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(e) For 2017 and 2018, CMS will annually assess the degree of use of certified EHR technology by eligible clinicians billing through the TINs of ACO participants for purposes of meeting the CEHRT criterion necessary for Advanced Alternative Payment Models under the Quality Payment Program.

(1) During years in which the measure is designated as pay for reporting, in order to demonstrate complete and accurate reporting, at least one eligible clinician billing through the TIN of an ACO participant must meet the reporting requirements under the Advancing Clinical Information category under the Quality Payment Program.

(2) During years in which the measure is designated as pay for performance, the quality measure regarding EHR adoption will be measured based on a sliding scale.

(f) For performance years starting on January 1, 2019, and subsequent performance years, ACOs in a track that—

(1) Does not meet the financial risk standard to be an Advanced APM must certify annually that the percentage of eligible clinicians participating in the ACO that use CEHRT to document and communicate clinical care to their patients or other health care providers meets or exceeds 50 percent; or

(2) Meets the financial risk standard to be an Advanced APM must certify annually that the percentage of eligible clinicians participating in the ACO that use CEHRT to document and communicate clinical care to their patients or other health care providers meets or exceeds the threshold established under § 414.1415(a)(1)(i) of this chapter.

[76 FR 67973, Nov. 2, 2011, as amended at 79 FR 68009, Nov. 13, 2014; 81 FR 80560, Nov. 15, 2016; 83 FR 60094, Nov. 23, 2018]

§ 425.508 Incorporating quality reporting requirements related to the Quality Payment Program.

(a) *For performance years (or a performance period) beginning in 2017–2020.* ACOs, on behalf of eligible clinicians who bill under the TIN of an ACO participant, must submit all of the CMS web interface measures determined under § 425.500 to satisfactorily report on behalf of their eligible clinicians for purposes of the quality performance

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category of the Quality Payment Program.

(b) *For performance years beginning on or after January 1, 2021.* ACOs must submit the quality data via the Alternative Payment Model Performance Pathway (APP) established under § 414.1367 of this chapter, to satisfactorily report on behalf of the eligible clinicians who bill under the TIN of an ACO participant for purposes of the MIPS Quality performance category of the Quality Payment Program.

[81 FR 80561, Nov. 15, 2016, as amended at 85 FR 85040, Dec. 28, 2020]

§ 425.510 Application of the Alternative Payment Model Performance Pathway (APP) to Shared Savings Program ACOs for performance years beginning on or after January 1, 2021.

(a) *General.* (1) 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 to receive shared savings.

(2) CMS seeks to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both.

(b) *Quality reporting.* ACOs must report quality data via the APP established under § 414.1367 of this chapter, according to the method of submission established by CMS.

(c) *Audit and validation of data.* CMS retains the right to audit and validate quality data reported by an ACO under paragraph (b) of this section according to § 414.1390 of this chapter.

[85 FR 85041, Dec. 28, 2020]

§ 425.512 Determining the ACO quality performance standard for performance years beginning on or after January 1, 2021.

(a) *Establishing a quality performance standard—*(1) *Overall standard.* The quality performance standard is the overall standard the ACO must meet in order to be eligible to receive shared savings for a performance year. An

ACO will not qualify to share in savings in any year it fails to meet the quality performance standard.

(2) For the first performance year of an ACO's first agreement period under the Shared Savings Program. If the ACO reports data via the APP and meets the data completeness requirement at § 414.1340 of this subchapter and the case minimum requirement at § 414.1380 of this subchapter on the measures specified in this paragraph (a)(2) for the applicable performance year, the ACO will meet the quality performance standard.

(i) For performance years 2022, 2023, and 2024. The ten CMS Web Interface measures or the three eCQMs/MIPS CQMs, and the CAHPS for MIPS survey.

(ii) For performance year 2025 and subsequent performance years. The three eCQMs/MIPS CQMs and the CAHPS for MIPS survey.

(3) For performance year 2021. (i) Except as specified in paragraph (a)(2) of this section, CMS designates the quality performance standard as the ACO reporting quality data via the APP established under § 414.1367 of this subchapter, according to the method of submission established by CMS and achieving a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring.

(ii) If an ACO does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard.

(4) For performance years 2022 and 2023. (i) Except as specified in paragraph (a)(2) of this section, CMS designates the quality performance standard as the ACO reporting quality data via the APP established under § 414.1367 of this subchapter according to the method of submission established by CMS and either:

(A) Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding

entities/providers eligible for facility-based scoring, or

(B) If the ACO reports the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement at § 414.1340 of this subchapter and the case minimum requirement at § 414.1380 of this subchapter for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set.

