

payments in accordance with § 425.316(e) if the ACO no longer meets the eligibility requirements specified in paragraphs (b)(3) and (b)(4) of this section.

(3) *No pre-termination actions.* CMS may immediately terminate an ACO's advance investment payments without taking any of the pre-termination actions set forth in § 425.216.

[87 FR 70242, Nov. 18, 2022]

§§ 425.631–425.649 [Reserved]

§ 425.650 Benchmarking methodology.

(a) *Scope and purpose.* The methodology by which CMS establishes, adjusts, updates and resets an ACO's historical benchmark is described within this subpart G. The benchmarking methodology for agreement periods beginning before January 1, 2024, is specified in §§ 425.601, 425.602, and 425.603. The benchmarking methodology for agreement periods beginning on or after January 1, 2024, is specified in §§ 425.652 through 425.660.

(b) [Reserved]

[87 FR 70243, Nov. 18, 2022]

§ 425.652 Establishing, adjusting, and updating the benchmark for agreement periods beginning on January 1, 2024, and in subsequent years.

(a) *Computing per capita Medicare Part A and Part B benchmark expenditures for an ACO's first agreement period.* For agreement periods beginning on January 1, 2024, and in subsequent years, in computing an ACO's historical benchmark for its first agreement period under the Shared Savings Program, 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 start of the agreement period using the ACO participant TINs identified before the start of the agreement period as required under § 425.118(a) and the beneficiary assignment methodology selected by the ACO for the first performance year of the agreement period as required under § 425.226(a)(1). CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-serv-

ice claims using a 3-month claims run out with a completion factor.

(i) This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals.

(ii) This calculation includes individually beneficiary identifiable final 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 for assignable beneficiaries identified for the 12-month calendar year corresponding to each benchmark year in order to minimize variation from catastrophically large claims.

(5) Trends forward expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars using a blend of national and regional growth rates.

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

(A) ESRD.

(B) Disabled.

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

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

(ii) National growth rates are computed using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark for assignable beneficiaries identified for the 12-month calendar year corresponding to each benchmark year.

(iii) Regional growth rates are computed using expenditures for the ACO's regional service area for each of the

years making up the historical benchmark as follows:

(A) Determine the counties included in the ACO's regional service area based on the ACO's assigned beneficiary population for the relevant benchmark year.

(B) Determine the ACO's regional expenditures as specified under § 425.654 of this section.

(iv) The national and regional growth rates are blended together by taking a weighted average of the two. The weight applied to the—

(A) National growth rate is calculated as the share of assignable beneficiaries in the ACO's regional service area for BY3 that are assigned to the ACO in BY3, as calculated in paragraph (a)(5)(v) of this section; and

(B) Regional growth rate is equal to 1 minus the weight applied to the national growth rate.

(v) CMS calculates the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO by doing all of the following:

(A) Calculating the county-level share of assignable beneficiaries that are assigned to the ACO for each county in the ACO's regional service area. The assignable population of beneficiaries is identified for the assignment window corresponding to BY3 that is consistent with the assignment window that applies under the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).

(B) Weighting the county-level shares according to the ACO's proportion of assigned beneficiaries in the county, determined by the number of the ACO's assigned beneficiaries residing in the county in relation to the ACO's total number of assigned beneficiaries.

(C) Aggregating the weighted county-level shares for all counties in the ACO's regional service area.

(6) Restates BY1 and BY2 trended and risk adjusted expenditures using BY3 proportions of ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(7) Weights each year of the benchmark for an ACO's initial agreement period using the following percentages:

(i) BY3 at 60 percent.

(ii) BY2 at 30 percent.

(iii) BY1 at 10 percent.

(8) Adjusts the historical benchmark based on the ACO's regional service area expenditures (as specified under § 425.656), or for savings generated by the ACO, if any, in the 3 most recent years prior to the start of the agreement period, if applicable (as specified under § 425.658), or a combination of these two adjustments. CMS does all of the following to determine the adjustment(s) applied to the historical benchmark:

(i) Computes the regional adjustment in accordance with § 425.656 and the prior savings adjustment in accordance with § 425.658.

(ii) If an ACO is not eligible to receive a prior savings adjustment under § 425.658(b)(3)(i), the ACO will receive the regional adjustment to its benchmark as described in § 425.656.

