

(i) For performance year 2023, the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D LIS or are dually eligible for Medicare and Medicaid divided by the total number of the ACO's assigned beneficiaries' person years.

(ii) For performance year 2024 and subsequent performance years, the proportion of the ACO's assigned beneficiaries with any months enrolled in LIS or dually eligible for Medicare and Medicaid divided by the total number of the ACO's assigned beneficiaries.

(B) If the proportion determined in accordance with paragraph (b)(3)(iv)(A) of this section is lower than 20 percent, the ACO is ineligible for health equity adjustment bonus points.

(v) Except as specified in paragraph (b)(3)(iv)(B) of this section, CMS calculates the ACO's health equity adjustment bonus points as the product of the measure performance scaler determined under paragraph (b)(3)(iii) of this section and the underserved multiplier determined under paragraph (b)(3)(iv) of this section. If the product of these values is greater than 10, the value of the ACO's health equity adjustment bonus points is set equal to 10.

(4) The ACO's health equity adjusted quality performance score, determined in accordance with paragraphs (b)(1) through (b)(3) of this section, is used as follows:

(i) In determining whether the ACO meets the quality performance standard as specified under paragraphs (a)(4)(i)(A), (a)(5)(i)(A)(I), (a)(5)(i)(B), and (a)(7) of this section.

(ii) In determining the final sharing rate for calculating shared savings payments under the BASIC track in accordance with § 425.605(d), and under the ENHANCED track in accordance with § 425.610(d), for an ACO that meets the alternative quality performance standard by meeting the criteria specified in paragraphs (a)(4)(ii) or (a)(5)(ii) of this section.

(iii) In determining the shared loss rate for calculating shared losses under the ENHANCED track in accordance with § 425.610(f), for an ACO that meets the quality performance standard established in paragraphs (a)(2), (a)(4)(i) and (a)(5)(i) of this section or the alter-

native quality performance standard established in paragraphs (a)(4)(ii) or (a)(5)(ii) of this section.

(iv) In determining the quality performance score for an ACO affected by extreme and uncontrollable circumstances as described in paragraphs (c)(3)(ii) and (iii) of this section.

(c) *Extreme and uncontrollable circumstances.* For performance year 2021 and subsequent performance years, including the applicable quality data reporting period for the performance year, CMS uses an alternative approach to calculating the quality score for ACOs affected by extreme and uncontrollable circumstances instead of the methodology specified in paragraph (a) of this section as follows:

(1) CMS determines the ACO was affected by an extreme and uncontrollable circumstance based on either of the following:

(i) Twenty percent or more of the ACO's assigned beneficiaries reside in an area identified under the Quality Payment Program as being affected by an extreme and uncontrollable circumstance.

(A) Assignment is determined under subpart E of this part.

(B) In making this determination, CMS uses the quarter four list of assigned beneficiaries.

(ii) The ACO's legal entity is located in an area identified under the Quality Payment Program as being affected by an extreme and uncontrollable circumstance. An ACO's legal entity location is based on the address on file for the ACO in CMS' ACO application and management system.

(2) If CMS determines the ACO meets the requirements of paragraph (c)(1) of this section, CMS calculates the ACO's quality score as follows:

(i) For performance years 2021, 2022, and 2023, the ACO's minimum quality performance score is set to the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(ii) For performance year 2024 and subsequent performance years, the ACO's minimum quality performance score is set to the equivalent of the

40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(3) If CMS determines the ACO meets the requirements of paragraph (c)(1) of this section and the ACO reports quality data via the APP, CMS calculates the ACO's quality score as follows:

(i) For performance years 2021 and 2022, if the ACO reports quality data via the APP and meets data completeness and case minimum requirements, CMS will use the higher of the ACO's quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(ii) For performance year 2023, if the ACO reports quality data via the APP and meets data completeness and case minimum requirements, CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(iii) For performance year 2024 and subsequent performance years, if the ACO reports quality data via the APP and meets the data completeness requirement at §414.1340 of this subchapter and receives a MIPS Quality performance category score under §414.1380(b)(1) of this subchapter, CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(4) CMS applies determinations made under the Quality Payment Program with respect to—

(i) Whether an extreme and uncontrollable circumstance has occurred; and

(ii) The affected areas.

(5) CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred, the percentage of the ACO's assigned beneficiaries residing in the affected areas, and the location of the ACO legal entity.

