

(3) Weighting the aggregate expenditure values determined for each population of beneficiaries (according to Medicare enrollment type) under paragraph (f)(2) of this section by a weight reflecting the proportion of the ACO's overall beneficiary population in the applicable Medicare enrollment type for the relevant benchmark or performance year.

(g) In determining performance for the January 1, 2019 through June 30, 2019 performance year described in § 425.609(b) CMS does all of the following:

(1) When adjusting the benchmark using the methodology set forth in paragraph (c)(10) of this section and § 425.609(b), CMS adjusts for severity and case mix between BY3 and CY 2019.

(2) When updating the benchmark using the methodology set forth in paragraph (d) of this section and § 425.609(b), CMS updates the benchmark based on growth between BY3 and CY 2019.

[81 FR 38014, June 10, 2016, as amended at 82 FR 53370, Nov. 15, 2017; 83 FR 60094, Nov. 23, 2018; 83 FR 68074, Dec. 31, 2018; 85 FR 85042, Dec. 28, 2020]

§ 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 or § 425.603.

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

(2) *Continuously assigned beneficiaries.* (i) CMS uses demographic factors to adjust the benchmark 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 the benchmark for changes in severity and case mix in this population using this lower prospective HCC risk score.

(3) Assigned beneficiary changes in demographics and health status are

used to adjust benchmark expenditures as described in § 425.602(a) or § 425.603(c). In adjusting the benchmark for health status and demographic changes CMS makes adjustments for separate categories for each of the following populations of beneficiaries:

(i) ESRD.

(ii) Disabled.

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

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

(4)(i) For performance years before 2017 to minimize variation from catastrophically large claims, CMS 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 performance year.

(ii) For the 2017 performance year and subsequent performance years, to minimize variation from catastrophically large claims, CMS 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 the applicable performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to the performance year.

(5) CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(A) For performance years beginning before 2018, these calculations will take into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

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(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by

at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings rate (MSR)*. CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for an ACO participating under the one-sided model. The MSR under the one-sided model for an ACO based on the number of assigned beneficiaries is as follows:

Number of Beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
1 – 499	≥12.2	
500 – 999	12.2	8.7
1,000 – 2,999	8.7	5.0
3,000 – 4,999	5.0	3.9
5,000 – 5,999	3.9	3.6
6,000 – 6,999	3.6	3.4
7,000 – 7,999	3.4	3.2
8,000 – 8,999	3.2	3.1
9,000 – 9,999	3.1	3.0
10,000 – 14,999	3.0	2.7
15,000 – 19,999	2.7	2.5
20,000 – 49,999	2.5	2.2
50,000 – 59,999	2.2	2.0
60,000 +	2.0	2.0

(c) *Qualification for shared savings payment*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* In order to qualify for shared savings, an ACO must meet or exceed its minimum savings rate determined under paragraph (b) of this section, meet the minimum quality performance standards established under § 425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(2) *For the performance year beginning on January 1, 2021.* To qualify for shared savings, an ACO must meet or exceed its minimum savings rate determined under paragraph (b) of this section, meet the quality performance standard

established under § 425.512, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the one-sided model will receive a shared savings payment of up to 50 percent of all savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (e)(2) of this section).

(2) *For the performance year beginning on January 1, 2021.* An ACO that meets

all the requirements for receiving shared savings payments under Track 1 will receive a shared savings payment of 50 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (e)(2) of this section).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the one-sided model may not exceed 10 percent of its updated benchmark.

(f) *Notification of savings.* CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(g) *January 1, 2019 through June 30, 2019 performance year.* Shared savings for the January 1, 2019 through June 30, 2019 performance year are calculated as described in § 425.609.

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§ 425.605 Calculation of shared savings and losses under the BASIC track.

(a) *General rules.* For each performance year, CMS determines whether the estimated average per capita Medicare Parts A and B fee-for-service expenditures for Medicare fee-for-service beneficiaries assigned to the ACO are above or below the updated benchmark determined under § 425.601 or § 425.652, as applicable. In order to qualify for a shared savings payment under the BASIC track, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate under paragraph (b) of this section except as provided in paragraph (h) of this section.

(1) CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary popu-

lation between BY3 and the performance year.

(i) For agreement periods beginning before January 1, 2024:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent.

(B) This cap is the maximum increase in risk scores for each agreement period, such that any positive adjustment between BY3 and any performance year in the agreement period cannot be larger than 3 percent.

(ii) For agreement periods beginning on January 1, 2024, and in subsequent years:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year (positive or negative) plus 3 percentage points.

(B) The cap described in paragraph (a)(1)(ii)(A) of this section will apply to prospective HCC risk score growth for a population described in paragraph (a)(2) of this section only if the ACO's aggregate growth in prospective HCC risk scores between BY3 and the performance year across all of the populations described in paragraph (a)(2) of this section exceeds this cap. If the cap described in paragraph (a)(1)(ii)(A) of this section is determined to apply, the value of the cap is the maximum increase in risk scores for the applicable performance year, such that any positive adjustment between BY3 and the performance year cannot be larger than the value of the cap for any of the populations described in paragraph (a)(2) of this section.

(C) The aggregate growth in demographic risk scores for purposes of paragraph (a)(1)(ii)(A) of this section and the aggregate growth in prospective HCC risk scores for purposes of paragraph (a)(1)(ii)(B) of this section is calculated by taking a weighted average of the growth in demographic risk scores or prospective HCC risk scores, as applicable, across the populations described in paragraph (a)(2) of this section. When calculating the weighted average growth in demographic risk scores or prospective HCC risk scores, as applicable, the weight applied to the growth in risk scores (expressed as a