

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; 88 FR 79545, Nov. 16, 2023]

§ 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—

(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.

§ 425.502 Calculating the ACO quality performance score for performance years (or a performance period) beginning on or before January 1, 2020.

(a) *Establishing a quality performance standard.* CMS designates the quality performance standard in each performance year. The quality performance standard is the overall standard the ACO must meet in order to be eligible for shared savings.

(1) For the first performance year of an ACO's first agreement period, CMS defines the quality performance standard at the level of complete and accurate reporting for all quality measures.

(2) During subsequent performance years of the ACO's first agreement period, the quality performance standard will be phased in such that the ACO must continue to report all measures but the ACO will be assessed on performance based on the quality performance benchmark and minimum attainment level of all measures.

(3) Under the quality performance standard for each performance year of an ACO's subsequent agreement period, the ACO must continue to report on all measures but the ACO will be assessed on performance based on the quality performance benchmark and minimum attainment level of all measures.

(4) A newly introduced measure is set at the level of complete and accurate

reporting for the first two reporting periods, the measure is required. For subsequent reporting periods, the quality performance standard for the measure will be assessed according to the phase-in schedule for the measure.

(5) CMS reserves the right to redesignate a measure as pay for reporting when the measure owner determines the measure no longer aligns with clinical practice or causes patient harm, or when there is a determination under the Quality Payment Program that the measure has undergone a substantive change.

(b) *Establishing a performance benchmark and minimum attainment level for measures.* (1) CMS designates a performance benchmark and minimum attainment level for each measure, and establishes a point scale for the measures.

(2)(i) CMS will define the quality benchmarks using fee-for-service Medicare data.

(ii) CMS will set benchmarks using flat percentages when the 60th percentile is equal to or greater than 80.00 percent, or when the 90th percentile is equal to or greater than 95 percent.

(iii) CMS reserves the right to use flat percentages for other measures when CMS determines that fee-for-service Medicare data are unavailable, inadequate, or unreliable to set the quality benchmarks.

(3) The minimum attainment level for pay for performance measures is set at 30 percent or the 30th percentile of the performance benchmark. The minimum attainment level for pay for reporting measures is set at the level of complete and accurate reporting.

(4)(i) CMS will update the quality performance benchmarks every 2 years.

(ii) For newly introduced measures that transition to pay for performance in the second year of the 2-year benchmarking cycle, the benchmark will be established for that year and updated along with the other measures at the start of the next 2-year benchmarking cycle.

(iii) CMS will use up to three years of data, as available, to set the benchmark for each quality measure.

(c) *Methodology for calculating a performance score for each measure.* (1) Performance below the minimum attain-

ment level for a measure will receive zero points for that measure.

(2) Performance equal to or greater than the minimum attainment level for a pay-for-performance measure will receive points on a sliding scale based on the level of performance.

(3) Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.

(4) Performance at or above 90 percent or the 90th percentile of the performance benchmark earns the maximum points available for the measure.

(5) Performance equal to or greater than the minimum attainment level for pay-for-reporting measures will receive the maximum available points.

(d) *Establishing quality requirements for domains.* (1) CMS groups individual measures into four domains:

- (i) Patient/care giver experience.
- (ii) Care coordination/Patient safety.
- (iii) Preventative health.
- (iv) At-risk population.

(2) To satisfy quality requirements for a domain:

(i) The ACO must report all measures within a domain.

(ii) CMS may take the compliance actions described in § 425.216 for ACOs exhibiting poor performance on a domain, as determined by CMS under § 425.316.

(iii)(A) If the ACO achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings under subpart G of this part, the ACO may receive the proportion of those shared savings for which it qualifies.

(B) If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated.

(e) *Methodology for calculating the ACO's overall performance score.* (1) CMS scores individual measures and determines the corresponding number of points that may be earned based on the ACO's performance.

(2) CMS adds the points earned for the individual measures within the domain and divides by the total points

available for the domain to determine the domain score.

(3) Domains are weighted equally and scores averaged to determine the ACO's overall performance score and sharing rate.

(4)(i) ACOs that demonstrate quality improvement on established quality measures from year to year will be eligible for up to 4 bonus points per domain.

