



Medicare Shared Savings Program

ACO PARTICIPANT LIST AND PARTICIPANT AGREEMENT

Guidance

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Version #10

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MEDICARE
SHARED SAVINGS
PROGRAM

Revision History – Version 10

TITLE OF SECTION & REVISIONS/CHANGES DESCRIPTION (since previous version)	LINK TO AFFECTED AREA
Introduction to ACO Participant Agreements: Updated guidance regarding sample ACO Participant Agreements.	Section 5.1

Table of Contents

1	Executive Summary	1
2	Background.....	2
3	ACO Participant List.....	2
3.1	Introduction to the ACO Participant List.....	2
3.2	ACO Participant List Requirements	4
3.2.1	Sole Proprietor ACO Participants.....	5
3.2.2	Merged or Acquired ACO Participant Requirements.....	6
3.2.3	Merged or Acquired TIN Documentation.....	8
3.3	ACO Participant List Changes	8
3.3.1	Initial and Renewal/Early Renewal Applicants	9
3.3.2	Currently Participating ACOs (Mid-Agreement Period)	9
3.3.3	ACO Participant Legal Business Name Changes	9
3.4	Impact of ACO Participant List Changes on Program Operations	10
3.4.1	How Changes in ACO Participants Affect Data Sharing	10
3.4.2	How Changes in ACO Participants Affect Quality Reporting.....	11
3.4.3	How Changes in ACO Participants Affect Benchmarking	11
3.4.4	How Changes in ACO Participants Affect Program Eligibility.....	11
4	Managing Changes to the ACO Provider/Supplier List.....	12
5	ACO Participant Agreements	13
5.1	Introduction to ACO Participant Agreements.....	13
5.2	ACO Participant Agreement Requirements	14
5.3	Sample ACO Participant Agreement Requirements	15
5.3.1	Executed ACO Participant Agreement Requirements.....	15
	Appendix A: Example ACO Participant Agreement Language	17
	Appendix B: Example ACO Participant Agreement Amendment Language	18
	Appendix C: Information on Digital Signature Requirements	19

1 Executive Summary

The purpose of this document is to describe the requirements that an Accountable Care Organization (ACO) participating in or applying to the Medicare Shared Savings Program (Shared Savings Program) must follow with respect to its ACO Participant List, ACO Provider/Supplier List, and ACO Participant Agreement. These requirements are reflected in the regulations for the Shared Savings Program, which are codified at [42 CFR part 425](#).

The ACO Participant List is critical to Shared Savings Program operations. The Centers for Medicare & Medicaid Services (CMS) uses the list to screen ACO participants, generate the ACO Provider/Supplier List, determine which Medicare fee-for-service (FFS) beneficiaries will be assigned to an ACO, establish the historical benchmark, perform financial calculations, and coordinate among CMS quality reporting initiatives. An ACO certifies its ACO Participant List and ACO Provider/Supplier List before the start of an agreement period and before every performance year thereafter.

ACO participants can be deleted from the ACO Participant List at any time during a performance year. The ACO participant is no longer an ACO participant as of the termination effective date of the ACO Participant Agreement. Absent unusual circumstances, the ACO participant data will continue to be utilized for certain operational purposes. CMS does not make adjustments during the performance year to the ACO's assignment, historical benchmark, performance year financial calculations, or the obligation of the ACO to report on behalf of eligible clinicians who bill under the taxpayer identification number (TIN) of an ACO participant for certain CMS quality initiatives to reflect the deletion of entities from the ACO Participant List that become effective during the performance year (refer to [Section 3.4](#)).

Through the Shared Savings Program, CMS establishes agreements with each ACO. Each ACO is required to have contractual agreements with its ACO participants, which are entities identified by a Medicare-enrolled billing TIN that, alone or together with one or more other ACO participants, compose an ACO. An ACO may not include an ACO participant on its ACO Participant List unless an individual authorized to legally bind the ACO participant has signed an ACO Participant Agreement with the ACO. This agreement ensures that the ACO participant, and each ACO provider/supplier billing through the TIN of the ACO participant, agrees to the requirements of the Shared Savings Program.

2 Background

This document is subject to periodic change. Any substantive changes to this document will be noted in the [Revision History table](#).

An ACO is composed of groups of doctors, hospitals, and other health care providers that come together voluntarily to give coordinated, high-quality care to their Medicare FFS beneficiaries. The Shared Savings Program rewards ACOs that improve the quality and cost efficiency of health care. The authority for the Shared Savings Program is Section 1899 of the Social Security Act (the Act), which was added by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. These public laws are collectively known as the Affordable Care Act. CMS has published four final rules regulating the Shared Savings Program. The first final rule was published in November 2011, the second was published in June 2015, the third was published in June 2016, and the fourth was published in December 2018. Additionally, CMS has addressed certain issues related to the Shared Savings Program in the annual Physician Fee Schedule (PFS) rulemaking. The Shared Savings Program's regulations can be found in the Code of Federal Regulations at 42 CFR part 425. Additionally, the [Electronic Code of Federal Regulations website](#) is a useful resource for viewing the program regulations.

The definitions of terms that are important to understanding the Shared Savings Program and this guidance document can be found at [42 CFR § 425.20](#).