[85 FR 85041, Dec. 28, 2020; 86 FR 65685, Nov. 19, 2021, as amended at 87 FR 70234, Nov. 18, 2022; 88 FR 79546, Nov. 16, 2023]

## Subpart G—Shared Savings and Losses

### § 425.600 Selection of risk model.

(a) An ACO may elect to operate under one of the following tracks:

(1) *Track 1.* For agreement periods beginning before July 1, 2019, an ACO in Track 1 operates under the one-sided model (as described under § 425.604) for the agreement period.

(2) *Track 2.* For agreement periods beginning before July 1, 2019, an ACO in Track 2 operates under a two-sided model (as described under § 425.606), sharing both savings and losses with the Medicare program for the agreement period.

(3) *ENHANCED track.* An ACO in the ENHANCED track operates under a two-sided model (as described under § 425.610), sharing both savings and losses with the Medicare program for the agreement period. For purposes of this part, all references to the ENHANCED track are deemed to include Track 3.

(4) *BASIC track.* For agreement periods beginning on July 1, 2019, and in subsequent years, an ACO in the BASIC track operates under either a one-sided model or a two-sided model (as described under § 425.605), either sharing savings only or sharing both savings and losses with the Medicare program, as specified in this paragraph (a)(4).

(i) *Levels of the BASIC track's glide path—(A) Phase-in of levels of the risk and reward.* Under the BASIC track's glide path, the level of risk and potential reward phases in over the course of the agreement period in the following order:

(1) *Level A.* The ACO operates under a one-sided model as described under § 425.605(d)(1)(i).

(2) *Level B.* The ACO operates under a one-sided model as described under § 425.605(d)(1)(ii).

(3) *Level C.* The ACO operates under a two-sided model as described under § 425.605(d)(1)(iii).

(4) *Level D.* The ACO operates under a two-sided model as described under § 425.605(d)(1)(iv).

(5) *Level E.* The ACO operates under a two-sided model as described under § 425.605(d)(1)(v).

(B) *Glide path progression for agreement periods beginning on or after July 1, 2019 and before January 1, 2024.* (1) Experience in Track 1. (i) Except for an ACO that previously participated in Track 1 under paragraph (a)(1) of this section or a new ACO identified as a re-entering ACO because more than 50 percent of its ACO participants have recent prior experience in a Track 1 ACO, an ACO eligible to enter the BASIC track's glide path as determined under paragraphs (d)(1)(i) and (d)(2)(i) of this section may elect to enter its agreement period at any of the levels of risk and potential reward available under paragraphs (a)(4)(i)(A)(1) through (5) of this section.

(ii) An ACO that previously participated in Track 1 under paragraph (a)(1) of this section or a new ACO identified as a re-entering ACO because more than 50 percent of its ACO participants have recent prior experience in a Track 1 ACO may elect to enter its agreement period at any of the levels of risk and potential reward available under paragraphs (a)(4)(i)(A)(2) through (5) of this section.

(2) Automatic advancement. Unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i), the ACO is automatically advanced to the next level of the BASIC track's glide path at the start of each subsequent performance year of the agreement period, if a higher level of risk and potential reward is available under the BASIC track.

(i) Exception for ACO entering the BASIC track's glide path for an agreement period beginning on July 1, 2019. The automatic advancement does not apply at the start of the second performance year for an ACO entering the

BASIC track's glide path for an agreement period beginning on July 1, 2019. For performance year 2020, the ACO remains in the same level of the BASIC track's glide path that it entered for the July 1, 2019 through December 31, 2019 performance year, unless the ACO chooses to advance more quickly in accordance with § 425.226(a)(2)(i). The ACO is automatically advanced to the next level of the BASIC track's glide path at the start of performance year 2021 and all subsequent performance years of the agreement period.

(ii) Exception for new legal entity identified as a low revenue ACO. An exception is available for a low revenue ACO that is a new legal entity and is not identified as a re-entering ACO that enters the BASIC track's glide path at Level A under paragraph (a)(4)(i)(A)(1) of this section, and is automatically advanced to Level B under paragraph (a)(4)(i)(A)(2) of this section for performance year 2 (or performance 3 in the case of ACOs entering an agreement period beginning on July 1, 2019). Prior to the automatic advancement of the ACO to Level C under paragraph (a)(4)(i)(A)(3) of this section, the ACO may elect to remain in Level B under paragraph (a)(4)(i)(A)(2) of this section for performance year 3 (performance year 4 in the case of ACOs entering an agreement period beginning on July 1, 2019). In the case of an ACO that elects to remain in Level B for an additional performance year pursuant to the second sentence of paragraph (a)(4)(i)(B)(2)(ii) of this section, and except as provided in paragraph (a)(4)(i)(B)(2)(vi) of this section, the ACO is automatically advanced to Level E under paragraph (a)(4)(i)(A)(5) of this section at the start of performance year 4 (or performance year 5 in the case of ACOs entering an agreement period beginning on July 1, 2019).

