to ensure that the ACO, ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to the ACO's activities cease avoidance of at-risk beneficiaries.

(B) Not receive any shared savings payments during the time it is under the CAP.

(C) Not be eligible to receive shared savings for the performance year attributable to the time that necessitated the CAP (the time period during which the ACO avoided at risk beneficiaries).

(iii) CMS will re-evaluate the ACO during and after the CAP implementation period to determine if the ACO has continued to avoid at-risk beneficiaries. The ACO will be terminated if CMS determines that the ACO has continued to avoid at-risk beneficiaries during or after the CAP implementation period.

(c) *Monitoring ACO compliance with quality performance standards.* To identify ACOs that are not meeting the quality performance standards, CMS will review an ACO's submission of quality measurement data under § 425.500. CMS may request additional documentation from an ACO, ACO participants, or ACO providers/suppliers, as appropriate. If an ACO does not meet quality performance standards or fails to report on one or more quality measures, in addition to actions set forth at § 425.216 and § 425.218, CMS will take the following actions:

(1) The ACO may be given a warning for the first time it fails to meet the

minimum attainment level in one or more domains as determined under § 425.502 and may be subject to a CAP. CMS, may forgo the issuance of the warning letter depending on the nature and severity of the noncompliance and instead subject the ACO to actions set forth at § 425.216 or immediately terminate the ACO's participation agreement under § 425.218.

(2) The ACO's compliance with the quality performance standards will be re-evaluated the following year. If the ACO continues to fail to meet quality performance standards in the following year, the agreement will be terminated.

(3)(i) If an ACO fails to report one or more quality measures or fails to report completely and accurately on all measures in a domain, CMS will request that the ACO submit—

(A) The required measure data;

(B) Correct the data;

(C) Provide a written explanation for why it did not report the data completely and accurately; or

(D) A combination of the submission requirements in paragraphs (c)(3)(i)(A) through (c)(3)(i)(C) of this section.

(ii) If ACO still fails to report, fails to report by the requested deadline, or does not provide a reasonable explanation for not reporting, the ACO will be terminated immediately.

(4) An ACO that exhibits a pattern of inaccurate or incomplete reporting of the quality performance measures, or fails to make timely corrections following notice to resubmit, may be terminated.

(5) An ACO will not qualify to share in savings in any year it fails to report fully and completely on the quality performance measures.

### Subpart E—Assignment of Beneficiaries

#### § 425.400 General.

(a)(1)(i) A Medicare fee-for-service beneficiary is assigned to an ACO when the beneficiary's utilization of primary care services meets the criteria established under the assignment methodology described in § 425.402.

(ii) CMS applies a step-wise process based on the beneficiary's utilization of primary care services provided under

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Title XVIII by a physician who is an ACO provider/supplier during the performance year for which shared savings are to be determined.

(2)(i) Medicare assigns beneficiaries in a preliminary manner at the beginning of a performance year based on most recent data available.

(ii) Assignment will be updated quarterly based on the most recent 12 months of data.

(iii) Final assignment is determined after the end of each performance year, based on data from the performance year.

(b) Beneficiary assignment to an ACO is for purposes of determining the population of Medicare fee-for-service beneficiaries for whose care the ACO is accountable under subpart F of this part, and for determining whether an ACO has achieved savings under subpart G of this part, and in no way diminishes or restricts the rights of beneficiaries assigned to an ACO to exercise free choice in determining where to receive health care services.

(c) Primary care services for purposes of assigning beneficiaries are identified by selected HCPCS codes, G codes, or revenue center codes as indicated in the definition of primary care services under § 425.20.

**§ 425.402 Basic assignment methodology.**

(a) CMS employs the following stepwise methodology to assign Medicare beneficiaries to an ACO after identifying all patients that had at least one primary care service with a physician who is an ACO provider/supplier of that ACO:

(1)(i) Identify all primary care services rendered by primary care physicians during one of the following:

(A) The most recent 12 months (for purposes of preliminary prospective assignment and quarterly updates to the preliminary prospective assignment).

(B) The performance year (for purposes of final assignment).

(ii) The beneficiary is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by all the primary care physicians who are ACO providers/suppliers in the ACO are greater than the allowed charges for primary care services

furnished by primary care physicians who are—

(A) ACO providers/suppliers in any other ACO; and

(B) Not affiliated with any ACO and identified by a Medicare-enrolled TIN.