(ii) Bonus points are awarded based on an ACO's net improvement in measures within a domain, which is calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures.

(iii) Up to four bonus points are awarded based on a comparison of the ACO's net improvement in performance on the measures for the domain to the total number of individual measures in the domain.

(iv) When bonus points are added to points earned for the quality measures in the domain, the total points received for the domain may not exceed the maximum total points for the domain in the absence of the quality improvement measure.

(v) If an ACO renews its participation agreement for a subsequent agreement period, quality improvement will be measured based on a comparison between performance in the first year of the new agreement period and performance in the last year of the previous agreement period.

(vi) For performance year 2017 and subsequent performance years, if an ACO receives the mean Shared Savings Program ACO quality score based on the extreme and uncontrollable circumstances policies in paragraph (f) of this section, the ACO is not eligible for bonus points awarded based on quality improvement.

(vii) For performance year 2017 and subsequent performance years, if an ACO receives the mean Shared Savings Program ACO quality score under paragraph (f) of this section, in the next performance year for which the ACO receives a quality performance score based on its own quality reporting, quality improvement is measured based on a comparison between the performance in that year and the most re-

cently available prior performance year in which the ACO reported quality.

(f) *Extreme and uncontrollable circumstances.* For performance year 2017 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 paragraphs (a) through (e) 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 for performance year 2017, CMS uses the final list of beneficiaries assigned to the ACO for the performance year. For performance year 2018 and subsequent performance years, CMS uses the list of assigned beneficiaries used to generate the Web Interface quality reporting sample.

(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 (f)(1) of this section, CMS calculates the ACO's quality score as follows:

(i) The ACO's minimum quality performance score is set to equal the mean quality performance score for all Shared Savings Program ACOs for the relevant performance year.

(ii) If the ACO completely and accurately reports all quality measures, CMS uses the higher of the ACO's quality performance score or the mean quality performance score for all Shared Savings Program ACOs.

(3) 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.

(4) 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.

[76 FR 67973, Nov. 2, 2011, as amended at 78 FR 74823, Dec. 10, 2013; 79 FR 68008, Nov. 13, 2014; 80 FR 71386, Nov. 16, 2015; 81 FR 80560, Nov. 15, 2016; 82 FR 53370, Nov. 15, 2017; 82 FR 60918, Dec. 26, 2017; 83 FR 60093, Nov. 23, 2018; 83 FR 68069, Dec. 31, 2018; 85 FR 19291, Apr. 6, 2020; 85 FR 85040, Dec. 28, 2020]

§ 425.504 Incorporating reporting requirements related to the Physician Quality Reporting System Incentive and Payment Adjustment.

(a) *Physician quality reporting system.*

(1) ACOs, on behalf of eligible professionals who bill under the TIN of an ACO participant, must submit the measures determined under § 425.500 using a CMS web interface, to qualify on behalf of their eligible professionals for the Physician Quality Reporting System incentive under the Shared Savings Program.

(2)(i) Eligible professionals who bill under the TIN of an ACO participant within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of receiving an incentive payment under the Physician Quality Reporting System.

(ii) Under the Shared Savings Program, an ACO, on behalf of eligible professionals who bill under the TIN of an ACO participant must satisfactorily report the measures determined under Subpart F of this part during the reporting period according to the method of submission established by CMS under the Shared Savings Program in order to receive a Physician Quality Reporting System incentive under the Shared Savings Program.

(3) If eligible professionals who bill under the TIN of an ACO participant within an ACO qualify for a Physician Quality Reporting System incentive payment, each ACO participant TIN, on behalf of its ACO supplier/provider participants who are eligible professionals, will receive an incentive, for those years an incentive is available, based on the allowed charges under the Physician Fee Schedule for that TIN.

(4) ACO participant TINs and individual eligible professionals who bill under the TIN of an ACO participant cannot earn a Physician Quality Reporting System incentive outside of the Medicare Shared Savings Program.

(5) The Physician Quality Reporting System incentive under the Medicare Shared Savings Program is equal to 0.5 percent of the Secretary's estimate of the ACO's eligible professionals' total Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the calendar year reporting period from January 1 through December 31, for years 2012 through 2014.