(iii) Exception for ACOs participating in the BASIC track's glide path that elect to maintain their participation level for performance year 2021. Prior to the automatic advancement for performance year 2021, an ACO that is participating in the BASIC track's glide path for performance year 2020 may elect to remain in the same level of the

BASIC track's glide path that it entered for the 2020 performance year, for performance year 2021. For performance year 2022, the ACO is automatically advanced to the level of the BASIC track's glide path to which the ACO would have automatically advanced absent the election to maintain its participation level for performance year 2021, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). A voluntary election by an ACO under this paragraph must be made in the form and manner and by a deadline established by CMS.

(iv) Exception for ACOs participating in the BASIC track's glide path that elect to maintain their participation level for performance year 2022. Prior to the automatic advancement for performance year 2022, an ACO that is participating in the BASIC track's glide path for performance year 2021 may elect to remain in the same level of the BASIC track's glide path in which it participated during the 2021 performance year, for performance year 2022. Except as provided in paragraph (a)(4)(i)(B)(2)(vi) of this section, for performance year 2023, the ACO is automatically advanced to the level of the BASIC track's glide path to which the ACO would have automatically advanced absent the election to maintain its participation level for performance year 2022 and, if applicable, the election to maintain its participation level for performance year 2021 under paragraph (a)(4)(i)(B)(2)(iii) of this section, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). A voluntary election by an ACO under this paragraph must be made in the form and manner and by a deadline established by CMS.

(v) Prior to entering performance-based risk, an ACO must meet all requirements to participate under performance-based risk, including establishing an adequate repayment mechanism as specified under § 425.204(f) and selecting a MSR/MLR from the options specified under § 425.605(b).

(vi) For performance year 2023, an ACO in Level A under paragraph

(a)(4)(i)(A)(I) of this section or in Level B under paragraph (a)(4)(i)(A)(2) of this section may elect to remain in the same level of the BASIC track's glide path in which it participated during performance year 2022, for the remainder of the agreement period, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). If the ACO does not elect to remain under Level A or Level B, for performance year 2023, the ACO is automatically advanced to the next level of the BASIC track's glide path to which the ACO would have automatically advanced absent any election to maintain its participation level for performance year 2022 under paragraph (a)(4)(i)(B)(2)(iv) of this section and, if applicable, the election to maintain its participation level for performance year 2021 under paragraph (a)(4)(i)(B)(2)(iii) of this section, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). A voluntary election by an ACO under this paragraph must be made in the form and manner and by a deadline established by CMS.

(vii) For performance year 2024, an ACO with an agreement period beginning January 1, 2023 in Level A under paragraph (a)(4)(i)(A)(I) of this section or in Level B under paragraph (a)(4)(i)(A)(2) of this section may elect to remain in the same level of the BASIC track's glide path in which it participated during performance year 2023, for the remainder of the agreement period, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). If the ACO does not elect to remain under Level A or Level B, for performance year 2024, the ACO is automatically advanced to the next level of the BASIC track's glide path, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i). A voluntary election by an ACO under this paragraph must be made in the form and manner and by a deadline established by CMS.

(3) If the ACO fails to meet the requirements to participate under performance-based risk under paragraph (a)(4)(i)(B)(2)(v) of this section, the agreement is terminated.

(4) If, in accordance with § 425.226(a)(2)(i), the ACO elects to transition to a higher level of risk and reward available under paragraphs (a)(4)(i)(A)(3) through (5) of this section, then the automatic transition to levels of higher risk and reward specified in paragraph (a)(4)(i)(B)(2) of this section applies to all subsequent performance years of the agreement period.

(C) *Glide path progression for agreement periods beginning on or after January 1, 2024.* (1) *Level of glide path entry.* An ACO eligible to enter the BASIC track's glide path as determined under paragraph (g)(1) of this section may elect to enter its agreement period at any of the levels of risk and potential reward available under paragraphs (a)(4)(i)(A)(1) through (5) of this section.