(2) The second step considers the remainder of the beneficiaries who have received at least one primary care service from an ACO physician, but who have not had a primary care service rendered by any primary care physician, either inside or outside the ACO. The beneficiary will be assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by all ACO professionals who are ACO providers/suppliers in the ACO are greater than the allowed charges for primary care services furnished by—

(i) All ACO professionals who are ACO providers/suppliers in any other ACO; and

(ii) Other physicians, nurse practitioners, physician assistants, clinical nurse specialists who are unaffiliated with an ACO and are identified by a Medicare-enrolled TIN.

(b) [Reserved]

**§ 425.404 Special assignment conditions for ACOs including FQHCs and RHCs.**

CMS assigns beneficiaries to ACOs based on services furnished in FQHCs or RHCs or both consistent with the general assignment methodology in § 425.402, with two special conditions:

(a) Such ACOs are required to identify, through an attestation, physicians who directly provide primary care services in each FQHC or RHC that is an ACO participant and/or ACO provider/supplier in the ACO.

(b) Under the assignment methodology in § 425.402, CMS treats a service reported on an FQHC/RHC claim as a primary care service if the—

(1) NPI of a physician included in the attestation is reported on the claim as the attending provider; and

(2) Claim includes a HCPCS or revenue center code that meets the definition of primary care services under § 425.20.

### Subpart F—Quality Performance Standards and Reporting

#### § 425.500 Measures to assess the quality of care furnished by an ACO.

(a) *General.* CMS establishes quality performance measures to assess the quality of care furnished by the ACO. If the ACO demonstrates to CMS that it has satisfied the quality performance requirements in this subpart, and the ACO meets all other applicable requirements, the ACO is eligible for shared savings.

(b) *Selecting measures.* (1) CMS selects the measures designated to determine an ACO's success in promoting the aims of better care for individuals, better health for populations, and lower growth in expenditures.

(2) CMS designates the measures for use in the calculation of the quality performance standard.

(3) CMS seeks to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both.

(c) ACOs must submit data on the measures determined under paragraph (b) of this section according to the method of submission established by CMS.

(d) *Patient experience of care survey.* For performance years beginning in 2014 and for subsequent performance years, ACOs must select a CMS-certified vendor to administer the survey and report the results accordingly.

(e) *Audit and validation of data.* CMS retains the right to audit and validate quality data reported by an ACO.

(1) In an audit, the ACO will provide beneficiary medical records data if requested by CMS.

(2) The audit will consist of three phases of medical record review.

(3) If, at the conclusion of the third audit process there is a discrepancy greater than 10 percent between the quality data reported and the medical records provided, the ACO will not be given credit for meeting the quality target for any measures for which this mismatch rate exists.

(f) Failure to report quality measure data accurately, completely, and timely (or to timely correct such data) may subject the ACO to termination or

other sanctions, as described in §§ 425.216 and 425.218.

#### § 425.502 Calculating the ACO quality performance score.

(a) *Establishing a quality performance standard.* CMS designates the quality performance standard in each performance year.

(1) For the first performance year of an ACO's agreement, CMS defines the quality performance standard at the level of complete and accurate reporting for all quality measures.

(2) During subsequent performance years, the quality performance standard will be phased in such that the ACO must continue to report all measures but the ACO will be assessed on performance based on the minimum attainment level of certain measures.

(b) *Establishing a performance benchmark and minimum attainment level for measures.* (1) CMS designates a performance benchmark and minimum attainment level for each measure, and establishes a point scale for the measures.

(2) Contingent upon data availability, performance benchmarks are defined by CMS based on national Medicare fee-for-service rates, national MA quality measure rates, or a national flat percentage.

(3) The minimum attainment level is set at 30 percent or the 30th percentile of the performance benchmark.

(c) *Methodology for calculating a performance score for each measure.* (1) Performance below the minimum attainment level for a measure will receive zero points for that measure.

(2) Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance.

(3) Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.

(4) Performance at or above 90 percent or the 90th percentile of the performance benchmark earns the maximum points available for the measure.

(d) *Establishing quality performance requirements for domains.* (1) CMS groups

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individual quality performance standard measures into four domains:

- (i) Patient/care giver experience.
- (ii) Care coordination/Patient safety.
- (iii) Preventative health.
- (iv) At-risk population.

(2) To satisfy quality performance requirements for a domain:

(i) The ACO must report all measures within a domain.

(ii) ACOs must score above the minimum attainment level determined by CMS on 70 percent of the measures in each domain. If an ACO fails to achieve the minimum attainment level on at least 70 percent of the measures in a domain, CMS will take the actions describe in § 425.216(c).

(iii)(A) If the ACO achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings under subpart G of this part, the ACO may receive the proportion of those shared savings for which it qualifies.

