

§ 425.658

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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.

[87 FR 70246, Nov. 18, 2022]

§ 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.

(ii) If the average per capita amount computed in paragraph (b)(2) of this section is positive, apply a proration factor to account for any upward growth in the ACO's assigned population in the benchmark years of the ACO's current agreement period as compared to the size of the assigned population when the ACO was recoupled for the corresponding performance years in its prior agreement period.

(c) *Applicability of the prior savings adjustment.* CMS compares the pro-rated average per capita savings amount determined in paragraph (b)(3)(ii) of this section with the regional adjustment described in § 425.656(c), to determine the applicability of the prior savings adjustment, the regional adjustment or a combination of these two adjustments in accordance with § 425.652(a)(8).

[87 FR 70248, Nov. 18, 2022]

§ 425.660 Accountable Care Prospective Trend (ACPT).

(a) *General.* For agreement periods beginning on January 1, 2024, and in subsequent years, CMS incorporates a fixed projected growth rate determined at the beginning of the ACO's agreement period called the Accountable Care Prospective Trend (ACPT) into the blended update factor described in § 425.652(b) when updating an ACO's benchmark for each performance year of the agreement period.

(b) *Determination of ACPT.* An ACPT is a flat dollar amount calculated using one or more annualized growth rates based on national fee-for-service Medicare expenditures projected by the CMS Office of the Actuary. In determining the ACPT for an enrollment type for each performance year, CMS does all of the following:

(1) Projects per capita growth in Parts A and B fee-for-service expenditures for benchmark year 3 (BY3) and each performance year of the ACO's agreement period. The calculation—

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

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

(A) ESRD.

(B) Aged/Disabled.

(2) Calculates one or more annualized growth rates for the population of beneficiaries described in paragraph (b)(1)(ii)(A) of this section (the ESRD ACPT) and one or more annualized growth rates for the population of beneficiaries described in paragraph (b)(1)(ii)(B) of this section (the Aged/Disabled ACPT). These annualized growth rates will remain fixed over the ACO's agreement period. The annualized growth rate is an annual rate of growth in projected expenditures during the ACO's 5-year agreement period relative to BY3, calculated as follows—

(i) Using a uniform annualized projected rate of growth over each of the 5 performance years of the 5-year agreement period; or

(ii) If annualization as specified in paragraph (b)(2)(i) of this section is determined not to reasonably fit the anticipated growth curve, CMS will apply an alternative annualization technique using two or more annualized growth rates reflecting the projected rates of growth during the 5 performance years comprising the 5-year agreement period.

(3) For each performance year, multiplies the applicable annualized growth rate described in paragraph (b)(2) of this section by BY3 truncated national per capita fee-for-service Medicare expenditures for assignable beneficiaries for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries) identified for the 12-month calendar year corresponding to BY3 to express the annualized growth rate as a flat dollar amount as follows:

(i) The ESRD ACPT is used for the ESRD population.

(ii) The Aged/Disabled ACPT is used for the following populations: disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(4) Adjusts the flat dollar amounts described in paragraph (b)(3) of this section for each performance year for