

## § 425.700

differences in severity and case mix between the ACO's BY3 assigned beneficiary population and the national assignable FFS population for each Medicare enrollment type identified for the 12-month calendar year corresponding to BY3.

(5) Divides the risk adjusted flat dollar amounts described in paragraph (b)(4) of this section by the ACO's historical benchmark expenditures described in § 425.652(a) for each Medicare enrollment type to calculate the percent increase to be included in the blended update factor described in § 425.652(b)(4).

[87 FR 70248, Nov. 18, 2022]

### Subpart H—Data Sharing With ACOs

#### § 425.700 General rules.

(a) CMS shares aggregate reports with the ACO.

(b) CMS shares beneficiary identifiable data with ACOs on the condition that the ACO, its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to the ACO's activities observe all relevant statutory and regulatory provisions regarding the appropriate use of data and the confidentiality and privacy of individually identifiable health information and comply with the terms of the data use agreement described in this subpart.

(c) The ACO must not limit or restrict appropriate sharing of medical record data with providers and suppliers both within and outside the ACO in accordance with applicable law.

#### § 425.702 Aggregate reports.

CMS shares aggregate reports with ACOs as follows:

(a) Aggregate reports are shared at the start of the agreement period based on beneficiary claims data used to calculate the benchmark, and each quarter thereafter during the agreement period.

(b) These aggregate reports include, when available, the following information, deidentified in accordance with 45 CFR 164.514(b):

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(1) Aggregated metrics on the assigned beneficiary population.

(2) Utilization and expenditure data at the start of the agreement period based on historical beneficiaries used to calculate the benchmark.

(c)(1)(i) For performance years 2012 through 2015, at the beginning of the agreement period, during each quarter (and in conjunction with the annual reconciliation), and at the beginning of each performance year, CMS, upon the ACO's request for the data for purposes of population-based activities relating to improving health or reducing growth in health care costs, process development, case management, and care coordination, will provide the ACO with information regarding preliminarily prospectively assigned beneficiaries whose data was used to generate the aggregate data reports under paragraphs (a) and (b) of this section. The information includes the following:

(A) Beneficiary name.

(B) Date of birth.

(C) HICN.

(D) Sex.

(ii) For performance year 2016 and subsequent performance years, at the beginning of the agreement period, during each quarter (and in conjunction with the annual reconciliation), and at the beginning of each performance year, CMS, upon the ACO's request for the data for purposes of population-based activities relating to improving health or reducing growth in health care costs, process development, case management, and care coordination, provides the ACO with information about its fee-for-service population.

(A) For an ACO participating under preliminary prospective assignment with retrospective reconciliation as specified under § 425.400(a)(2), the following information is made available regarding preliminarily prospectively assigned beneficiaries and beneficiaries that received a primary care service during the previous 12 months from one of the ACO participants that submits claims for primary care services used to determine the ACO's assigned population under subpart E of this part:

(1) Beneficiary name.

(2) Date of birth.

(3) Health Insurance Claim Number (HICN).

(4) Sex.

(B) For an ACO participating under preliminary prospective assignment with retrospective reconciliation as specified under § 425.400(a)(2), information in the following categories, which represents the minimum data necessary for ACOs to conduct health care operations work, is made available regarding preliminarily prospectively assigned beneficiaries:

(1) Demographic data such as enrollment status.

(2) Health status information such as risk profile and chronic condition subgroup.

(3) Utilization rates of Medicare services such as the use of evaluation and management, hospital, emergency, and post-acute services, including the dates and place of service.

(4) Expenditure information related to utilization of services.

(C) The information under paragraphs (c)(1)(ii)(A) and (B) of this section is made available to ACOs participating under prospective assignment as specified under § 425.400(a)(3), but is limited to the ACO's prospectively assigned beneficiaries.

(2) In its request for these data, the ACO must certify that it is seeking the following information:

(i) As a HIPAA-covered entity, and the request reflects the minimum data necessary for the ACO to conduct its own health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501.

(ii) As the business associate of its ACO participants and ACO providers/suppliers, who are HIPAA-covered entities, and the request reflects the minimum data necessary for the ACO to conduct health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501 on behalf of those participants.

(iii) As an organized health care arrangement (as defined at 45 CFR 160.103), and the request reflects the minimum data necessary for the ACO to conduct health care operations work that falls within the first or second paragraph of the definition of health

care operations at 45 CFR 164.501 on behalf of the organized health care arrangement.

(d) For an ACO eligible to be reconciled under § 425.609(b), CMS shares with the ACO quarterly aggregate reports as provided in paragraphs (b) and (c)(1)(ii) of this section for CY 2019.

[76 FR 67973, Nov. 2, 2011, as amended at 80 FR 32844, June 9, 2015; 83 FR 60096, Nov. 23, 2018; 83 FR 68081, Dec. 31, 2018; 87 FR 70249, Nov. 18, 2022]

#### **§ 425.704 Beneficiary-identifiable claims data.**

Subject to providing the beneficiary with the opportunity to decline data sharing as described in this § 425.708, and subject to having a valid DUA in place, CMS, upon the ACO's request for the data for purposes of evaluating the performance of its ACO participants or its ACO providers/suppliers, conducting quality assessment and improvement activities, and conducting population-based activities relating to improved health, will provide the ACO with beneficiary identifiable claims data for preliminarily prospectively and prospectively assigned beneficiaries and other beneficiaries who receive primary care services from an ACO participant that submits claims for primary care services used to determine the ACO's assigned population under subpart E of this part during the performance year.

(a) If an ACO wishes to receive beneficiary identifiable claims data, it must sign a DUA and it must submit a formal request for data. ACOs may access requested data as often as once per month.

(b) The ACO must certify that it is requesting claims data about any of the following:

(1) Its own patients, as a HIPAA-covered entity, and the request reflects the minimum data necessary for the ACO to conduct its own health care operations work that falls within the first or second paragraph of the definition of health care operations at 45 CFR 164.501.

(2) The patients of its HIPAA-covered entity ACO participants or its ACO providers/suppliers as the business associate of these HIPAA covered entities, and the request reflects the minimum data necessary for the ACO to