(B) If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated.

(e) *Methodology for calculating the ACO's overall performance score.* (1) CMS scores individual measures and determines the corresponding number of points that may be earned based on the ACO's performance.

(2) CMS adds the points earned for the individual measures within the domain and divides by the total points available for the domain to determine the domain score.

(3) Domains are weighted equally and scores averaged to determine the ACO's overall performance score and sharing rate.

**§ 425.504 Incorporating reporting requirements related to the Physician Quality Reporting System.**

(a) *Physician quality reporting system.*

(1) ACOs, on behalf of their ACO provider/suppliers who are eligible professionals, must submit the measures determined under § 425.500 using the GPRO web interface established by CMS, to qualify on behalf of their eligible professionals for the Physician

Quality Reporting System incentive under the Shared Savings Program.

(2)(i) ACO providers/suppliers that are eligible professionals within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of receiving an incentive payment under the Physician Quality Reporting System.

(ii) Under the Shared Savings Program, an ACO, on behalf of its ACO providers/suppliers who are eligible professionals, must satisfactorily report the measures determined under Subpart F of this part during the reporting period according to the method of submission established by CMS under the Shared Savings Program in order to receive a Physician Quality Reporting System incentive under the Shared Savings Program.

(3) If ACO providers/suppliers who are eligible professionals within an ACO qualify for a Physician Quality Reporting System incentive payment, each ACO participant TIN, on behalf of its ACO supplier/provider participants who are eligible professionals, will receive an incentive, for those years an incentive is available, based on the allowed charges under the Physician Fee Schedule for that TIN.

(4) ACO participant TINs and individual ACO providers/suppliers who are eligible professionals cannot earn a Physician Quality Reporting System incentive outside of the Medicare Shared Savings Program.

(5) The Physician Quality Reporting System incentive under the Medicare Shared Savings Program is equal to 0.5 percent of the Secretary's estimate of the ACO's eligible professionals' total Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the calendar year reporting period from January 1 through December 31, for years 2012 through 2014.

(b) *Physician Quality Reporting System payment adjustment.* (1) ACOs, on behalf of their ACO provider/suppliers who are eligible professionals, must submit one of the measures determined under § 425.500 using the GPRO web interface established by CMS, to satisfactorily

report on behalf of their eligible professionals for purposes of the 2015 Physician Quality Reporting System payment adjustment under the Shared Savings Program.

(2)(i) ACO providers/suppliers that are eligible professionals within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of the 2015 Physician Quality Reporting System payment adjustment under the Shared Savings Program.

(ii) Under the Shared Savings Program, an ACO, on behalf of its ACO providers/suppliers who are eligible professionals, must satisfactorily report one of the measures determined under Subpart F of this part during the reporting period for a year, as defined in paragraph (b)(6) of this section, according to the method of submission established by CMS under the Shared Savings Program for purposes of the 2015 Physician Quality Reporting System payment adjustment.

(3) If an ACO, on behalf of its ACO providers/suppliers who are eligible professionals, does not satisfactorily report for purposes of a 2015 Physician Quality Reporting System payment adjustment, each ACO supplier/provider who is an eligible professional, will receive a payment adjustment, as described in paragraph (b)(5) of this section.

(4) ACO participant TINs and individual ACO providers/suppliers who are eligible professionals cannot satisfactorily report for purposes of a 2015 Physician Quality Reporting System payment adjustment outside of the Medicare Shared Savings Program.

(5) For eligible professionals subject to the 2015 Physician Quality Reporting System payment adjustment under the Medicare Shared Savings Program, the Medicare Part B Physician Fee Schedule amount for covered professional services furnished during the program year is equal to the applicable percent of the Medicare Part B Physician Fee Schedule amount that would otherwise apply to such services under section 1848 of the Act.

(i) The applicable percent for 2015 is 98.5 percent.

(ii) The applicable percent for 2016 and subsequent years is 98.0 percent.

(6) The reporting period for a year is the calendar year from January 1 through December 31 that occurs 2 years prior to the program year in which the payment adjustment is applied.

[76 FR 67973, Nov. 2, 2011, as amended at 77 FR 69372, Nov. 16, 2012]

#### **§ 425.506 Electronic health records technology.**

(a) ACOs, ACO participants, and ACO providers/suppliers are encouraged to develop a robust EHR infrastructure.

(b) As part of the quality performance score, the quality measure regarding EHR adoption will be measured based on a sliding scale.

(c) Performance on this measure will be weighted twice that of any other measure for scoring purposes and for determining compliance with quality performance requirements for domains.

