ACO providers-suppliers who are eligible professionals, 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 and subsequent years.

(2) ACO providers-suppliers that are eligible professionals 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 its ACO providers-suppliers who are eligible professionals, does not satisfactorily report for purposes of the Physician Quality Reporting System payment adjustment for 2016 and subsequent years, each ACO provider-supplier who is an eligible professional, 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.

(d) 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.

Section 425.602 Establishing the benchmark.

(a) Computing per capita Medicare Part A and Part B benchmark expenditures. In computing an ACO’s fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, CMS determines the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period.
§ 425.604 Calculation of savings under the one-sided model.

(a) Savings determination. For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark determined under § 425.602.

(1) Newly assigned beneficiaries. CMS uses an ACO’s HCC prospective risk score to adjust for changes in severity and case mix in this population.

(2) Continuously assigned beneficiaries.

(i) CMS uses demographic factors to adjust for changes in the continuously assigned population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust for changes in severity and case mix in this population using this lower prospective HCC risk score.

Using the ACO participants’ TINs identified at the start of the agreement period, CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service claims using a 3-month claims run out with a completion factor.

(ii) This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) This calculation considers individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(2) Makes separate expenditure calculations for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(3) Adjusts expenditures for changes in severity and case mix using prospective HCC risk scores.

(4) Truncates an assigned beneficiary’s total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each benchmark year in order to minimize variation from catastrophically large claims.

(5)(i) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates and trends expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

(ii) To trend forward the benchmark, CMS makes separate calculations for each of the following populations of beneficiaries:

(iii) ESRD.

(ii) Disabled.

(iii) Aged/dual eligible Medicare and Medicaid beneficiaries.

(iv) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

(c) Resetting the benchmark. An ACO’s benchmark will be reset at the start of each agreement period.

§ 425.604 Calculation of savings under the one-sided model.

(a) Savings determination. For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark determined under § 425.602.

(1) Newly assigned beneficiaries. CMS uses an ACO’s HCC prospective risk score to adjust for changes in severity and case mix in this population.

(2) Continuously assigned beneficiaries.

(i) CMS uses demographic factors to adjust for changes in the continuously assigned population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust for changes in severity and case mix in this population using this lower prospective HCC risk score.