

§ 425.700

the ACO's first 6 or 9 months of performance within CY 2012 for beneficiaries assigned for the interim payment calculation and aggregate dollars calculated for CY2013 for beneficiaries assigned for CY 2013.

(5) Adjustments for health status and demographic changes are performed as described in §425.604 through §425.606 with the following exceptions:

(i) Beneficiaries from the CY2013 assignment window are identified as continuously assigned or newly assigned relative to the previous calendar year.

(ii) The adjustment factor identified for purposes of the interim payment calculation is applied to the 6 months or 9 months of the ACO's first performance year that lie within CY2012.

(6) The updated benchmark, stated in aggregate dollars, is the sum of the interim updated benchmark for the average fraction of expenditures incurred in the latter 6 or 9 months of CY 2012 and an updated aggregate benchmark representing CY 2013.

(7) A savings percentage (based on a comparison of summed expenditures to summed updated benchmark dollars) for the ACO's 18 or 21 month performance year is compared to the ACO's MSR or MLR. The reconciled amount of the shared savings or losses owed to or by the ACO for the performance year is net of any interim payments of shared savings or losses.

(8) Quality performance for the first year reconciliation is based on complete and accurate reporting, of all required quality measures, for CYs 2012 and 2013.

(d) An ACO with a start date of April 1, 2012 or July 1, 2012 has the option to request an interim payment calculation based on quality and financial performance for its first 12 months of program participation. As required under §425.204(f), the ACO requesting an interim payment calculation must have a mechanism in place to pay back the interim payment if final reconciliation determines an overpayment.

(e) Unless otherwise stated, program requirements which apply in the course of a performance year apply to the interim payment calculation and first year reconciliation.

42 CFR Ch. IV (10–1–14 Edition)

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):

(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) 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