### **Subpart G—Shared Savings and Losses**

#### **§ 425.600 Selection of risk model.**

(a) For its initial agreement period, an ACO may elect to operate under one of the following tracks:

(1) *Track 1.* Under Track 1, the ACO operates under the one-sided model (as described under § 425.604 of this part) for the agreement period.

(2) *Track 2.* Under Track 2, the ACO operates under the two-sided model (as described under § 425.606), sharing both savings and losses with the Medicare program for the agreement period.

(b) For subsequent agreement periods, an ACO may not operate under the one-sided model.

(c) An ACO experiencing a net loss during the initial agreement period may reapply to participate under the conditions in § 425.202(a), except the ACO must also identify in its application the cause(s) for the net loss and specify what safeguards are in place to enable the ACO to potentially achieve savings in its next agreement period.

**§ 425.602 Establishing the benchmark.**

(a) *Computing per capita Medicare Part A and Part B benchmark expenditures.* In computing an ACO's fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, CMS determines the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period using the ACO participants' TINs identified at the start of the agreement period. CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service claims using a 3-month claims run out with a completion factor.

(i) This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) This calculation considers individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(2) Makes separate expenditure calculations for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(3) Adjusts expenditures for changes in severity and case mix using prospective HCC risk scores.

(4) Truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each benchmark year in order to minimize variation from catastrophically large claims.

(5)(i) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates and trends expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

(ii) To trend forward the benchmark, CMS makes separate calculations for expenditure categories for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries

and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(6) Restates BY1 and BY2 trended and risk adjusted expenditures in BY3 proportions of ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(7) Weights each year of the benchmark using the following percentages:

(i) BY3 at 60 percent.

(ii) BY2 at 30 percent.

(iii) BY1 at 10 percent.

(8) The ACO's benchmark may be adjusted for the addition and removal of ACO participants or ACO providers/suppliers during the term of the agreement period.

(b) *Updating the benchmark.* CMS updates the historical benchmark annually for each year of the agreement period based on the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program.

(1) CMS updates this fixed benchmark by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program using data from CMS' Office of the Actuary.

(2) To update the benchmark, CMS makes expenditure calculations for separate categories for each of the following populations of beneficiaries:

(i) ESRD.

(ii) Disabled.

(iii) Aged/dual eligible Medicare and Medicaid beneficiaries.

(iv) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

(c) *Resetting the benchmark.* An ACO's benchmark will be reset at the start of each agreement period.

**§ 425.604 Calculation of savings under the one-sided model.**

(a) *Savings determination.* For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark determined under § 425.602.

(1) *Newly assigned beneficiaries.* CMS uses an ACO's HCC prospective risk score to adjust for changes in severity and case mix in this population.

(2) *Continuously assigned beneficiaries.* (i) CMS uses demographic factors to adjust for changes in the continuously assigned population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust for changes in severity and case mix in this population using this lower prospective HCC risk score.

(3) Assigned beneficiary changes in demographics and health status are used to adjust benchmark expenditures as described in §425.602(a). In adjusting for health status and demographic changes CMS makes adjustments for separate categories for each of the following populations of beneficiaries:

- (i) ESRD.
- (ii) Disabled.
- (iii) Aged/dual eligible Medicare and Medicaid beneficiaries.
- (iv) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

(4) To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each performance year.

(5) CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings rate (MSR).* CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for an ACO participating under the one-sided model. The MSR under the one-sided model for an ACO based on the number of assigned beneficiaries is as follows:

Number of beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
5,000–5,999	3.9	3.6
6,000–6,999	3.6	3.4
7,000–7,999	3.4	3.2
8,000–8,999	3.2	3.1
9,000–9,999	3.1	3.0
10,000–14,999	3.0	2.7
15,000–19,999	2.7	2.5
20,000–49,999	2.5	2.2
50,000–59,999	2.2	2.0
60,000 +	2.0	

(c) *Qualification for shared savings payment.* In order to qualify for shared savings, an ACO must meet or exceed its minimum savings rate determined under paragraph (b) of this section, meet the minimum quality performance standards established under

§ 425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate.* An ACO that meets all the requirements for receiving shared savings payments under the one-sided model will receive a shared

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savings payment of up to 50 percent of all savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 of this part (up to the performance payment limit described in paragraph (e)(2) of this section).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the one-sided model may not exceed 10 percent of its updated benchmark.

(f) *Notification of savings.* CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

**§ 425.606 Calculation of shared savings and losses under the two-sided model.**

(a) *General rule.* For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are above or below the updated benchmark determined under § 425.602. In order to qualify for a shared savings payment under the two-sided model, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate under paragraph (b) of this section.