3 ACO Participant List

This section provides detailed information about the process for submitting and updating the ACO participants that comprise a given ACO Participant List. It also addresses how changes to an ACO Participant List impact critical program operations.

3.1 INTRODUCTION TO THE ACO PARTICIPANT LIST

An ACO Participant List identifies all of an ACO's participants by their Medicare-enrolled billing TINs. The Shared Savings Program refers to the legal name of the ACO as the "legal entity name" and the legal name of an ACO participant as the "legal business name" (LBN). Each ACO establishes its ACO Participant List during the application process. After multiple feedback cycles that include CMS feedback and ACO responses, an ACO must certify its ACO Participant List as accurate prior to the start of its participation agreement with CMS and annually thereafter before the start of the next performance year.

A currently participating ACO may submit change requests to modify its ACO Participant List, and these changes will become effective only at the start of the next performance year. During Phase 1 of the Shared Savings Program application submission period, an ACO, both applicants and currently participating, is able to add new ACO participants and/or update existing ACO participants (e.g., TIN LBN change).

An ACO may delete an ACO participant at any time, and the TIN is no longer considered an ACO participant as of the agreement termination date. Absent unusual circumstances, CMS does not make adjustments during the performance year to the ACO's assignment, historical benchmark, performance-year financial calculations, or the obligation of the ACO to report on behalf of eligible clinicians who bill under the TIN of an ACO participant for certain CMS quality initiatives to reflect the deletion of entities from the ACO Participant List that become effective during the performance year.

The accuracy of an ACO Participant List is critical to program operations, including but not limited to the following:

- Determining which beneficiaries will be assigned to the ACO (including determining whether the ACO has the required minimum of 5,000 assigned beneficiaries);
- Establishing the historical benchmark;
- Performing financial calculations that ultimately contribute to the generation of quarterly and annual program reports;
- Determining the providers and suppliers that will be considered part of the ACO;
- Vetting ACO participant and ACO provider/supplier enrollment in Medicare and conducting program integrity screenings, including any history of Medicare program exclusions or other sanctions;
- Coordinating among CMS quality initiatives;
- Determining an ACO's experience with performance-based risk Medicare ACO initiatives;
- Determining whether an ACO is "low revenue" or "high revenue;"
 - **Note:** CMS monitors for changes in revenue during the agreement period. ACOs participating under Level E of the BASIC track determined to be experienced with performance-based risk Medicare ACO initiatives at the start of their agreement period that become high revenue during the agreement period are required to take corrective action and if the issue is not remedied, the ACO may be terminated. Refer to [42 CFR § 425.600\(e\)](#).
- Identifying an ACO as "re-entering" based on prior participation of its ACO participants; and
- Determining changes to repayment mechanism amounts that may need to be updated during the ACO's agreement period.

[Figure 1](#) lists the information each ACO must gather and maintain regarding its ACO participants.

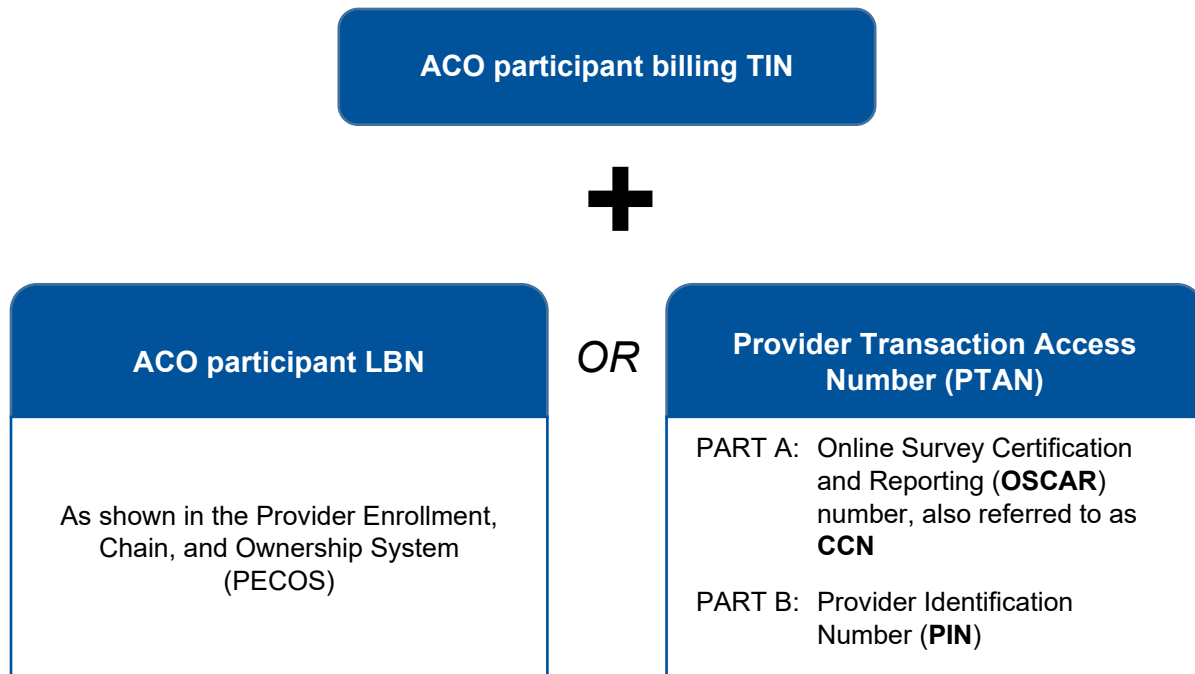


Figure 1. Required ACO Participant Information

The billing TINs submitted in the [ACO Management System](#) (ACO-MS) for an ACO Participant List, as well as individuals and entities that have reassigned their billing rights to TINs on the ACO Participant List (i.e., ACO providers/suppliers), will undergo a screening process that may be repeated periodically throughout the agreement period to ensure the ACO participants and ACO providers/suppliers continue to meet program requirements ([42 CFR § 425.305\(a\)](#)). The CMS screening process includes, at a minimum, the following:

- Updating Medicare-enrollment status periodically;
- Vetting program integrity history with CMS and law enforcement partners;
- Verifying LBNs;
- Ensuring the ACO participant does not participate in another Medicare shared savings initiative; and
- Determining whether the ACO participant participates in another Shared Savings Program ACO.

3.2 ACO PARTICIPANT LIST REQUIREMENTS

Each ACO is responsible for ensuring its ACO Participant List is accurate and includes only those entities that have agreed to participate in the Shared Savings Program as participants of the ACO ([42 CFR § 425.118](#)). Specifically, the ACO must:

- Certify the accuracy of its ACO Participant List prior to the start of an agreement period, before every performance year thereafter, and at such other times as specified by CMS in accordance with [42 CFR § 425.302\(a\)\(2\)](#).

- Certify the accuracy of its ACO Provider/Supplier List prior to the start of an agreement period, before every performance year thereafter, and at such other times as specified by CMS.
- Maintain and update, as necessary, its ACO Participant List within the time frames specified by CMS.
 - Notify CMS of any entities to be added to the ACO Participant List at such time and in the form and manner specified by CMS (refer to [Section 3.3](#) for additional information on adding ACO participants); and
 - Notify CMS of any entities to be deleted from the ACO Participant List by deleting the ACO participant from the ACO Participant List in ACO-MS no later than 30 days after the ACO Participant Agreement terminates (refer to [Section 3.3](#) for additional information for deleting and terminating ACO participants). Failure to comply with the requirement to timely delete an ACO Participant from the ACO Participant List may subject the ACO to compliance actions. Refer to 42 CFR §§ 425.118(b)(3)(ii) and [425.216](#).

3.2.1 SOLE PROPRIETOR ACO PARTICIPANTS

If an ACO participant is a sole proprietor that is enrolled in Medicare under its Social Security Number (SSN) and bills Medicare under a separate Employer Identification Number (EIN) that is linked to the SSN's enrollment, both the SSN and the EIN must be included on the ACO Participant List. It is the responsibility of the ACO to communicate with each of its ACO participants to understand how the ACO participant is enrolled in and billing Medicare. ACO participants should contact their respective Medicare Administrative Contractors (MACs) with any questions regarding their Medicare enrollment.

In ACO-MS, an ACO may provide the EIN used for billing as the ACO participant TIN, along with the LBN and/or PTAN attached to that EIN, in the change request. If the EIN and LBN/PTAN records match a PECOS record for a sole proprietor, the system will complete the change request. If, after submitting an EIN which passes the enrollment check and the LBN check, ACO-MS does not complete the change request, then ACO-MS has not identified the ACO participant as a sole proprietor. Thus, for the purpose of the ACO Participant List, the proposed ACO participant associated with this change request will not be identified as a sole proprietor.

Table 1. Sole Proprietor ACO Participants

Information Provided by ACO for ACO Participant Enrolled in Medicare Under SSN and Billing Medicare Under Linked EIN	ACO-MS Response
ACO submits a Medicare-enrolled SSN with the correct LBN or PTAN entered.	ACO-MS will auto-populate the billing EIN. Once the information for the EIN has been auto-populated, the ACO will not be able to delete either identifier from the change request.
ACO submits an EIN with the correct LBN or PTAN entered.	ACO-MS will auto-populate the Medicare-enrolled SSN. Once the information for the SSN has been auto-populated, the ACO will not be able to delete either identifier from the change request.
ACO submits an incorrect SSN or EIN. ACO submits an EIN or an SSN without the correct LBN or PTAN entered.	If CMS cannot verify two data points (EIN and LBN/PTAN or SSN and LBN/PTAN) in PECOS, ACO-MS cannot auto-populate information for either the SSN or the EIN. The change request will fail both the PECOS and LBN check and will not be identified as a sole proprietor. In addition, at the time of final disposition, the request to add the entity to the ACO Participant List will be denied if it is not Medicare-enrolled.
ACO submits an SSN with the correct LBN or PTAN entered, but ACO-MS does not auto-populate a billing EIN.	If ACO-MS cannot identify the SSN as a sole proprietor, ACO-MS will not auto-populate a separate, linked billing EIN. The ACO participant may not be a sole proprietor, but rather a sole owner of a practice (in which case only the billing EIN, not an SSN, is required). It is also possible the SSN is not enrolled in Medicare. ACOs should ensure that they understand how the ACO participant is enrolled in and billing Medicare, including if the ACO participant is identified as a sole proprietor in PECOS.

