

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

calculated in paragraphs (c)(2) or (3) of this section by 1 minus an offset factor equal to the sum of the following—

(i) Proportion of the ACO's BY3 assigned beneficiaries that are dually eligible for Medicare and Medicaid; and

(ii) The difference between the ACO's weighted average prospective HCC risk score for BY3 taken across the four Medicare enrollment types and 1. When calculating the weighted average prospective HCC risk score, the weight applied to the prospective HCC risk score for BY3 for each Medicare enrollment type is equal to the product of the BY3 per capita expenditures for that enrollment type and the BY3 person years for that enrollment type.

(5) The offset factor described in paragraph (c)(4) of this section is subject to a minimum value of zero (representing no offset to the negative regional adjustment) and a maximum value of 1 (representing a full offset to the negative regional adjustment).

(d) *Phase-in of weights used in regional adjustment calculation.* (1) The first time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment as follows:

(i) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's initial or rebased historical benchmark, if the ACO is determined to have lower spending than the ACO's regional service area.

(ii) Using 15 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's initial or rebased historical benchmark, if the ACO is determined to have higher spending than the ACO's regional service area.

(2) The second time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment as follows:

(i) Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to

have lower spending than the ACO's regional service area.

(ii) Using 25 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(3) The third time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment as follows:

(i) Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area.

(ii) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(4) The fourth or subsequent time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment to the historical benchmark using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark.

(5) To determine if an ACO has lower or higher spending compared to the ACO's regional service area, CMS does the following:

(i) Multiplies the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's historical benchmark for each population of beneficiaries (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) as calculated under paragraph (c)(1) of this section by the applicable proportion of

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the ACO's assigned beneficiary population (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) for BY3 of the historical benchmark.

(ii) Sums the amounts determined in paragraph (d)(5)(i) of this section across the populations of beneficiaries (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries).

(iii) If the resulting sum is a net positive value, the ACO is considered to have lower spending compared to the ACO's regional service area. If the resulting sum is a net negative value, the ACO is considered to have higher spending compared to the ACO's regional service area.

(iv) If during the term of the agreement period CMS adjusts the ACO's benchmark, as specified in § 425.652(a)(9), CMS redetermines whether the ACO is considered to have lower spending or higher spending compared to the ACO's regional service area for purposes of determining the percentage in paragraphs (d)(1) through (3) of this section used in calculating the regional adjustment.

(e) *Special rules for determining the weights used in the regional adjustment calculation for a re-entering ACO.* For a re-entering ACO whose prior agreement period benchmark was calculated according to § 425.603(c), CMS determines the weight used in the regional adjustment calculation described in paragraphs (b) through (d) of this section by considering the agreement period the ACO is entering into according to § 425.600(f) in combination with either of the following—

(1) The weight previously applied to calculate the regional adjustment to the ACO's benchmark under § 425.603(c)(9) in its most recent prior agreement period; or

(2) For a new ACO identified as a re-entering ACO, CMS considers the weight previously applied to calculate the regional adjustment to the benchmark under § 425.603(c)(9) in its most recent prior agreement period of the ACO in which the majority of the new ACO's

participants were participating previously.

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### **§ 425.658 Calculating the prior savings adjustment to the historical benchmark.**

(a) *General.* For agreement periods beginning on January 1, 2024, and in subsequent years, CMS calculates an adjustment to the historical benchmark to account for savings generated in the 3 years prior to the start of the ACO's current agreement period for renewing or re-entering ACOs that were reconciled for one or more performance years in the Shared Savings Program during this period.

(b) *Calculate average per capita savings amount.* (1) Calculate total per capita savings or losses for each performance year during the 3 years prior to the start of the ACO's current agreement period. CMS applies the following requirements in determining the amount of per capita savings or losses for each performance year:

(i) Per capita savings or losses will be set to zero for a performance year if the ACO was not reconciled for the performance year.

(ii) If an ACO generated savings for a performance year but was not eligible to receive a shared savings payment for that year due to noncompliance with the requirements of this part, per capita savings for that year will be set to zero.

(iii) For a new ACO identified as re-entering ACO, per capita savings or losses will be determined based on the per capita savings or losses of the ACO in which the majority of the ACO's ACO participants were participating.

(2) Take the simple average of the per capita savings or losses calculated in paragraph (b)(1) of this section, including values of zero, if applicable.

(3) Determine the ACO's eligibility for the prior savings adjustment as follows:

(i) If the average per capita amount computed in paragraph (b)(2) of this section is less than or equal to zero, the ACO is not eligible to receive an adjustment for prior savings. The ACO will receive the regional adjustment to its benchmark as described in § 425.656.