(1) *Newly assigned beneficiaries.* CMS uses an ACO's HCC prospective risk score to adjust for changes in severity and case mix in this population.

(2) *Continuously assigned beneficiaries.* (i) CMS uses demographic factors to adjust for changes in the continuously assigned beneficiary population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust for changes in severity and case mix for this population using this lower prospective HCC risk score.

(3) Assigned beneficiary changes in demographics and health status are used to adjust benchmark expenditures as described in § 425.602(a). In adjusting for health status and demographic changes CMS makes separate adjustments for each of the following populations of beneficiaries:

(i) ESRD.

(ii) Disabled.

(iii) Aged/dual eligible Medicare and Medicaid beneficiaries.

(iv) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

(4) To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each performance year.

(5) CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings or loss rate.* (1) To qualify for shared savings under the two-sided model, an ACO's average per capita Medicare expenditures for the performance year must be below its updated benchmark costs for the year by at least 2 percent.

(2) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare expenditures for the performance year

must be at least 2 percent above its updated benchmark costs for the year.

(c) *Qualification for shared savings payment.* To qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the minimum quality performance standards established under § 425.502 of this part, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate.* An ACO that meets all the requirements for receiving shared savings payments under the two-sided model will receive a shared savings payment of up to 60 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 of this part (up to the performance payment limit described in paragraph (e)(2) of this section).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the two-sided model may not exceed 15 percent of its updated benchmark.

(f) *Shared loss rate.* The shared loss rate—

(1) For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on the inverse of its final sharing rate described in § 425.606(d) (that is, 1 minus the final shared savings rate determined under § 425.606(d) of this part); and

(2) May not exceed 60 percent.

(g) *Loss recoupment limit.* The amount of shared losses for which an eligible ACO is liable may not exceed the following percentages of its updated benchmark as determined under § 425.602:

(1) 5 percent in the first performance year of participation in a two-sided model under the Shared Savings Program.

(2) 7.5 percent in the second performance year.

(3) 10 percent in the third and any subsequent performance year.

(h) *Notification of savings and losses.*

(1) CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(2) CMS provides written notification to an ACO of the amount of shared losses, if any, that it must repay to the program.

(3) If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification.

**§ 425.608 Determining first year performance for ACOs beginning April 1 or July 1, 2012.**

(a) For April 1 and July 1, 2012 starters, first year (defined as 21 and 18 months respectively) performance will be based on an optional interim payment calculation (based on the ACO's first 12 months of participation) and a final reconciliation at the end of the ACO's first performance year. Unless stated otherwise, for purposes of the interim payment calculation and first year reconciliation, the methodology under subpart E of this part for assigning beneficiaries and the methodology described in § 425.602 through § 425.606 for calculating shared savings and losses will apply, and quality performance will be assessed as described in subpart F of this part.

(b) In the interim payment calculation, based on the ACO's first 12 months of performance—

(1) CMS compares the first 12 months of per capita beneficiary expenditures to a historical benchmark updated for the period which includes the ACO's first 12 months of participation, taking into account changes in health status and demographics; and

(2) Quality performance is based on GPRO quality data reported for CY 2012.

(c)(1) The interim payment calculation is reconciled with the ACO's performance for its complete first performance year, defined as 21 months for April 1, 2012 starters and 18 months for July 1, 2012 starters.

(2) The first year reconciliation takes into account expenditures spanning the entire 21 or 18 months of the first performance year.

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(3) First performance year expenditures are summed over beneficiaries assigned in two overlapping 12 month assignment windows.

(i) The first window will be the first 12 months used for interim payment calculation.

(ii) The second window will be CY2013.

(4) Expenditures for the first performance year are the sum of aggregate expenditure dollars accounting for the ACO's first 6 or 9 months of performance within CY 2012 for beneficiaries assigned for the interim payment calculation and aggregate dollars calculated for CY2013 for beneficiaries assigned for CY 2013.

(5) Adjustments for health status and demographic changes are performed as described in § 425.604 through § 425.606 with the following exceptions:

(i) Beneficiaries from the CY2013 assignment window are identified as continuously assigned or newly assigned relative to the previous calendar year.

(ii) The adjustment factor identified for purposes of the interim payment calculation is applied to the 6 months or 9 months of the ACO's first performance year that lie within CY2012.

(6) The updated benchmark, stated in aggregate dollars, is the sum of the interim updated benchmark for the average fraction of expenditures incurred in the latter 6 or 9 months of CY 2012 and an updated aggregate benchmark representing CY 2013.

