

(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

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differences in severity and case mix between the ACO's BY3 assigned beneficiary population and the national assignable FFS population for each Medicare enrollment type identified for the 12-month calendar year corresponding to BY3.

(5) Divides the risk adjusted flat dollar amounts described in paragraph (b)(4) of this section by the ACO's historical benchmark expenditures described in § 425.652(a) for each Medicare enrollment type to calculate the percent increase to be included in the blended update factor described in § 425.652(b)(4).

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Subpart H—Data Sharing With ACOs

§ 425.700 General rules.

(a) CMS shares aggregate reports with the ACO.

(b) CMS shares beneficiary identifiable data with ACOs on the condition that the ACO, its ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to the ACO's activities observe all relevant statutory and regulatory provisions regarding the appropriate use of data and the confidentiality and privacy of individually identifiable health information and comply with the terms of the data use agreement described in this subpart.

(c) The ACO must not limit or restrict appropriate sharing of medical record data with providers and suppliers both within and outside the ACO in accordance with applicable law.

§ 425.702 Aggregate reports.

CMS shares aggregate reports with ACOs as follows:

(a) Aggregate reports are shared at the start of the agreement period based on beneficiary claims data used to calculate the benchmark, and each quarter thereafter during the agreement period.

(b) These aggregate reports include, when available, the following information, deidentified in accordance with 45 CFR 164.514(b):

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(1) Aggregated metrics on the assigned beneficiary population.

(2) Utilization and expenditure data at the start of the agreement period based on historical beneficiaries used to calculate the benchmark.

(c)(1)(i) For performance years 2012 through 2015, at the beginning of the agreement period, during each quarter (and in conjunction with the annual reconciliation), and at the beginning of each performance year, CMS, upon the ACO's request for the data for purposes of population-based activities relating to improving health or reducing growth in health care costs, process development, case management, and care coordination, will provide the ACO with information regarding preliminarily prospectively assigned beneficiaries whose data was used to generate the aggregate data reports under paragraphs (a) and (b) of this section. The information includes the following:

(A) Beneficiary name.

(B) Date of birth.

(C) HICN.

(D) Sex.

(ii) For performance year 2016 and subsequent performance years, at the beginning of the agreement period, during each quarter (and in conjunction with the annual reconciliation), and at the beginning of each performance year, CMS, upon the ACO's request for the data for purposes of population-based activities relating to improving health or reducing growth in health care costs, process development, case management, and care coordination, provides the ACO with information about its fee-for-service population.

(A) For an ACO participating under preliminary prospective assignment with retrospective reconciliation as specified under § 425.400(a)(2), the following information is made available regarding preliminarily prospectively assigned beneficiaries and beneficiaries that received a primary care service during the previous 12 months from one of the ACO participants that submits claims for primary care services used to determine the ACO's assigned population under subpart E of this part:

(1) Beneficiary name.

(2) Date of birth.