(iii) If an ACO is eligible to receive a prior savings adjustment, CMS compares the pro-rated positive average per capita savings amount calculated in § 425.658(b)(3)(ii) with the regional adjustment described in § 425.656(c), expressed as a single per capita value by taking a person-year weighted average of the Medicare enrollment type-specific regional adjustment values.

(A) If the regional adjustment, expressed as a single value, is negative or zero, calculate the sum of the regional adjustment value and the pro-rated positive average per capita savings amount.

(1) If the sum is positive, the ACO will receive a prior savings adjustment in place of the negative regional adjustment equal to the lesser of 50 percent of the positive sum and the cap described in paragraph (a)(8)(iv) of this section. The adjustment will be applied as a flat dollar amount to the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(2) If the sum is negative, the ACO will receive a reduced negative regional adjustment amount equal to the negative sum. The adjustment will be applied as a flat dollar amount to the following populations of beneficiaries:

ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(B) If the regional adjustment, expressed as a single value, is positive, the ACO will receive an adjustment to the benchmark equal to the higher of the following:

(1) The positive regional adjustment amount. The adjustment will be calculated as described in § 425.656(c) and applied separately to the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(2) A prior savings adjustment equal to the lesser of 50 percent of the prorated positive average per capita savings amount described in § 425.658(b)(3)(ii) and the cap described in paragraph (a)(8)(iv) of this section. The adjustment will be applied as a flat dollar amount to the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(iv) The cap on the prior savings adjustment calculated in either paragraph (a)(8)(iii)(A)(1) or paragraph (a)(8)(iii)(B)(2) of this section is equal to 5 percent of national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary and expressed as a single value by taking a person-year weighted average of the Medicare enrollment type-specific values.

(9) For the second and each subsequent performance year during the term of the agreement period, the ACO's benchmark is adjusted for the following, as applicable: For the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b), for a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1), and for a change to the beneficiary assignment methodology specified in subpart E of this part. To

adjust the benchmark, CMS does the following:

(i) Takes into account the expenditures of beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period.

(ii) Redetermines the regional adjustment amount under § 425.656 according to the ACO's assigned beneficiaries for BY3, and based on the assignable population of beneficiaries identified for the assignment window corresponding to BY3 that is consistent with the assignment window that applies under the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.226(a)(1).

(iii) Redetermines the offset factor used in determining the negative regional adjustment amount under § 425.656(c)(4) and (5).

(iv) Redetermines the proration factor used in calculating the prior savings adjustment under § 425.658(b)(3)(ii) to account for changes in the ACO's assigned beneficiary population in the benchmark years of the ACO's current agreement period due to the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b), a change to the ACO's beneficiary assignment methodology selection under § 425.400(a)(4)(ii), or changes to the beneficiary assignment methodology under subpart E of this part.

(v) In accordance with paragraph (a)(8) of this section, CMS redetermines the adjustment to the historical benchmark based on the redetermined regional adjustment (as specified under § 425.656), or the prior savings adjustment (as specified under § 425.658), or a combination of these two adjustments.

(10) The historical benchmark is further adjusted at the time of reconciliation for a performance year to account for changes in severity and case mix of the ACO's assigned beneficiary population as described under §§ 425.605(a) and 425.610(a).

(b) *Updating the benchmark.* For all agreement periods beginning on January 1, 2024, and in subsequent years, CMS updates the historical benchmark annually for each year of the agreement period using a three-way blend calculated as a weighted average of a

two-way blend of national and regional growth rates determined after the end of each performance year and a fixed projected growth rate determined at the beginning of the ACO's agreement period called the Accountable Care Prospective Trend (ACPT).

(1) To update the benchmark, CMS makes separate calculations for expenditure 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.

(2) CMS computes the two-way blend of national and regional growth rates as follows:

(i) Computes national growth rates using CMS Office of the Actuary national Medicare expenditure data for BY3 and the performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to each year.

(ii) Computes regional growth rates using expenditures for the ACO's regional service area for BY3 and the performance year, computed as follows:

(A) Determine the counties included in the ACO's regional service area based on the ACO's assigned beneficiary population for the year.

(B) Determine the ACO's regional expenditures as specified under § 425.654.

(iii) The national and regional growth rates are blended together by taking a weighted average of the two. The weight applied to the—

(A) National growth rate is calculated as the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO for the applicable performance year as specified in paragraph (b)(2)(iv) of this section; and

(B) Regional growth rate is equal to 1 minus the weight applied to the national growth rate.