(7) A savings percentage (based on a comparison of summed expenditures to summed updated benchmark dollars) for the ACO's 18 or 21 month performance year is compared to the ACO's MSR or MLR. The reconciled amount of the shared savings or losses owed to or by the ACO for the performance year is net of any interim payments of shared savings or losses.

(8) Quality performance for the first year reconciliation is based on complete and accurate reporting, of all required quality measures, for CYs 2012 and 2013.

(d) An ACO with a start date of April 1, 2012 or July 1, 2012 has the option to request an interim payment calculation based on quality and financial performance for its first 12 months of program participation. As required under

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§ 425.204(f), the ACO requesting an interim payment calculation must have a mechanism in place to pay back the interim payment if final reconciliation determines an overpayment.

(e) Unless otherwise stated, program requirements which apply in the course of a performance year apply to the interim payment calculation and first year reconciliation.

### Subpart H—Data Sharing With ACOs

#### § 425.700 General rules.

(a) CMS shares aggregate reports with the ACO.

(b) CMS shares beneficiary identifiable data with ACOs on the condition that the ACO, its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to the ACO's activities observe all relevant statutory and regulatory provisions regarding the appropriate use of data and the confidentiality and privacy of individually identifiable health information and comply with the terms of the data use agreement described in this subpart.

(c) The ACO must not limit or restrict appropriate sharing of medical record data with providers and suppliers both within and outside the ACO in accordance with applicable law.

#### § 425.702 Aggregate reports.

CMS shares aggregate reports with ACOs as follows:

(a) Aggregate reports are shared at the start of the agreement period based on beneficiary claims data used to calculate the benchmark, and each quarter thereafter during the agreement period.

(b) These aggregate reports include, when available, the following information, deidentified in accordance with 45 CFR 164.514(b):

(1) Aggregated metrics on the assigned beneficiary population.

(2) Utilization and expenditure data at the start of the agreement period based on historical beneficiaries used to calculate the benchmark.

(c)(1) At the beginning of the agreement period, during each quarter (and

in conjunction with the annual reconciliation), and at the beginning of each performance year, CMS, upon the ACO's request for the data for purposes of population-based activities relating to improving health or reducing growth in health care costs, process development, case management, and care coordination, will provide the ACO with information regarding preliminarily prospectively assigned beneficiaries whose data was used to generate the aggregate data reports under paragraphs (a) and (b) of this section. The information includes the following:

- (i) Beneficiary name.
- (ii) Date of birth.
- (iii) HICN.
- (iv) Sex.

(2) In its request for these data, the ACO must certify that it is seeking the following information:

(i) As a HIPAA-covered entity, and the request reflects the minimum data necessary for the ACO to conduct its own health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501.

(ii) As the business associate of its ACO participants and ACO providers/suppliers, who are HIPAA-covered entities, and the request reflects the minimum data necessary for the ACO to conduct health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501 on behalf of those participants.

**§ 425.704 Beneficiary-identifiable data.**

Subject to providing the beneficiary with the opportunity to decline data sharing as described in this § 425.708, and subject to having a valid DUA in place, CMS, upon the ACO's request for the data for purposes of evaluating the performance of its ACO participants or its ACO providers/suppliers, conducting quality assessment and improvement activities, and conducting population-based activities relating to improved health, will provide the ACO with beneficiary identifiable claims data for preliminary prospective assigned beneficiaries and other beneficiaries who receive primary care services from an ACO participant upon whom assign-

ment is based during the agreement period.

(a) If an ACO wishes to receive beneficiary identifiable claims data, it must sign a DUA and it must submit a formal request for data. ACOs may request data as often as once per month.

(b) The ACO must certify that it is requesting claims data about either of the following:

(1) Its own patients, as a HIPAA-covered entity, and the request reflects the minimum data necessary for the ACO to conduct its own health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501.

(2) The patients of its HIPAA-covered entity ACO participants or its ACO providers/suppliers as the business associate of these HIPAA covered entities, and the request reflects the minimum data necessary for the ACO to conduct health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501 on behalf of those participants.

(c) The use of identifiers and claims data will be limited to developing processes and engaging in appropriate activities related to coordinating care and improving the quality and efficiency of care that are applied uniformly to all Medicare beneficiaries with primary care services at the ACO, and that these data will not be used to reduce, limit or restrict care for specific beneficiaries.

(d) To ensure that beneficiaries have a meaningful opportunity to decline having their claims data shared with the ACO, the ACO may only request claims data about a beneficiary if—

(1) The beneficiary name appears on the preliminary prospective assignment list found on the initial or quarterly aggregate report, or has received primary care services from an ACO participant upon whom assignment is based (under Subpart E of this part), during the agreement period.