3.2.2 MERGED OR ACQUIRED ACO PARTICIPANT REQUIREMENTS

Under certain circumstances, per [42 CFR § 425.204\(g\)](#), CMS may allow the ACO to include ACO participants that come to participate in the ACO as a result of an acquisition or merger. Merged or acquired TINs may be included for purposes of meeting the minimum assigned beneficiary threshold and creating a more accurate historical benchmark and a preliminary prospective assignment list or prospective list of assigned beneficiaries for the upcoming performance year.

Under the following circumstances, CMS may take into account the claims billed under TINs of entities acquired through purchase or merger, for purposes of beneficiary assignment and the ACO's historical benchmark:

- The ACO participant must have subsumed the acquired entity's TIN in its entirety, including all the providers and suppliers that reassigned the right to receive Medicare payment to that acquired entity's TIN;
- All the providers and suppliers that previously reassigned the right to receive Medicare payment to the acquired entity's TIN must reassign that right to the TIN of the acquiring ACO participant and be added to the ACO Provider/Supplier List; and
- The acquired entity's TIN must no longer be used to bill Medicare.

[Table 2](#) lists the actions that an ACO can take to add a merged/acquired TIN to its ACO Participant List if the TIN meets certain criteria.

Table 2. ACO Participants with Merged/Acquired TINs

MERGED/ACQUIRED RELATIONSHIP	ACO ACTIONS TO TAKE IN ACO-MS
TIN A acquires TIN B. (Neither is a current ACO participant.)	<ul style="list-style-type: none"> ▪ ACO submits a change request to add TIN A. ACO should not mark TIN A as merged/acquired. ▪ ACO uploads an executed ACO Participant Agreement for TIN A. ▪ ACO submits a separate change request to add TIN B. In the change request, ACO selects "Yes" that TIN B was merged with/acquired by another TIN and enters TIN A's data in the appropriate subfields. ACO uploads the appropriate merged/acquired supporting documentation (refer to Section 3.2.3) for TIN B.
TIN C acquires TIN D. (Both TIN C and TIN D are currently approved ACO participants.)	<ul style="list-style-type: none"> ▪ ACO should not make any changes to TIN C. ▪ ACO deletes TIN D from its ACO Participant List (the existing record for the TIN remains on the ACO's Participant List for the remainder of the current performance year but will not be included in the next performance year). ▪ ACO submits a change request to add TIN D (for the next performance year). In the change request, ACO selects "Yes" that TIN D was merged with/acquired by another TIN and enters TIN C's data in the appropriate subfields. ▪ ACO submits the appropriate merged/acquired supporting documentation (refer to Section 3.2.3) for TIN D.
TIN E acquires TIN F. (TIN E is a current ACO participant, however, TIN F is not a current ACO participant.)	<ul style="list-style-type: none"> ▪ ACO submits a change request to add TIN F. In the change request, ACO selects "Yes" that TIN F was merged with/acquired by another TIN and enters TIN E's data in the appropriate subfields. ▪ ACO submits the appropriate merged/acquired supporting documentation (refer to Section 3.2.3) for TIN F.

<p>TIN G acquires TIN H. (TIN H is a current ACO participant, however, TIN G is not a current ACO participant.)</p>	<ul style="list-style-type: none"> ▪ ACO submits a change request to add TIN G. ACO should not mark TIN G as merged/acquired. ▪ ACO uploads an executed ACO Participant Agreement for TIN G. ▪ ACO deletes TIN H from its ACO Participant List (the existing record for the TIN remains on the ACO's Participant List for the remainder of the current performance year but will not be included in the next performance year). ▪ ACO submits a change request to add TIN H (for the next performance year). In the change request, ACO selects "Yes" that TIN H was merged with/acquired by another TIN and enters TIN G's data in the appropriate subfields. ▪ ACO submits the appropriate merged/acquired supporting documentation (refer to Section 3.2.3) for TIN H.
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3.2.3 MERGED OR ACQUIRED TIN DOCUMENTATION

An ACO submitting an ACO participant that has merged with or been acquired by another TIN must also include an attestation stating that all providers and suppliers that previously billed under the acquired TIN have reassigned their billings to the acquiring ACO participant TIN and have been added to the ACO Provider/Supplier List, and that the acquired entity's TIN is no longer used to bill Medicare. In addition, the attestation must identify which ACO participant acquired the TIN.

In addition to the required attestation, an ACO must submit supporting documentation demonstrating that the TIN was acquired by the acquiring ACO participant through a sale or merger (e.g., a bill of sale, joinder agreement, or other legal document).

3.3 ACO PARTICIPANT LIST CHANGES

An ACO is required to maintain and update, as necessary, its ACO Participant List. ACO Participant List changes must be submitted electronically in ACO-MS. An ACO may request to add an entity to its ACO Participant List during Phase 1 of the application submission period in accordance with the CMS-established schedule for submitting change requests. Upon entering a TIN and its corresponding LBN (as registered in PECOS) or PTAN in ACO-MS, the ACO will be notified immediately of the TIN's current Medicare enrollment status. Please note the Medicare enrollment status of the TIN may change during the change request review cycle (e.g., the TIN could be Medicare enrolled at the time the ACO submits the TIN but then comes disenrolled at a later time during the change request cycle). A TIN must be enrolled in Medicare as of the final PECOS check conducted by CMS.