(iv) CMS calculates the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO by doing all of the following:

(A) Calculating the county-level share of assignable beneficiaries that are assigned to the ACO for each county in the ACO's regional service area.

The assignable population of beneficiaries is identified for the assignment window corresponding to the performance year that is consistent with the assignment window that applies under the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).

(B) Weighting the county-level shares according to the ACO's proportion of assigned beneficiaries in the county, determined by the number of the ACO's assigned beneficiaries residing in the county in relation to the ACO's total number of assigned beneficiaries.

(C) Aggregating the weighted county-level shares for all counties in the ACO's regional service area.

(3) CMS computes the ACPT as described in § 425.660.

(4) The two-way blend computed under paragraph (b)(2) of this section and the ACPT are blended together by taking a weighted average of the two.

(i) Absent unforeseen circumstances, the weight applied to the components of the blend is as follows—

(A) Two-way blend is equal to two-thirds; and

(B) ACPT is equal to one-third.

(ii) CMS has sole discretion to determine whether an unforeseen circumstance exists that warrants a reduction to the weight of the ACPT and the reduced weight that will apply to the ACPT.

(5) If an ACO's average per capita Medicare expenditures for the performance year are above its updated benchmark for the year determined as described in paragraph (b)(4) of this section by at least the MLR or negative MSR established for the ACO, CMS will compute a recalculated updated benchmark using the two-way blend described in paragraph (b)(2) of this section.

(i) If the ACO's average per capita Medicare expenditures for the performance year are above the recalculated updated benchmark by a smaller amount than the amount by which they are above the updated benchmark determined as described in paragraph (b)(4) of this section, CMS will use the recalculated updated benchmark to determine the following:

(A) The ACO's responsibility for sharing losses with the Medicare program for ACOs in two-sided models as described under §§ 425.605 and 425.610.

(B) The ACO's financial performance for purposes of monitoring ACO financial performance as described under § 425.316(d).

(ii) If the ACO's average per capita Medicare expenditures for the performance year are below the recalculated updated benchmark, the ACO will neither be responsible for sharing losses with the Medicare program nor eligible for sharing in savings.

(c) *Resetting the benchmark.* (1) An ACO's benchmark is reset at the start of each subsequent agreement period.

(2) For second or subsequent agreements periods beginning on January 1, 2024, and in subsequent years, CMS establishes, adjusts, and updates the rebased historical benchmark in accordance with paragraphs (a) and (b) of this section except that rather than weighting each year of the benchmark using the percentages provided in paragraph (a)(7) of this section, each benchmark year is weighted equally.

[87 FR 70244, Nov. 18, 2022]

§ 425.654 Calculating county expenditures and regional expenditures.

(a) *Calculating county expenditures.* For agreement periods beginning on January 1, 2024, and in subsequent years, CMS does all of the following to determine risk adjusted county fee-for-service expenditures for use in calculating the ACO's regional fee-for-service expenditures:

(1)(i) Determines average county fee-for-service expenditures based on expenditures for the assignable population of beneficiaries in each county in the ACO's regional service area. The assignable population of beneficiaries is identified for the assignment window corresponding to the relevant benchmark or performance year that is consistent with the assignment window that applies under the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).

(ii) Makes separate expenditure calculations for each of the following populations of beneficiaries:

(A) ESRD.

(B) Disabled.

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

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

(2) Calculates assignable beneficiary expenditures using the payment amounts included in Parts A and B fee-for-service claims with dates of service in the 12-month calendar year for the relevant benchmark or performance year, using a 3-month claims run out with a completion factor. The calculation—

(i) Excludes IME and DSH payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals; and

(ii) Considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(3) Truncates a 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 for assignable beneficiaries identified for the 12-month calendar year that corresponds to the relevant benchmark or performance year, in order to minimize variation from catastrophically large claims.

(4) Adjusts fee-for-service expenditures for severity and case mix of assignable beneficiaries in the county using prospective HCC risk scores. The calculation is made according to 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.

(b) *Calculating regional expenditures.* For all agreement periods beginning on January 1, 2024, and in subsequent years, CMS calculates an ACO's risk adjusted regional expenditures by:

(1) Weighting the risk adjusted county-level fee-for-service expenditures determined under paragraph (a) of this section according to the ACO's proportion of assigned beneficiaries in the county, determined by the number of the ACO's assigned beneficiaries in the applicable population (according to Medicare enrollment type) residing in