(2) The beneficiary has been notified in writing how the ACO intends to use beneficiary identifiable claims data in order to improve the quality of care that is furnished to the beneficiary

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and, where applicable, coordinate care offered to the beneficiary; and

(3) The beneficiary did not exercise the opportunity to decline having his/her claims data shared with the ACO as provided in § 425.708.

(e) At the ACO's request, CMS continues to provide ACOs with updates to the requested beneficiary identifiable claims data, subject to beneficiary's opportunity to decline data sharing under § 425.708.

(f) If an ACO requests beneficiary identifiable information, compliance with the terms of the data use agreement described in § 425.710 is a condition of an ACO's participation in the Shared Savings Program.

**§ 425.706 Minimum necessary data.**

(a) ACOs must limit their identifiable data requests to the minimum necessary to accomplish a permitted use of the data. The minimum necessary Parts A and B data elements may include but are not limited to the following data elements:

- (1) Beneficiary ID.
- (2) Procedure code.
- (3) Gender.
- (4) Diagnosis code.
- (5) Claim ID.
- (6) The from and through dates of service.
- (7) The provider or supplier ID.
- (8) The claim payment type.
- (9) Date of birth and death, if applicable.
- (10) TIN.
- (11) NPI.

(b) The minimum necessary Part D data elements may include but are not limited to the following data elements:

- (1) Beneficiary ID.
- (2) Prescriber ID.
- (3) Drug service date.
- (4) Drug product service ID.
- (5) Quantity dispensed.
- (6) Days supplied.
- (7) Brand name.
- (8) Generic name.
- (9) Drug strength.
- (10) TIN.
- (11) NPI.
- (12) Indication if on formulary.
- (13) Gross drug cost.

**§ 425.708 Beneficiaries may decline data sharing.**

(a) Before requesting claims data about a particular beneficiary, the ACO must inform the beneficiary that it may request personal health information about the beneficiary for purposes of its care coordination and quality improvement work, and give the beneficiary meaningful opportunity to decline having his/her claims information shared with the ACO.

(b) ACOs may contact preliminarily prospective assigned beneficiaries, in writing to request data sharing.

(1) If these beneficiaries do not decline within 30 days after the letter is sent, the ACO may request identifiable claims data from CMS.

(2) These beneficiaries must also be provided a form explaining the beneficiary's opportunity to decline data sharing as part of their first primary care service visit with an ACO participant upon whom assignment is based (under Subpart E of this part) during the agreement period.

(c) For beneficiaries that have a primary care service office visit with an ACO participant who provides primary care services, the ACO must supply the beneficiaries with a written notification explaining their opportunity to decline data sharing. The form must be provided to each beneficiary as part of their first primary care service visit with an ACO participant upon whom assignment is based (under Subpart E of this part) during the agreement period.

(d) The requirements specified in paragraphs (a) through (c) of this section do not apply to the initial identifiable data points that CMS provides to ACOs under § 425.702(d).

(e) CMS does not share beneficiary identifiable claims data relating to treatment for alcohol and substance abuse in accordance with 42 CFR 290dd-2 and the implementing regulations at 42 CFR part 2.

(f) The provisions of this section relate only to the sharing of Medicare claims data between the Medicare program and the ACO under the Shared Savings Program and are in no way intended to impede existing or future data sharing under other authorities.

**§ 425.710 Data use agreement.**

(a)(1) Before receiving any beneficiary identifiable data, ACOs must enter into a DUA with CMS. Under the DUA, the ACO must comply with the limitations on use and disclosure that are imposed by HIPAA, the applicable DUA, and the statutory and regulatory requirements of the Shared Savings Program.

(2) If the ACO misuses or discloses data in a manner that violates any applicable statutory or regulatory requirements or that is otherwise non-compliant with the provisions of the DUA, it will no longer be eligible to receive data under subpart H of this part, may be terminated from the Shared Savings Program under § 425.218, and may be subject to additional sanctions and penalties available under the law.

(b) [Reserved]

### Subpart I—Reconsideration Review Process

**§ 425.800 Preclusion of administrative and judicial review.**

(a) There is no reconsideration, appeal, or other administrative or judicial review of the following determinations under this part:

(1) The specification of quality and performance standards under § 425.500 and § 425.502.

(2) The assessment of the quality of care furnished by an ACO under the performance standards established in § 425.502.

(3) The assignment of Medicare fee-for-service beneficiaries under Subpart E of this part.

