(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, dispute, 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