(ii) For performance year 2023, CMS designates an alternative quality performance standard for an ACO that does not meet the criteria described in paragraphs (a)(2) or (a)(4)(i) of this section, but reports quality data via the APP established under § 414.1367 of this subchapter according to the method of submission established by CMS and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set.

(iii) If an ACO does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative quality performance standard.

(5) For performance year 2024 and subsequent performance years.

(i) Except as specified in paragraph (a)(2) of this section, CMS designates the quality performance standard as the ACO reporting quality data via the APP established under § 414.1367 of this subchapter, according to the method of submission established by CMS and the following:

(A) For performance year 2024—

(1) Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding

entities/providers eligible for facility-based scoring, or

(2) If the ACO reports the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement at §414.1340 of this subchapter and the case minimum requirement at §414.1380 of this subchapter for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set.

(B) For performance year 2025 and subsequent years—Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring.

(ii) CMS designates an alternative quality performance standard for an ACO that does not meet the criteria described in paragraphs (a)(2) or (a)(5)(i) of this section, but reports quality data via the APP established under §414.1367 of this subchapter according to the method of submission established by CMS and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set.

(iii) An ACO will not meet the quality performance standard or the alternative quality performance standard if:

(A) For performance year 2024, the ACO does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and does not administer a CAHPS for MIPS survey under the APP.

(B) For performance year 2025 and subsequent years, the ACO does not report any of the three eCQMs/MIPS CQMs and does not administer a CAHPS for MIPS survey under the APP.

(6) For performance years 2022, 2023, and 2024, CMS designates a performance benchmark and minimum attain-

ment level for each CMS Web Interface measure and establishes a point scale for the measure as described in §425.502(b).

(b) *Calculation of ACO's health equity adjusted quality performance score for performance year 2023 and subsequent performance years.*

(1) For an ACO that reports the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement at §414.1340 of this subchapter for all three eCQMs/MIPS CQMs, and administers the CAHPS for MIPS survey, CMS calculates the ACO's health equity adjusted quality performance score as the sum of the ACO's MIPS Quality performance category score for all measures in the APP measure set and the ACO's health equity adjustment bonus points calculated in accordance with paragraph (b)(2) of this section. The sum of these values may not exceed 100 percent.

(2) CMS calculates the ACO's health equity adjustment bonus points as follows:

(i) For each measure in the APP measure set, CMS groups an ACO's performance into the top, middle, or bottom third of ACO measure performers by reporting mechanism.

(ii) CMS assigns values to the ACO for its performance on each measure as follows:

(A) Values of four, two, or zero for each measure for which the ACO's performance places it in the top, middle, or bottom third of ACO measure performers, respectively.

(B) Values of zero for each measure that CMS does not evaluate because the ACO does not meet the case minimum or the minimum sample size for the measure.

(iii) CMS sums the values assigned to the ACO according to paragraph (b)(2)(ii) of this section, to calculate the ACO's measure performance scaler.

(iv) CMS calculates an underserved multiplier for the ACO.

(A) CMS determines the proportion ranging from zero to one of the ACO's assigned beneficiary population for the performance year that is considered underserved based on the highest of —

(1) The proportion of the ACO's assigned beneficiaries residing in a census block group with an Area Deprivation Index national percentile rank of at least 85; or

(2) The proportion of the ACO's assigned beneficiaries that are enrolled in the Medicare Part D low-income subsidy (LIS); or are dually eligible for Medicare and Medicaid.

(B) If the proportion determined in accordance with paragraph (b)(2)(iv)(A) of this section is lower than 20 percent, the ACO is ineligible for health equity adjustment bonus points.

(v) Except as specified in paragraph (b)(2)(iv)(B) of this section, CMS calculates the ACO's health equity adjustment bonus points as the product of the measure performance scaler determined under paragraph (b)(2)(iii) of this section and the underserved multiplier determined under paragraph (b)(2)(iv) of this section. If the product of these values is greater than 10, the value of the ACO's health equity adjustment bonus points is set equal to 10.

(3) The ACO's health equity adjusted quality performance score, determined in accordance with paragraphs (b)(1) and (b)(2) of this section, is used as follows:

(i) In determining whether the ACO meets the quality performance standard as specified under paragraphs (a)(4)(i)(A), (a)(5)(i)(A)(I), and (a)(5)(i)(B) of this section.