(4) The determination of whether an ACO is eligible for shared savings, and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under § 425.602, § 425.604, and § 425.606.

(5) The percent of shared savings specified by the Secretary and the limit on the total amount of shared savings established under § 425.604 and 425.606.

(6) The termination of an ACO for failure to meet the quality performance standards established under § 425.502.

(b) [Reserved]

**§ 425.802 Request for review.**

(a) An ACO may appeal an initial determination that is not prohibited from administrative or judicial review under § 425.800 by requesting a reconsideration review by a CMS reconsideration official.

(1) An ACO that wants to request reconsideration review by a CMS reconsideration official must submit a written request by an authorized official for receipt by CMS within 15 days of the notice of the initial determination.

(i) If the 15th day is a weekend or a Federal holiday, then the timeframe is extended until the end of the next business day.

(ii) Failure to submit a request for reconsideration within 15 days will result in denial of the request for reconsideration.

(2) The reconsideration review may be held orally (that is, in person, by telephone or other electronic means) or on the record (review of submitted documentation) at the discretion of the reconsideration official.

(b) An ACO that requests a reconsideration review for termination will remain operational throughout the review process.

**§ 425.804 Reconsideration review process.**

(a) *Acknowledgement of reconsideration review request.* The reconsideration official sends an acknowledgement of the reconsideration review request to the ACO and CMS that includes the following:

(1) Review procedures.

(2) Procedures for submission of evidence including format and timelines.

(3) Date, time, and location of the review.

(b) *Burden of proof, standard of proof, and standards of review.* The burden of proof is on the ACO to demonstrate to the reconsideration official with convincing evidence that the initial determination is not consistent with the requirements of this part or applicable statutory authority.

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(c) *Reconsideration official.* The reconsideration official is an independent CMS official who did not participate in the initial determination that is being reviewed.

(d) *Time and place of hearing.* The reconsideration official may, on his or her own motion, or at the request of CMS or the ACO, change the time and place for the reconsideration review, but must give CMS and the ACO notice of the change.

(e) *Evidence.* (1) The reconsideration official's review will be based only on evidence submitted by the reconsideration official's requested deadline, unless otherwise requested by the reconsideration official.

(2) Documentation submitted for the record as evidence cannot be documentation that was not previously submitted to CMS by the applicable deadline and in the requested format.

(3) All evidence submitted by the ACO and CMS, in preparation for the reconsideration review will be shared with the other party to the hearing.

(f) The reconsideration official will notify CMS and the ACO of his or her recommendation.

**§ 425.806 On-the-record review of reconsideration official's recommendation by independent CMS official.**

(a)(1) If CMS or the ACO disagrees with the recommendation of the reconsideration official, it may request an on the record review of the initial determination and recommendation by an independent CMS official who was not involved in the initial determination or the reconsideration review process.

(2) In order to request an on-the-record review, CMS or the ACO must submit an explanation of why it disagrees with the recommendation by the timeframe and in the format indicated in the reconsideration official's recommendation letter.

(b) The on-the-record review process is based only on evidence presented during the reconsideration review.

(c) The independent CMS official considers the recommendation of the reconsideration official and makes a final agency determination.

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**§ 425.808 Effect of independent CMS official's decision.**

(a) The decision of the independent CMS official is final and binding.

(b) The reconsideration review process under this subpart must not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by other government agencies.

**§ 425.810 Effective date of decision.**

(a) If the initial determination denying an ACO's application to participate in the Shared Savings Program is upheld, the application will remain denied based on the effective date of the original notice of denial.

(b) If the initial determination to terminate an agreement with an ACO is upheld, the decision to terminate the agreement is effective as of the date indicated in the initial notice of termination.

(c) If the initial determination to terminate an ACO is reversed, the ACO is reinstated into the Shared Savings Program, retroactively back to the original date of termination.

**PART 426—REVIEW OF NATIONAL COVERAGE DETERMINATIONS AND LOCAL COVERAGE DETERMINATIONS**

**Subpart A—General Provisions**

- Sec.
- 426.100 Basis and scope.
- 426.110 Definitions.
- 426.120 Calculation of deadlines.
- 426.130 Party submissions.

**Subpart B [Reserved]**

**Subpart C—General Provisions for the Review of LCDs and NCDs**

- 426.300 Review of LCDs, NCDs, and deemed NCDs.
- 426.310 LCD and NCD reviews and individual claim appeals.
- 426.320 Who may challenge an LCD or NCD.
- 426.325 What may be challenged.
- 426.330 Burden of proof.
- 426.340 Procedures for review of new evidence.