(b) *Physician Quality Reporting System payment adjustment for 2015.* (1) ACOs, on behalf of eligible professionals who bill under the TIN of an ACO participant, must submit one of the ACO GPRO measures determined under § 425.500 using a CMS web interface, to satisfactorily report on behalf of their eligible professionals for purposes of the 2015 Physician Quality Reporting System payment adjustment under the Shared Savings Program.

(2)(i) Eligible professionals who bill under the TIN of an ACO participant within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of the 2015 Physician Quality Reporting System payment adjustment under the Shared Savings Program.

(ii) Under the Shared Savings Program, an ACO, on behalf of eligible professionals who bill under the TIN of an ACO participant, must satisfactorily report one of the measures determined under Subpart F of this part during the reporting period for a year, as defined

in paragraph (b)(6) of this section, according to the method of submission established by CMS under the Shared Savings Program for purposes of the 2015 Physician Quality Reporting System payment adjustment.

(3) If an ACO, on behalf of eligible professionals who bill under the TIN of an ACO participant, does not satisfactorily report for purposes of a 2015 Physician Quality Reporting System payment adjustment, each eligible professional who bills under the TIN of an ACO participant, will receive a payment adjustment, as described in paragraph (b)(5) of this section.

(4) ACO participant TINs and individual eligible professionals who bill under the TIN of an ACO participant cannot satisfactorily report for purposes of a 2015 Physician Quality Reporting System payment adjustment outside of the Medicare Shared Savings Program.

(5) For eligible professionals subject to the 2015 Physician Quality Reporting System payment adjustment under the Medicare Shared Savings Program, the Medicare Part B Physician Fee Schedule amount for covered professional services furnished during the program year is equal to the applicable percent of the Medicare Part B Physician Fee Schedule amount that would otherwise apply to such services under section 1848 of the Act.

(i) The applicable percent for 2015 is 98.5 percent.

(ii) The applicable percent for 2016 and subsequent years is 98.0 percent.

(6) The reporting period for a year is the calendar year from January 1 through December 31 that occurs 2 years prior to the program year in which the payment adjustment is applied.

(c) *Physician Quality Reporting System payment adjustment for 2016.* (1) ACOs, on behalf of eligible professionals who bill under the TIN of an ACO participant, must submit all of the ACO GPRO measures determined under § 425.500 using a CMS web interface, to satisfactorily report on behalf of their eligible professionals for purposes of the Physician Quality Reporting System payment adjustment under the Shared Savings Program for 2016.

(2) Eligible professionals who bill under the TIN of an ACO participant within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of the Physician Quality Reporting System payment adjustment under the Shared Savings Program for 2016 and subsequent years.

(3) If an ACO, on behalf of eligible professionals who bill under the TIN of an ACO participant, does not satisfactorily report for purposes of the Physician Quality Reporting System payment adjustment for 2016 and subsequent years, each eligible professional who bills under the TIN of an ACO participant, will receive a payment adjustment, as described in § 414.90(e) of this chapter.

(4) For eligible professionals subject to the Physician Quality Reporting System payment adjustment under the Medicare Shared Savings Program for 2016 and subsequent years, the Medicare Part B Physician Fee Schedule amount for covered professional services furnished during the program year is equal to the applicable percent of the Medicare Part B Physician Fee Schedule amount that would otherwise apply to such services under section 1848 of the Act, as described in § 414.90(e) of this chapter.

(5) The reporting period for a year is the calendar year from January 1 through December 31 that occurs 2 years prior to the program year in which the payment adjustment is applied.

(d) *Physician Quality Reporting System payment adjustment for 2017 and 2018.* (1) ACOs, on behalf of eligible professionals who bill under the TIN of an ACO participant, must submit all of the ACO GPRO measures determined under § 425.500 using a CMS web interface, to satisfactorily report on behalf of their eligible professionals for purposes of the Physician Quality Reporting System payment adjustment under the Shared Savings Program for 2017 and 2018.

(2) Eligible professionals who bill under the TIN of an ACO participant within an ACO participate under their

ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of the Physician Quality Reporting System payment adjustment under the Shared Savings Program for 2017 and 2018.

