

as inducements for influencing a Medicare beneficiary's decision to designate or not to designate an ACO professional under paragraph (e) of this section. The ACO, ACO participants, ACO providers/suppliers, ACO professionals, and other individuals or entities performing functions and services related to ACO activities must not, directly or indirectly, commit any act or omission, nor adopt any policy that coerces or otherwise influences a Medicare beneficiary's decision to designate or not to designate an ACO professional as responsible for coordinating their overall care under paragraph (e) of this section, including but not limited to the following:

(i) Offering anything of value to the Medicare beneficiary as an inducement to influence the Medicare beneficiary's decision to designate or not to designate an ACO professional as responsible for coordinating their overall care under paragraph (e) of this section. Any items or services provided in violation of paragraph (e)(3) of this section are not considered to have a reasonable connection to the medical care of the beneficiary, as required under § 425.304(b)(1).

(ii) Withholding or threatening to withhold medical services or limiting or threatening to limit access to care.

(f) For performance year 2023 and subsequent performance years, CMS employs the following process to identify services furnished by FQHCs, RHCs, Method II CAHs, and ETA hospitals for purposes of the beneficiary assignment methodology under this section.

(1) Prior to the start of the performance year and periodically during the performance year, CMS will determine the CCNs for all FQHCs, RHCs, Method II CAHs, and ETA hospitals enrolled under the TIN of an ACO participant, including all CCNs with an active enrollment in Medicare and all CCNs with a deactivated enrollment status.

(2) CMS uses the CCNs identified in paragraph (f)(1) of this section in determining assignment for the performance year.

(3) CMS accounts for changes in CCN enrollment status during the performance year as follows:

(i) If a CCN with no prior Medicare claims experience enrolls under the TIN of an ACO participant after the ACO certifies its ACO participant list for a performance year as required under § 425.118(a)(3), CMS will consider services furnished by that CCN in determining beneficiary assignment to the ACO for the applicable performance year for ACOs under preliminary prospective assignment with retrospective reconciliation.

(ii) Services furnished by a CCN with a deactivated enrollment status that is enrolled under an ACO participant at the start of a performance year will be considered in determining beneficiary assignment to the ACO for the applicable performance year or benchmark year.

(iii) If a CCN enrolled under the TIN of an ACO participant at the start of the performance year enrolls under a different TIN during a performance year, CMS will continue to treat services billed by the CCN as services furnished by the ACO participant it was enrolled under at the start of the performance year for purposes of determining beneficiary assignment to the ACO for the applicable performance year.

[76 FR 67973, Nov. 2, 2011, as amended at 80 FR 32841, June 9, 2015; 80 FR 71386, Nov. 16, 2015; 81 FR 80559, Nov. 15, 2016; 83 FR 60093, Nov. 23, 2018; 83 FR 68069, Dec. 31, 2018; 87 FR 70234, Nov. 18, 2022]

#### **§ 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 special conditions:

(a) For performance years 2012 through 2018—

(1) 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.

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

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(i) If the claim includes a HCPCS or revenue center code that meets the definition of primary care services under § 425.20;

(ii) Performed by a primary care physician if the NPI of a physician identified in the attestation provided under paragraph (a)(1) of this section is reported on the claim for a primary care service (as described in paragraph (a)(2)(i) of this section) as the attending provider; and

(iii) Performed by a non-physician ACO professional if the NPI reported on the claim for a primary care service (as described in paragraph (a)(2)(i) of this section) as the attending provider is an ACO professional but is not identified in the attestation provided under paragraph (a)(1) of this section.

(b) For performance years starting on January 1, 2019, and subsequent performance years, under the assignment methodology in § 425.402, CMS treats a service reported on an FQHC/RHC claim as a primary care service performed by a primary care physician.

[76 FR 67973, Nov. 2, 2011, as amended at 80 FR 32841, June 9, 2015; 82 FR 53369, Nov. 15, 2017; 83 FR 60093, Nov. 23, 2018]

### Subpart F—Quality Performance Standards and Reporting

#### § 425.500 Measures to assess the quality of care furnished by an ACO for performance years (or a performance period) beginning on or before January 1, 2020.

(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.*

(1) For performance years (or a performance period) beginning in 2014 through 2019, ACOs must select a CMS-certified vendor to administer the survey and report the results accordingly.

(2) For performance year 2020, CMS waives the CAHPS for ACOs reporting requirement and will assign all ACOs automatic credit for the CAHPS for ACOs survey measures.

(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) If, at the conclusion of the audit process the overall audit match rate between the quality data reported and the medical records provided under paragraph (e)(1) of this section is less than 80 percent, absent unusual circumstances, CMS will adjust the ACO's overall quality score proportional to the ACO's audit performance.

(3) If, at the conclusion of the audit process CMS determines there is an audit match rate of less than 90 percent, the ACO may be required to submit a CAP under § 425.216 for CMS approval.

(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.

[76 FR 67973, Nov. 2, 2011, as amended at 81 FR 80559, Nov. 15, 2016; 82 FR 53370, Nov. 15, 2017; 85 FR 85040, Dec. 28, 2020]

EDITORIAL NOTE: At 82 FR 53370, Nov. 15, 2017, § 425.500 was amended; however, a portion of the amendment could not be incorporated due to inaccurate amendatory instruction.