(2) *Automatic advancement.* An ACO is automatically advanced to the next level of the BASIC track's glide path at the start of each subsequent performance year of the agreement period, if a higher level of risk and potential reward is available under the BASIC track, except as follows:

(i) The ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i).

(ii) The ACO elects to maintain its level of participation as provided in paragraph (a)(4)(i)(C)(3) of this section.

(iii) The ACO is automatically advanced to Level E pursuant to paragraph (h)(2)(i) of this section.

(3) *Election to remain under a one-sided model.* An eligible ACO that enters the BASIC track's glide path at Level A under paragraph (a)(4)(i)(A)(1) of this section and is currently at Level A may elect to remain in Level A under paragraph (a)(4)(i)(A)(1) of this section for all subsequent performance years of the agreement period.

(i) To be eligible to participate under Level A of the BASIC track as described in this paragraph, the ACO must meet the following requirements: the ACO is participating in its first

agreement period under the BASIC track under paragraph (a)(4) of this section, and is not participating in an agreement period under the BASIC track as a renewing ACO (as defined at § 425.20) or a re-entering ACO (as defined in § 425.20) that previously participated in the BASIC track's glide path under paragraph (a)(4) of this section; and the ACO is inexperienced with performance-based risk Medicare ACO initiatives (as defined in § 425.20).

(ii) A voluntary election by an ACO under this paragraph (a)(4)(i)(C)(3) must be made in the form and manner and by a deadline established by CMS.

(iii) The ACO's election to remain in Level A applies for the entirety of the agreement period, unless the ACO elects to transition to a higher level of risk and potential reward within the BASIC track's glide path as provided in § 425.226(a)(2)(i).

(4) Prior to entering performance-based risk, an ACO must meet all requirements to participate under performance-based risk, including establishing an adequate repayment mechanism as specified under § 425.204(f) and selecting a MSR/MLR from the options specified under § 425.605(b).

(5) If the ACO fails to meet the requirements to participate under performance-based risk under paragraph (a)(4)(i)(C)(4) of this section, the agreement is terminated.

(6) If, in accordance with § 425.226(a)(2)(i), the ACO elects to transition to a higher level of risk and reward available under paragraphs (a)(4)(i)(A)(3) through (5) of this section, then the automatic transition to levels of higher risk and reward specified in paragraph (a)(4)(i)(C)(2) of this section applies to all subsequent performance years of the agreement period.

(ii) *Agreement period under Level E of the BASIC track.* If an ACO enters the BASIC track and is ineligible to participate under the glide path described in paragraph (a)(4)(i) of this section, as determined under paragraph (d) or paragraph (g)(2) of this section, as applicable, Level E as described in paragraph (a)(4)(i)(A)(5) of this section applies to all performance years of the agreement period.

(b) For agreement periods beginning before July 1, 2019, ACOs may operate under the one-sided model for a maximum of 2 agreement periods. An ACO may not operate under the one-sided model for a second agreement period unless the—

(1) Immediately preceding agreement period was under the one-sided model; and

(2) The ACO meets the criteria established for ACOs seeking to renew their agreements under § 425.224(b).

(c) For agreement periods beginning before July 1, 2019, an ACO experiencing a net loss during a previous agreement period may reapply to participate under the conditions in § 425.202(a), except the ACO must also identify in its application the cause(s) for the net loss and specify what safeguards are in place to enable the ACO to potentially achieve savings in its next agreement period.

(d) For agreement periods beginning on or after July 1, 2019, and before January 1, 2024, CMS determines an ACO's eligibility for the Shared Savings Program participation options specified in paragraph (a) of this section as follows:

(1) If an ACO is identified as a high revenue ACO, the ACO is eligible for the participation options indicated in paragraph (a) of this section as follows:

(i) If the ACO is determined to be inexperienced with performance-based risk Medicare ACO initiatives, the ACO may enter either the BASIC track's glide path at any of the levels of risk and potential reward available under paragraphs (a)(4)(i)(A)(I) through (5) of this section, except as provided in paragraph (a)(4)(i)(B) of this section, or the ENHANCED track under paragraph (a)(3) of this section.

(ii) If the ACO is determined to be experienced with performance-based risk Medicare ACO initiatives:

(A) The ACO may enter the ENHANCED track under paragraph (a)(3) of this section except as provided in paragraph (d)(1)(ii)(B) of this section.