(3) If an ACO, on behalf of eligible professionals who bill under the TIN of an ACO participant, does not satisfactorily report for purposes of the Physician Quality Reporting System payment adjustment for 2017 or 2018, each eligible professional who bills under the TIN of an ACO participant will receive a payment adjustment, as described in § 414.90(e) of this chapter, unless such eligible professionals have reported quality measures apart from the ACO in the form and manner required by the Physician Quality Reporting System.

(4) For eligible professionals subject to the Physician Quality Reporting System payment adjustment under the Medicare Shared Savings Program for 2017 or 2018, the Medicare Part B Physician Fee Schedule amount for covered professional services furnished during the program year is equal to the applicable percent of the Medicare Part B Physician Fee Schedule amount that would otherwise apply to such services under section 1848 of the Act, as described in § 414.90(e) of this chapter.

(5) The reporting period for a year is the calendar year from January 1 through December 31 that occurs 2 years prior to the program year in which the payment adjustment is applied, unless otherwise specified by CMS under the Physician Quality Reporting System.

[76 FR 67973, Nov. 2, 2011, as amended at 77 FR 69372, Nov. 16, 2012; 78 FR 74283, Dec. 10, 2013; 80 FR 71386, Nov. 16, 2015; 81 FR 80560, Nov. 15, 2016]

§ 425.506 Incorporating reporting requirements related to adoption of certified electronic health record technology.

(a) ACOs, ACO participants, and ACO providers/suppliers are encouraged to develop a robust EHR infrastructure.

(b) For performance years 2012 through 2018, as part of the quality performance score, the quality measure

regarding EHR adoption will be measured based on a sliding scale.

(c) For performance years 2012 through 2018, performance on this measure will be weighted twice that of any other measure for scoring purposes and for determining compliance with quality performance requirements for domains.

(d) Through reporting period 2016, eligible professionals participating in an ACO under the Shared Savings Program satisfy the CQM reporting component of meaningful use for the Medicare EHR Incentive Program when the following occurs:

(1) The eligible professional extracts data necessary for the ACO to satisfy the quality reporting requirements under this subpart from certified EHR technology.

(2) The ACO reports the ACO GPRO measures through a CMS web interface.

(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 through 2024, 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

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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; 88 FR 79546, Nov. 16, 2023]

§ 425.507 Incorporating Promoting Interoperability requirements related to the Quality Payment Program for performance years beginning on or after January 1, 2025.

(a) For performance years beginning on or after January 1, 2025, unless otherwise excluded under paragraph (b) of this section, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP), or Partial Qualifying APM Participant (Partial QP) (each as defined at § 414.1305 of this chapter) must satisfy all of the following:

(1) Report the MIPS Promoting Interoperability performance category measures and requirements to MIPS according to 42 CFR part 414 subpart O at the individual, group, virtual group, or APM entity level.

(2) Earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM entity level.

(b) An ACO participant, ACO provider/supplier, or ACO professional is excluded from the requirements specified in paragraph (a) of this section in accordance with applicable policies that exclude or otherwise exempt eligible clinicians from reporting the MIPS Promoting Interoperability performance category as set forth in 42 CFR part 414 subpart O, provided however, that an ACO participant, ACO provider/supplier, or ACO professional cannot be excluded from the requirements specified in paragraph (a) solely on the basis of being a QP or Partial QP. Applicable exclusions may include:

(1) Low volume threshold as set forth at § 414.1310(b)(1)(iii) of this chapter.

(2) Eligible clinician as defined at § 414.1305 of this chapter who is not a

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MIPS eligible clinician as set forth in § 414.1310(b)(2) of this chapter.

(3) Reweighting of the MIPS Promoting Interoperability performance category to zero percent of the final score in accordance with applicable policies set forth at § 414.1380(c)(2) of this chapter.

[88 FR 79546, Nov. 16, 2023]

§ 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 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, the ACO will meet the quality performance standard if it meets the requirements under this paragraph (a)(2).

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

(ii) For performance year 2024. If the ACO reports data via the APP and meets the data completeness requirement at § 414.1340 of this subchapter on the ten CMS Web Interface measures or the three eCQMs/MIPS CQMs/Medicare CQMs, and the CAHPS for MIPS survey (except as specified in § 414.1380(b)(1)(vii)(B) of this subchapter), and receives a MIPS Quality performance category score under § 414.1380(b)(1) of this subchapter, for the applicable performance year.