If CMS approves the change request, the ACO participant is added to the ACO Participant List effective January 1st of the upcoming performance year. An ACO may delete an entity from its ACO Participant List during the performance year, but all ACO participants deleted after the final deadline to delete ACO participants during the

Phase 1 application submission period for the upcoming performance year will appear on the ACO's Participant List for all of the upcoming performance year for purposes related to ACO's assignment, historical benchmark, performance year financial calculations, quality reporting sample, or the obligation of the ACO to report on behalf of eligible clinicians who bill under the TIN of an ACO participant for certain CMS quality initiatives.

• **IMPORTANT**

Any change to the digit(s) of a required identifier TIN is considered a request to add a new entity to the ACO Participant List and is not permitted after the final deadline established by CMS to add ACO participants. For example, if an ACO submits a change request to its ACO Participant List and a required identifier is submitted incorrectly (e.g., the digits of the TIN are typed incorrectly), the error can only be corrected by submitting a new change request. ACOs should ensure that all information submitted for ACO Participant List changes is correct.

3.3.1 INITIAL AND RENEWAL/EARLY RENEWAL APPLICANTS

CMS is required to review ACO participants for all ACOs adding ACO participants to their ACO Participant List. As part of this review, CMS may require an ACO to correct or update the information on the ACO Participant List submitted as part of its application. CMS will provide the ACO with request for information (RFI) notifications. The RFIs will summarize CMS' review of submitted application information, including feedback on ACO participant submissions. An ACO may receive multiple RFIs during the application process. It is important that the ACO carefully review any RFIs, as there are limited opportunities to correct CMS-identified deficiencies.

Whether an ACO is an initial or a renewal/early renewal applicant, it must adhere to the deadlines listed in the Application Timeline on the Shared Savings Program [Application Types & Timeline webpage](#). Please note that while application deadlines are subject to change, CMS will not accept late submissions.

3.3.2 CURRENTLY PARTICIPATING ACOs (MID-AGREEMENT PERIOD)

An ACO that is not in the last performance year of its agreement period and not applying to renew or early renew may make changes to its ACO Participant List during Phase 1 of the application submission period. CMS reviews change requests during an established review cycle in advance of the upcoming performance year that includes CMS feedback and the opportunity for the ACO to correct deficiencies. The review cycle includes opportunities for ACOs to submit change requests for CMS review, feedback, and disposition.

3.3.3 ACO PARTICIPANT LEGAL BUSINESS NAME CHANGES

If an ACO participant changes its LBN for any reason, a currently participating ACO must update the relevant ACO Participant Agreement to reflect the new LBN. This procedure is necessary to ensure the accuracy of the relevant ACO Participant

Agreement. This document should be maintained internally and available for CMS review upon request. The updated ACO Participant Agreement should be submitted at the time of renewal if the ACO plans to carry the ACO participant forward into the next performance year. If the submission of the change request to carry forward the ACO participant generates a TIN-LBN-mismatch deficiency due to the ACO participant LBN entered in the change request not matching the LBN of the TIN as it appears in PECOS, the ACO will have the opportunity to update the LBN in the change request during the Phase 1 RFI response periods.

3.4 IMPACT OF ACO PARTICIPANT LIST CHANGES ON PROGRAM OPERATIONS

This section describes how changes to an ACO Participant List impact critical downstream program operations. Absent unusual circumstances, CMS does not make adjustments during the performance year to the certified ACO participant list and will continue to utilize the data for certain operational purposes.

3.4.1 HOW CHANGES IN ACO PARTICIPANTS AFFECT DATA SHARING

CMS provides beneficiary identifiable claims data through Claim and Claim Line Feed (CCLF) files. CMS does not share this data for any beneficiaries who have declined sharing their claims data. For ACOs that have selected the prospective assignment methodology, the CCLF files contain claims data for beneficiaries who appear on the prospective assignment list. For ACOs that have selected the preliminary prospective with retrospective reconciliation assignment methodology, the CCLF files contain data for assignable or voluntarily aligned beneficiaries, as defined below.

Assignable beneficiaries are those who have received at least one primary care service billed by an ACO participant upon whom assignment is based during the most recent 12-month period. CMS will use the ACO's certified ACO Participant List to determine which assignable beneficiaries will be included in the CCLF files. Refer to the current version of the Shared Savings and Losses and Assignment Methodology Specifications, available on the [Program Guidance & Specifications webpage](#), for additional information on assignable beneficiaries.

For example, if an ACO certifies an ACO Participant List for Performance Year (PY) 1 with three ACO participants and deletes an ACO participant with a termination effective date at the end of PY 1, that ACO participant will not appear on the PY 2 ACO Participant List. In this example, any beneficiary who does not appear on the preliminary prospective assignment list for the ACO and did not receive a primary care service from one of the remaining two ACO participants during the assignment window will be excluded from that ACO's PY 2 CCLF files.

3.4.2 HOW CHANGES IN ACO PARTICIPANTS AFFECT QUALITY REPORTING

The Shared Savings Program has aligned quality measures and quality reporting with other CMS quality initiatives, including the Quality Payment Program. For purposes of determining the eligible clinicians on whose behalf the ACO is responsible for reporting, CMS uses the ACO Participant List that the ACO certified before the start of the applicable performance year. Resources are available on the [Quality Payment Program \(QPP\) website](#) that describe the interactions between the Shared Savings Program and the QPP.

