§ 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 noncompliant 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.