(iii) For performance year 2025 and subsequent performance years. If the ACO reports data via the APP and meets the data completeness requirement at § 414.1340 of this subchapter on

the three eCQMs/MIPS CQMs/Medicare CQMs, and the CAHPS for MIPS survey (except as specified in § 414.1380(b)(1)(vii)(B) of this subchapter), and receives a MIPS Quality performance category score under § 414.1380(b)(1) of this subchapter, for the applicable performance year.

(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 paragraphs (a)(2) and (a)(7) 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 for all three eCQMs/MIPS CQMs, and 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 re-

maining 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, any of the three eCQMs/MIPS CQMs/Medicare CQMs and does not administer a CAHPS for MIPS survey (except as specified in § 414.1380(b)(1)(vii)(B) of this subchapter) under the APP.

(B) For performance year 2025 and subsequent years, the ACO does not report any of the three eCQMs/MIPS CQMs/Medicare CQMs and does not administer a CAHPS for MIPS survey (except as specified in § 414.1380(b)(1)(vii)(B) of this subchapter) under the APP.

(6) For performance years 2022, 2023, and 2024, CMS designates a performance benchmark and minimum attainment level for each CMS Web Interface measure and establishes a point scale for the measure as described in § 425.502(b).

(7) For performance years 2024 and subsequent performance years, if an ACO reports all of the required measures, meeting the data completeness requirement at § 414.1340 of this subchapter for each measure in the APP measure set and receiving a MIPS Quality performance category score as

described at §414.1380(b)(1) of this subchapter, 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 when the ACO meets either of the following:

(i) The ACO's total available measure achievement points used to calculate the ACO's MIPS Quality performance category score is reduced under §414.1380(b)(1)(vii)(A) of this subchapter.

(ii) At least one of the eQMs/MIPS CQMs/Medicare CQMs does not have a benchmark as described at §414.1380(b)(1)(i)(A) of this subchapter.

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

(1) For performance year 2023. For an ACO that reports the three eQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement at §414.1340 of this subchapter for all three eQMs/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)(3) of this section. The sum of these values may not exceed 100 percent.

(2) For performance year 2024 and subsequent performance years. For an ACO that reports the three eQMs/MIPS CQMs/Medicare CQMs in the APP measure set, meeting the data completeness requirement at §414.1340 of this subchapter for all three eQMs/MIPS CQMs/Medicare CQMs, and administers the CAHPS for MIPS survey (except as specified in §414.1380(b)(1)(vii)(B) of this subchapter), 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)(3) of this section. The sum of these values may not exceed 100 percent.

(3) 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 measure is unscored or 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)(3)(ii) of this section, to calculate the ACO's measure performance scaler.

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

(A) (I) 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 either of the following:

(i) The proportion of the ACO's assigned beneficiaries residing in a census block group with an Area Deprivation Index (ADI) national percentile rank of at least 85. An ACO's assigned beneficiaries without an available numeric ADI national percentile rank are excluded from the calculation of the proportion of the ACO's assigned beneficiaries residing in a census block group with an ADI national percentile rank of at least 85.

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

(2) CMS calculates the proportions specified in paragraph (b)(3)(iv)(A)(I)(ii) of this section as follows:

(i) For performance year 2023, the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D LIS or are dually eligible for Medicare and Medicaid divided by the total number of the ACO's assigned beneficiaries' person years.

(ii) For performance year 2024 and subsequent performance years, the proportion of the ACO's assigned beneficiaries with any months enrolled in LIS or dually eligible for Medicare and Medicaid divided by the total number of the ACO's assigned beneficiaries.

(B) If the proportion determined in accordance with paragraph (b)(3)(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)(3)(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)(3)(iii) of this section and the underserved multiplier determined under paragraph (b)(3)(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.

(4) The ACO's health equity adjusted quality performance score, determined in accordance with paragraphs (b)(1) through (b)(3) 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), (a)(5)(i)(B), and (a)(7) 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 alter-

native 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