(B) An ACO in a first or second agreement period beginning in 2016 or 2017 identified as experienced with performance-based risk Medicare ACO initiatives based on participation in the Track 1+ Model may renew for a consecutive agreement period beginning

on July 1, 2019, or January 1, 2020 (respectively), under either the BASIC track Level E under paragraph (a)(4)(i)(A)(5) of this section, or the ENHANCED track under paragraph (a)(3) of this section.

(2) If an ACO is identified as a low revenue ACO, the ACO is eligible for the participation options indicated in paragraph (a) of this section as follows:

(i) If the ACO is determined to be inexperienced with performance-based risk Medicare ACO initiatives, the ACO may enter either the BASIC track's glide path at any of the levels of risk and potential reward available under paragraphs (a)(4)(i)(A)(I) through (5) of this section, except as provided in paragraph (a)(4)(i)(B) of this section, or the ENHANCED track under paragraph (a)(3) of this section.

(ii) If the ACO is determined to be experienced with performance-based risk Medicare ACO initiatives, the ACO may enter under either the BASIC track Level E under paragraph (a)(4)(i)(A)(5) of this section, except as provided in paragraph (d)(3) of this section, or the ENHANCED track under paragraph (a)(3) of this section.

(3) Low revenue ACOs may participate under the BASIC track for a maximum of two agreement periods. A low revenue ACO may only participate in the BASIC track for a second agreement period if it satisfies either of the following:

(i) The ACO is the same legal entity as a current or previous ACO that previously entered into a participation agreement for participation in the BASIC track only one time.

(ii) For a new ACO identified as a re-entering ACO, the ACO in which the majority of the new ACO's participants were participating previously entered into a participation agreement for participation in the BASIC track only one time.

(e) For performance years beginning on or after July 1, 2019 and before January 1, 2024, CMS monitors low revenue ACOs identified as experienced with performance-based risk Medicare ACO initiatives, during an agreement period in the BASIC track, for changes in the revenue of ACO participants that would cause the ACO to be considered a high revenue ACO and ineligible for

participation in the BASIC track. If the ACO meets the definition of a high revenue ACO (as specified in § 425.20)—

(1) The ACO is permitted to complete the remainder of its current performance year under the BASIC track, but is ineligible to continue participation in the BASIC track after the end of that performance year if it continues to meet the definition of a high revenue ACO; and

(2) CMS takes compliance action as specified in §§ 425.216 and 425.218, up to and including termination of the participation agreement, to ensure the ACO does not continue in the BASIC track for subsequent performance years of the agreement period if it continues to meet the definition of a high revenue ACO.

(f) For agreement periods beginning on July 1, 2019, and in subsequent years, CMS determines the agreement period an ACO is entering for purposes of applying program requirements that phase-in over multiple agreement periods, as follows:

(1) An ACO entering an initial agreement period is considered to be entering a first agreement period in the Shared Savings Program.

(2) A re-entering ACO is considered to be entering a new agreement period in the Shared Savings Program as follows—

(i) An ACO whose participation agreement expired without having been renewed re-enters the program under the next consecutive agreement period in the Shared Savings Program;

(ii) An ACO whose participation agreement was terminated under § 425.218 or § 425.220 re-enters the program at the start of the same agreement period in which it was participating at the time of termination from the Shared Savings Program, beginning with the first performance year of that agreement period; or

(iii) A new ACO identified as a re-entering ACO enters the program in an agreement period that is determined based on the prior participation of the ACO in which the majority of the new ACO's participants were participating.

(A) If the participation agreement of the ACO used in this determination expired without having been renewed or was terminated, the agreement period

of the re-entering ACO is determined in accordance with paragraph (f)(2)(i) or (ii) of this section, as applicable.

(B) If the ACO used in this determination is currently participating in the program, the new ACO is considered to be entering into the same agreement period as this currently participating ACO, beginning with the first performance year of that agreement period.

(3) A renewing ACO is considered to be entering the next consecutive agreement period in the Shared Savings Program.

(4) For purposes of this paragraph (f), program requirements that phase in over multiple agreement periods are as follows:

(i) The quality performance standard as described in § 425.502(a) or § 425.512(a), as applicable.

(ii) The weight used in calculating the regional adjustment to the ACO's historical benchmark as described in §§ 425.601(f), and 425.656(e).

(iii) The use of equal weights to weight each benchmark year as specified in §§ 425.601(e), and 425.652(c)(2).

