

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.