

management structure not meeting paragraphs (b) through (c) of this section.

§ 425.110 Number of ACO professionals and beneficiaries.

(a)(1) The ACO must include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subpart E of this part. The ACO must have at least 5,000 assigned beneficiaries.

(2) CMS deems an ACO to have initially satisfied the requirement to have at least 5,000 assigned beneficiaries specified in paragraph (a)(1) of this section if the number of beneficiaries historically assigned to the ACO participants in each of the three years before the start of the agreement period, using the assignment methodology in subpart E of this part, is 5,000 or more.

(b) If at any time during the performance year, an ACO's assigned population falls below 5,000, the ACO will be issued a warning and placed on a CAP.

(1) While under the CAP, the ACO remains eligible for shared savings and losses during that performance year and its MSR will be set at a level consistent with the number of assigned beneficiaries.

(2) If the ACO's assigned population is not returned to at least 5,000 or more by the end of next performance year, the ACO's agreement will be terminated and the ACO will not be eligible to share in savings for that performance year.

§ 425.112 Required processes and patient-centeredness criteria.

(a) *General.* (1) An ACO must—

(i) Promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care;

(ii) Adopt a focus on patient centeredness that is promoted by the governing body and integrated into practice by leadership and management working with the organization's health care teams; and

(iii) Have defined processes to fulfill these requirements.

(2) An ACO must have a qualified healthcare professional responsible for the ACO's quality assurance and im-

provement program, which must include the defined processes included in paragraphs (b)(1) through (4) of this section.

(3) For each process specified in paragraphs (b)(1) through (4) of this section, the ACO must—

(i) Explain how it will require ACO participants and ACO providers/suppliers to comply with and implement each process (and subelement thereof), including the remedial processes and penalties (including the potential for expulsion) applicable to ACO participants and ACO providers/suppliers for failure to comply with and implement the required process; and

(ii) Explain how it will employ its internal assessments of cost and quality of care to improve continuously the ACO's care practices.

(b) *Required processes.* The ACO must define, establish, implement, evaluate, and periodically update processes to accomplish the following:

(1) Promote evidence-based medicine. These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements taking into account the circumstances of individual beneficiaries.

(2) Promote patient engagement. These processes must address the following areas:

(i) Compliance with patient experience of care survey requirements in § 425.500.

(ii) Compliance with beneficiary representative requirements in § 425.106.

(iii) A process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient populations, and a plan to address the needs of its population.

(A) In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population.

(B) An ACO that has a stakeholder organization serving on its governing body will be deemed to have satisfied the requirement to partner with community stakeholders.

(iv) Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them.