

(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

the county in relation to the ACO's total number of assigned beneficiaries in the applicable population (according to Medicare enrollment type) for the relevant benchmark or performance year 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) Aggregating the values determined under paragraph (b)(1) of this section for each population of beneficiaries (according to Medicare enrollment type) across all counties within the ACO's regional service area.

[87 FR 70246, Nov. 18, 2022]

§ 425.656 Calculating the regional adjustment to the historical benchmark.

(a) *General.* This section describes the methodology for calculating the regional adjustment to the historical benchmark based on the ACO's regional service area expenditures, making separate calculations for the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries. This section applies to regional adjustment calculations for agreement periods beginning on January 1, 2024, and in subsequent years.

(b) *Calculation of an average per capita expenditure amount for the ACO's regional service area.* To compute an average per capita expenditure amount for the ACO's regional service area, CMS does all of the following:

- (1) Determines the counties included in the ACO's regional service area based on the ACO's BY3 assigned beneficiary population.
- (2) Determines the ACO's regional expenditures as specified under § 425.654 for BY3.
- (3) Adjusts for differences in severity and case mix between the ACO's assigned beneficiary population for BY3 and the assignable population of beneficiaries for the ACO's regional service area for BY3. The assignable population of beneficiaries is identified

using 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).

(c) *Calculation of the adjustment.* To calculate the adjustment, CMS does all of the following:

- (1) Determines the difference between the average per capita amount of expenditures for the ACO's regional service area as specified under paragraph (b)(1) of this section and the average per capita amount of the ACO's historical benchmark determined under § 425.652(a)(1) through (7) and (c)(2), 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) Applies a percentage, as determined in paragraph (d) of this section.

(3) Caps the per capita dollar amount for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) calculated under paragraph (c)(2) of this section at a dollar amount equal to a percentage of national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary. The cap is applied as follows:

- (i) For positive adjustments, the per capita dollar amount for a Medicare enrollment type is capped at 5 percent of the national per capita expenditure amount for the enrollment type for BY3.
- (ii) For negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at negative 1.5 percent of the national per capita expenditure amount for the enrollment type for BY3.
- (4) For negative adjustments, CMS will multiply the regional adjustments