As noted previously, ACO Participant List changes submitted during a given performance year do not change the eligible clinicians on whose behalf the ACO is responsible for reporting.

3.4.3 HOW CHANGES IN ACO PARTICIPANTS AFFECT BENCHMARKING

Historical benchmarks are established at the start of an ACO's agreement period using the ACO's certified ACO Participant List to derive the assigned beneficiary population. For more information on the historical benchmark, refer to the current version of the Shared Savings and Losses and Assignment Methodology Specifications available on the [Program Guidance & Specifications webpage](#).

CMS will adjust an ACO's historical benchmark at the start of a performance year to reflect changes to the ACO's certified Participant List made since the start of the previous performance year (42 CFR § 425.118(b)(3)(i)). The ACO's updated certified ACO Participant List is used to assign beneficiaries to the ACO for the benchmark period (the 3 years prior to the start of the ACO's agreement period) in order to determine the ACO's adjusted historical benchmark. The historical benchmark may be adjusted upward or downward since it is a function of the assigned beneficiary population derived from the ACO's newly constructed ACO Participant List.

3.4.4 HOW CHANGES IN ACO PARTICIPANTS AFFECT PROGRAM ELIGIBILITY

ACO Participant List changes may impact an ACO's compliance with Shared Savings Program eligibility requirements in [42 CFR part 425, subpart B](#). These include, but are not limited to, the following examples:

- **ACO participants must hold at least 75 percent control of the ACO's governing body;** additions to or deletions from the ACO Participant List may affect compliance with this requirement.
- **An ACO's clinical management and oversight must be managed by a senior-level Medical Director** who is a board-certified physician licensed in a state in which the ACO operates and is physically present on a regular basis at a clinic,

office, or other location of the ACO, an ACO participant, or an ACO provider/supplier. Additions to or deletions from the ACO Participant List may affect compliance with this requirement.

- For example, if the ACO's Medical Director is physically present on a regular basis at the location of a single ACO participant and that ACO participant is removed from the ACO Participant List, the ACO would need to identify a new Medical Director who meets requirements or the current Medical Director would have to be physically present on a regular basis at the location of another current ACO participant.
- **When the ACO adds ACO participants**, these new ACO participants and their affiliated providers and suppliers must demonstrate a meaningful commitment to the mission of the ACO to ensure its likely success.
 - For example, 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 [42 CFR § 425.112](#) and is held accountable for meeting the ACO's performance standards for each required process.
- **When the ACO removes ACO participants**, the ACO may fall below the requirement to maintain at least 5,000 assigned beneficiaries during the performance year and be subject to compliance action.
- **An ACO's repayment mechanism amount may need to be updated** to reflect the addition or deletion of ACO participants during an agreement period.

If any changes to an ACO Participant List are determined to cause the ACO to become noncompliant with program eligibility requirements regarding the composition and control of the governing body, the ACO should contact its ACO coordinator. The ACO may be issued a compliance action and asked to submit a narrative for review describing why it seeks to deviate from certain requirements and how it will continue to meet the goals and objectives of the Shared Savings Program.

4 Managing Changes to the ACO Provider/Supplier List

CMS uses an ACO Participant List to generate the ACO's Provider/Supplier List. Annually, CMS will provide each ACO with all of the providers/suppliers that have reassigned their billing rights to the TINs on their ACO Participant List. As with its ACO Participant List, each ACO must certify its CMS-generated ACO Provider/Supplier List prior to the start of every performance year and at such other times as specified by CMS. The initial ACO Provider/Supplier List provided by CMS reflects PECOS reassignments from a single point in time; therefore, [ACO-MS](#) provides ACOs the functionality to electronically add or delete providers/suppliers from the initial list provided by CMS prior to the beginning of the performance year.

Thereafter, each ACO is required to notify CMS within 30 days of a change to its ACO Provider/Supplier List. An example of a change would be if a provider or supplier is no longer Medicare-enrolled. The ACO must notify CMS no later than 30 days after the provider or supplier ceases to be Medicare-enrolled.

**REMINDER**

Updates to the ACO Provider/Supplier List in ACO-MS will not be reflected in PECOS. If the ACO participant wishes to update PECOS information, it must follow PECOS instructions.

An ACO may need to add a provider or supplier that has reassigned its billing to the TIN of an ACO participant after the ACO certified its ACO Provider/Supplier List. The ACO must notify CMS within 30 days after the provider or supplier reassigns its billing to the TIN of an ACO participant. An ACO that needs to make a change to its certified ACO Provider/Supplier List must notify CMS by making changes to the ACO Provider/Supplier List directly in ACO-MS. ACO entries in ACO-MS do not modify PECOS. Modifying ACO providers/suppliers in ACO-MS does not impact beneficiary assignment or Medicare FFS billing rules.

If an ACO submits timely notice to CMS, the addition of an individual or entity to the ACO Provider/Supplier List is effective on the date specified in the notice furnished to CMS, but no earlier than 30 days before the date of the notice. If the ACO fails to submit timely notice to CMS, the addition of an individual or entity to the ACO Provider/Supplier List is effective on the date of the notice. The deletion of an individual or entity from the ACO Provider/Supplier List is effective on the date the individual or entity ceased to be a Medicare-enrolled provider or supplier that bills for items and services it furnishes to Medicare FFS beneficiaries under a billing number assigned to the TIN of an ACO participant.