(ii) In determining the final sharing rate for calculating shared savings payments under the BASIC track in accordance with § 425.605(d), and under the ENHANCED track in accordance with § 425.610(d), for an ACO that meets the alternative quality performance standard by meeting the criteria specified in paragraphs (a)(4)(ii) or (a)(5)(ii) of this section.

(iii) In determining the shared loss rate for calculating shared losses under the ENHANCED track in accordance with § 425.610(f), for an ACO that meets the quality performance standard established in paragraphs (a)(2), (a)(4)(i) and (a)(5)(i) of this section or the alternative quality performance standard established in paragraphs (a)(4)(ii) or (a)(5)(ii) of this section.

(iv) In determining the quality performance score for an ACO affected by extreme and uncontrollable circumstances as described in paragraphs (c)(3)(ii) and (iii) of this section.

(c) *Extreme and uncontrollable circumstances.* For performance year 2021 and subsequent performance years, including the applicable quality data reporting period for the performance year, CMS uses an alternative approach to calculating the quality score for ACOs affected by extreme and uncontrollable circumstances instead of the methodology specified in paragraph (a) of this section as follows:

(1) CMS determines the ACO was affected by an extreme and uncontrollable circumstance based on either of the following:

(i) Twenty percent or more of the ACO's assigned beneficiaries reside in an area identified under the Quality Payment Program as being affected by an extreme and uncontrollable circumstance.

(A) Assignment is determined under subpart E of this part.

(B) In making this determination, CMS uses the quarter four list of assigned beneficiaries.

(ii) The ACO's legal entity is located in an area identified under the Quality Payment Program as being affected by an extreme and uncontrollable circumstance. An ACO's legal entity location is based on the address on file for the ACO in CMS' ACO application and management system.

(2) If CMS determines the ACO meets the requirements of paragraph (c)(1) of this section, CMS calculates the ACO's quality score as follows:

(i) For performance years 2021, 2022, and 2023, the ACO's minimum quality performance score is set to the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(ii) For performance year 2024 and subsequent performance years, the ACO's minimum quality performance score is set to the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores,

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excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(3) If the ACO reports quality data via the APP and meets data completeness and case minimum requirements:

(i) For performance years 2021 and 2022, CMS will use the higher of the ACO's quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(ii) For performance year 2023, CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(iii) For performance year 2024 and subsequent performance years, CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(4) CMS applies determinations made under the Quality Payment Program with respect to—

(i) Whether an extreme and uncontrollable circumstance has occurred; and

(ii) The affected areas.

(5) CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred, the percentage of the ACO's assigned beneficiaries residing in the affected areas, and the location of the ACO legal entity.

[85 FR 85041, Dec. 28, 2020; 86 FR 65685, Nov. 19, 2021, as amended at 87 FR 70234, Nov. 18, 2022]

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Subpart G—Shared Savings and Losses

§ 425.600 Selection of risk model.

(a) An ACO may elect to operate under one of the following tracks:

(1) *Track 1.* For agreement periods beginning before July 1, 2019, an ACO in Track 1 operates under the one-sided model (as described under § 425.604) for the agreement period.

(2) *Track 2.* For agreement periods beginning before July 1, 2019, an ACO in Track 2 operates under a two-sided model (as described under § 425.606), sharing both savings and losses with the Medicare program for the agreement period.

(3) *ENHANCED track.* An ACO in the ENHANCED track operates under a two-sided model (as described under § 425.610), sharing both savings and losses with the Medicare program for the agreement period. For purposes of this part, all references to the ENHANCED track are deemed to include Track 3.

(4) *BASIC track.* For agreement periods beginning on July 1, 2019, and in subsequent years, an ACO in the BASIC track operates under either a one-sided model or a two-sided model (as described under § 425.605), either sharing savings only or sharing both savings and losses with the Medicare program, as specified in this paragraph (a)(4).

(i) *Levels of the BASIC track's glide path—(A) Phase-in of levels of the risk and reward.* Under the BASIC track's glide path, the level of risk and potential reward phases in over the course of the agreement period in the following order:

(1) *Level A.* The ACO operates under a one-sided model as described under § 425.605(d)(1)(i).

(2) *Level B.* The ACO operates under a one-sided model as described under § 425.605(d)(1)(ii).

(3) *Level C.* The ACO operates under a two-sided model as described under § 425.605(d)(1)(iii).

(4) *Level D.* The ACO operates under a two-sided model as described under § 425.605(d)(1)(iv).

(5) *Level E.* The ACO operates under a two-sided model as described under § 425.605(d)(1)(v).