

§ 425.308

42 CFR Ch. IV (10–1–23 Edition)

(2) Each ACO participant that submits claims for services used to determine the ACO's assigned population under subpart E of this part must be exclusive to one Shared Savings Program ACO. If, during a benchmark or performance year (including the 3-month claims runout for such benchmark or performance year), an ACO participant that participates in more than one ACO submits claims for services used in assignment under subpart E of this part, then:

(i) CMS will not consider any services billed through the TIN of the ACO participant when performing assignment under subpart E of this part for the benchmark or performance year.

(ii) The ACO may be subject to the pre-termination actions set forth in § 425.216, termination under § 425.218, or both.

[80 FR 32840, June 9, 2015, as amended at 82 FR 53369, Nov. 15, 2017]

§ 425.308 Public reporting and transparency.

(a) *ACO public reporting Web page.* Each ACO must create and maintain a dedicated Web page on which it publicly reports the information set forth in paragraph (b) of this section. The ACO must report the address of such Web page to CMS in a form and manner specified by CMS and must notify CMS of changes to the web address in the form and manner specified by CMS.

(b) *Information to be reported.* The ACO must publicly report the following information in a standardized format specified by CMS:

- (1) Name and location.
- (2) Primary contact.
- (3) Organizational information, including all of the following:
 - (i) Identification of ACO participants.
 - (ii) Identification of participants in joint ventures between ACO professionals and hospitals.
 - (iii) Identification of the members of its governing body.
 - (iv) Identification of key clinical and administrative leadership.
 - (v) Identification of associated committees and committee leadership.
 - (vi) Identification of the types of ACO participants or combinations of

ACO participants (as listed in § 425.102(a)) that formed the ACO.

(4) Shared savings and losses information, including the following:

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

(ii) 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.

(5) The ACO's performance on all quality measures.

(6) Use of payment rule waivers under § 425.612, if applicable, or telehealth services under § 425.613, if applicable, or both.

(7) Information about a beneficiary incentive program established under § 425.304(c), if applicable, including the following, for each performance year:

(i) Total number of beneficiaries who received an incentive payment.

(ii) Total number of incentive payments furnished.

(iii) HCPCS codes associated with any qualifying service for which an incentive payment was furnished.

(iv) Total value of all incentive payments furnished.

(v) Total of each type of incentive payment (for example, check or debit card) furnished.

(8) Information, updated annually about the ACO's use of advance investment payments under § 425.630, for each performance year, including the following:

(i) The ACO's spend plan.

(ii) The total amount of any advance investment payments received from CMS.

(iii) An itemization of how advance investment payments were spent during the year, including expenditure categories, the dollar amounts spent on the various categories, any changes to the spend plan submitted under § 425.630(d), and such other information as may be specified by CMS.

(c) *Approval of public reporting information.* Information reported on an ACO's public reporting Web page in compliance with the requirements of

the standardized format specified by CMS is not subject to marketing review and approval under § 425.310.

(d) *Public reporting by CMS.* CMS may publicly report ACO-specific information, including but not limited to the ACO public reporting Web page address and the information required to be publicly reported under paragraph (b) of this section.

[80 FR 32840, June 9, 2015, as amended at 83 FR 68068, Dec. 31, 2018; 87 FR 70232, Nov. 18, 2022]

§ 425.310 Marketing requirements.

(a) *Requirements.* Marketing materials and activities must:

(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 regarding beneficiary incentives.

(4) Not be materially inaccurate or misleading.

(b) *Monitoring.* (1) CMS may request the submission of marketing materials and activities at any time. If CMS determines that the marketing materials and activities do not comply with the requirements of paragraph (a) of this section, CMS will issue written notice of disapproval to the ACO.

(2) The ACO shall discontinue, and require its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to discontinue, use of any marketing materials or activities disapproved by CMS.

(c) *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.

[87 FR 70233, Nov. 18, 2022]

§ 425.312 Beneficiary notifications.

(a) *Notifications to fee-for-service beneficiaries.* (1) An ACO shall ensure that Medicare fee-for-service beneficiaries are notified about all of the following in the manner set forth in paragraph (a)(2) of this section:

(i) That each ACO participant and its ACO providers/suppliers are participating in the Shared Savings Program.

(ii) The beneficiary's opportunity to decline claims data sharing under § 425.708.

(iii) Beginning July 1, 2019, the beneficiary's ability to, and the process by which, he or she may identify or change identification of the individual he or she designated for purposes of voluntary alignment (as described in § 425.402(e)).

(2) Notification of the information specified in paragraph (a)(1) of this section must be carried out through the following methods:

(i) By an ACO participant posting signs in all of its facilities.

(ii) By an ACO participant making standardized written notices available upon request in all settings in which beneficiaries receive primary care services.

(iii) In the case of an ACO that has selected preliminary prospective assignment with retrospective reconciliation, by the ACO or ACO participant providing each fee-for-service beneficiary with a standardized written notice at least once during an agreement period in the form and manner specified by CMS. The standardized written notice must be furnished to all fee-for-service beneficiaries prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant.

(iv) In the case of an ACO that has selected prospective assignment, by the ACO or ACO participant providing each prospectively assigned beneficiary with a standardized written notice at least once during an agreement period in the form and manner specified by CMS. The standardized written notice must be furnished during the performance year for which the beneficiary is prospectively assigned to the ACO.

(v) Following the provision of the standardized written notice to a beneficiary, as specified in paragraphs (a)(2)(iii) and (iv) of this section, the ACO or ACO participant must provide a verbal or written follow-up communication to the beneficiary.

(A) The follow-up communication must occur no later than the earlier of the beneficiary's next primary care service visit or 180 days from the date