CMS is aware that there are certain types of practitioners who complete the Opt-Out Affidavit. Physicians and practitioners who have opted out of Medicare do not enroll in Medicare, and neither the physician/practitioner nor the beneficiary submits the bill to Medicare for services rendered. Therefore, a physician or practitioner who has opted out of Medicare would not meet the definition of an ACO professional or ACO provider/supplier. If such a physician or practitioner opts out of Medicare after he or she had been identified on an ACO Provider/Supplier List, the ACO must remove the individual from the list. For more information on opting out, please refer to the [Opt-Out Affidavits webpage](#).

5 ACO Participant Agreements

This section provides information on ACO Participant Agreement requirements.

5.1 INTRODUCTION TO ACO PARTICIPANT AGREEMENTS

CMS requires each ACO to execute contractual agreements with each of its ACO participants—that have not merged with or been acquired by another ACO participant—

to ensure that the requirements and expectations of participation in the Shared Savings Program are clearly articulated, understood, and agreed upon.

An ACO may not include an ACO participant on its ACO Participant List unless an authorized individual of the ACO participant has signed an ACO Participant Agreement with the ACO. The ACO must submit supporting documentation demonstrating that an agreement is in place between the ACO and each of its ACO participants as part of its change request to add the ACO participant. Supporting documentation includes the first page and signature page of the executed ACO Participant Agreement or, for a merged/acquired ACO participant, refer to [Section 3.2.3](#) for the requirements for supporting documentation. CMS does not provide a boilerplate agreement for the ACO. CMS does not require that ACOs upload and submit sample ACO Participant Agreements as part of an initial or renewal application. CMS is authorized to review all ACO Participant Agreements, including executed and sample ACO Participant Agreements, as a part of any compliance monitoring activities.

The ACO is instructed to complete the attestation within the application indicating that the ACO:

- Has addressed all regulatory requirements in the ACO Participant Agreement(s);
- Understands CMS may review all ACO Participant Agreement(s) to determine compliance; and
- Understands that if the ACO's ACO Participant Agreement(s) do not meet regulatory requirements, they must be updated or the ACO may be subject to compliance actions.

The final executed ACO Participant Agreement that the ACO secures with its ACO participants must be consistent with the ACO's sample ACO Participant Agreement. The ACO must provide an executed ACO Participant Agreement when seeking to add a new ACO participant, or when a change to an approved ACO participant occurs—such as an LBN change—if the agreement itself is impacted. Executed ACO Participant Agreements must be uploaded following the same schedule for ACO Participant List change requests.

5.2 ACO PARTICIPANT AGREEMENT REQUIREMENTS

In addition to the requirements detailed in [Section 5.1](#), each ACO must submit with its application an executed ACO Participant Agreement (first page and signature page) for each of its ACO participants that complies with the requirements of 42 CFR § 425.116(a). An ACO can submit documentation of this agreement in the form of a newly executed ACO Participant Agreement that includes either a digital signature ([Appendix C](#)) or a “wet signature,” and a signature date. A wet signature is a handwritten signature (i.e., not stamped).

Renewal/early renewal applicants entering into a new Shared Savings Program agreement period are not required to submit a newly executed ACO Participant Agreement for any ACO participants the ACO wishes to carry over into the new agreement period, provided that the current agreement meets the Shared Savings Program requirements under 42 CFR § 425.116. When renewal/early renewal applicants select an ACO participant the ACO wishes to carry over into the new agreement period, the ACO will have the option in the change request generated by ACO-MS to either submit a newly executed ACO Participant Agreement or to have ACO-MS carry forward the previously submitted executed ACO Participant Agreement associated with the ACO participant.

All ACO Participant Agreements (for currently participating ACOs, initial applicants, and renewal/early renewal applicants) must meet all Shared Savings Program requirements under the regulations, as described in Section 5.3.

5.3 SAMPLE ACO PARTICIPANT AGREEMENT REQUIREMENTS

CMS recommends that ACO Participant Agreements explicitly address how participation in the ACO may impact the ACO participants. The ACO is also expected to confirm the accuracy of the following information with respect to its ACO Participant Agreements:

- The ACO legal entity name matches the name in [ACO-MS](#);
- The ACO participant LBN matches the LBN in PECOS;
- The ACO participant TIN matches the TIN listed for the entity in PECOS; and
- The ACO participant TIN is correctly entered into the change request and it is correctly presented on the Participant Agreement, if included.

CMS does not require that ACOs upload and submit sample ACO Participant Agreements as part of an initial or renewal application. Please review example introductory paragraphs and signature pages for ACO Participant Agreements and amendments in [Appendix A](#) and [Appendix B](#). CMS strongly encourages each ACO to include the information indicated in the format referenced in these examples.

5.3.1 EXECUTED ACO PARTICIPANT AGREEMENT REQUIREMENTS

Each executed ACO Participant Agreement must be consistent with the sample ACO Participant Agreement and include a signature page that is signed by individuals who have the legal authority to bind the ACO and the ACO participant (e.g., the ACO Executive or Authorized to Sign contacts in [ACO-MS](#)). The first page and signature page must reflect correct legal name information for the ACO and the ACO participant.

CMS must receive a copy of each fully executed agreement (first page and signature page) and any amendments (if applicable). A fully executed agreement or amendment

is one that includes digital or handwritten signatures for both the ACO and the ACO participant. CMS may request complete, original, wet signature executed agreements.

Appendix A: Example ACO Participant Agreement Language

Sample Introductory Paragraph:

This ACO Participant Agreement (“**Agreement**”) is by and between Accountable Care Organization of ABC, LLC D/B/A ABC ACO (“**ACO**”), and XYZ Group Practice P.C. (“**ACO Participant**”) and is effective [Month, Day, Year] (“**Effective Date**”).

<Body of Agreement>

Sample Signature Page:

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the dates below.

<u>For the ACO</u>	<u>For the ACO Participant</u>
_____	_____
Legal Entity Name	Legal Business Name
_____	_____
DBA Name (if applicable)	DBA Name (if applicable)
_____	_____
Authorized Signatory	Authorized Signatory
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Date	Date
_____	_____
Address	Address
_____	_____
City, State ZIP Code	City, State ZIP Code
_____	_____
Business Phone	Business Phone

Appendix B: Example ACO Participant Agreement Amendment Language

Sample Introductory Paragraph:

This Amendment to ACO Participant Agreement (“**Amendment**”) by and between Accountable Care Organization of ABC, LLC D/B/A ABC ACO (“**ACO**”), and XYZ Group Practice P.C. (“**ACO Participant**”) is effective [Month, Day, Year] (“**Effective Date**”).

WHEREAS, the **ACO** and **ACO participant** entered into an ACO Participant Agreement on or about [Month, Day, Year] (the “Agreement”); and both parties wish to amend the Agreement to [insert purpose of amendment].

NOW, THEREFORE, in reliance on the mutual agreements contained herein, the parties agree as follows:

[Enumerate and describe the various amendments]

Sample Signature Page:

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives as of the dates below.

<u>For the ACO</u>	<u>For the ACO Participant</u>
_____	_____
Legal Entity Name	Legal Business Name
_____	_____
DBA Name	DBA Name
_____	_____
Authorized Signatory	Authorized Signatory
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Date	Date
_____	_____
Address	Address
_____	_____
City, State ZIP Code	City, State ZIP Code
_____	_____
Business Phone	Business Phone

Appendix C: Information on Digital Signature Requirements

General Overview of Digital Signatures

If an ACO and ACO participant both consent to the use of digital signatures to execute an ACO Participant Agreement, they must use industry-accepted software to verify that the digital signatures represent the signers' consent to the terms of the agreement. Generally, a digital signature requires two components: the signature generation process (i.e., when a signer embeds a unique signature in the electronic document, thus legally executing the document), and the signature verification process (i.e., the mechanism by which an auditing party is able to verify the signature's authenticity).

ACOs should maintain all physical and/or electronic records necessary to verify each digital signature that they submit for CMS review and provide these records to the Shared Savings Program upon request.

Digital Signature Programs

The Shared Savings Program does not require the use of any particular software product to execute an ACO Participant Agreement, and any software that employs digital signature algorithms and that fulfills the two requirements—signature generation and signature verification—may be employed. Should CMS question the integrity of the software used, it may send the ACO an RFI. Should an ACO receive an RFI, it should provide CMS with documented evidence of the verification process for the signature in question.

Regulation of Digital Signatures

The [Electronic Signatures in Global and National Commerce Act \(E-Sign Act\)](#), which was enacted on June 30, 2000, promotes the use of electronic contract formation, signatures, and recordkeeping in private commerce by establishing legal equivalence between paper and electronic contracts; pen and ink signatures and electronic signatures; and other legally required written documents (termed “records”) and their electronic equivalents.

Additional Questions

Q1. What is the difference between a digital signature and an electronic signature?

Per Section 106 of the E-Sign Act, an electronic signature is defined as “an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record.” A digital signature consists of both the electronic signature itself and the verification process used to authenticate it. Digital signatures require the signer to use a digital certificate that links the signer with the document being

signed, and a unique digital “fingerprint” is embedded in the document once signed. An electronic signature that lacks an authentication verification process will not be accepted. Any non-handwritten signature must be verifiable according to industry standards.

Q2. Do both parties to the Agreement have to use digital signatures to sign the ACO Participant Agreement?

No. So long as both parties agree that a digital signature has the full force and effect of a handwritten signature, one party may use a digital signature while the other uses a handwritten signature.

However, if only one party will be executing the document by a handwritten signature, then that party must sign the document first. The remaining party should then scan in the signed document and embed their digital signature upon that scanned document. Printing out a document that contains a digital signature hinders validation of the encryption required for authentication in this format.

Q3. What if a party needs to amend or change an agreement that was executed with digital signatures?

Should an agreement containing a digital signature need to be amended, it must be re-executed with a new digital signature to indicate consent to the changes.

Q4. Can CMS recommend any digital signature programs for ACOs to use in executing agreements with ACO participants?

The E-Sign Act does not permit agencies to require the use of specific products and/or manufacturers. Therefore, CMS cannot recommend any specific products or companies. However, in choosing a digital signature program, an ACO should review the E-Sign Act requirements and focus on the particular product’s signature generation and verification capabilities.