(g) For agreement periods beginning on or after January 1, 2024, CMS determines an ACO's eligibility for the Shared Savings Program participation options specified in paragraph (a) of this section as follows:

(1) If an ACO is determined to be inexperienced with performance-based risk Medicare ACO initiatives, the ACO may enter either the BASIC track's glide path at any of the levels of risk and potential reward under paragraphs (a)(4)(i)(A)(I) through (5) of this section, or the ENHANCED track under paragraph (a)(3) of this section.

(i) An ACO that is inexperienced with performance-based risk Medicare ACO initiatives may participate under the BASIC track's glide path for a maximum of two agreement periods, as specified in paragraph (a)(4)(i)(C) of this section.

(ii) An ACO that enters an agreement under the BASIC track's glide path at either Level A under paragraph (a)(4)(i)(A)(I) of this section or Level B under paragraph (a)(4)(i)(A)(2) of this section is deemed to have completed one agreement under the BASIC track's glide path and is only eligible

to enter a second agreement under the BASIC track's glide path if the ACO continues to meet the definition of inexperienced with performance-based risk Medicare ACO initiatives and satisfies either of the following:

(A) The ACO is the same legal entity as a current or previous ACO that previously entered into a participation agreement for participation in the BASIC track's glide path only one time.

(B) For a new ACO identified as a re-entering ACO, the ACO in which the majority of the new ACO's participants were participating previously entered into a participation agreement for participation in the BASIC track's glide path only one time.

(iii) An ACO that is determined to be inexperienced with performance-based risk Medicare ACO initiatives but is not eligible to enter the BASIC track's glide path as specified in paragraph (a)(4)(i)(C) of this section may enter either the BASIC track Level E under paragraph (a)(4)(i)(A)(5) of this section for all performance years of the agreement period, or the ENHANCED track under paragraph (a)(3) of this section.

(2) If an ACO is determined to be experienced with performance-based risk Medicare ACO initiatives, the ACO may enter either the BASIC track Level E under paragraph (a)(4)(i)(A)(5) of this section for all performance years of the agreement period, or the ENHANCED track under paragraph (a)(3) of this section.

(h)(1) For performance years beginning on or after January 1, 2024, CMS monitors ACOs identified as inexperienced with performance-based risk Medicare ACO initiatives and participating in the BASIC track under a one-sided model during an agreement period pursuant to an election under paragraph (a)(4)(i)(B)(2)(vi), paragraph (a)(4)(i)(B)(2)(vii), or paragraph (a)(4)(i)(C)(3) of this section for changes to their certified list of ACO participants that would cause the ACO to be considered experienced with performance-based risk Medicare ACO initiatives and ineligible for participation in a one-sided model.

(2) If the ACO meets the definition of experienced with performance-based

risk Medicare ACO initiatives (under § 425.20)—

(i) The ACO is permitted to complete the performance year for which it met the definition of experienced with performance-based risk Medicare ACO initiatives in a one-sided model of the BASIC track, but is ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives. The ACO will be automatically advanced to Level E within the BASIC track under paragraph (a)(4)(i)(A)(5) of this section at the start of the next performance year and will remain in Level E for all subsequent performance years of the agreement period; and

(ii) Prior to entering performance-based risk, the ACO must meet all requirements to participate under performance-based risk, including establishing an adequate repayment mechanism as specified under § 425.204(f) and selecting a MSR/MLR from the options specified under § 425.605(b), in accordance with paragraph (a)(4)(i)(B)(2)(v) of this section or paragraph (a)(4)(i)(C)(4) of this section, as applicable. If the ACO fails to meet the requirements to participate under performance-based risk, the agreement is terminated in accordance with paragraph (a)(4)(i)(B)(3) of this section or paragraph (a)(4)(i)(C)(5) of this section, as applicable.

[76 FR 67973, Nov. 2, 2011, as amended at 80 FR 32841, June 9, 2015; 83 FR 68069, Dec. 31, 2018; 85 FR 27625, May 8, 2020; 85 FR 85041, Dec. 28, 2020; 86 FR 45521, Aug. 13, 2021; 87 FR 70235, Nov. 18, 2022; 88 FR 79547, Nov. 16, 2023]

**§ 425.601 Establishing, adjusting, and updating the benchmark for agreement periods beginning on or after July 1, 2019, and before January 1, 2024.**

(a) *Computing per capita Medicare Part A and Part B benchmark expenditures for an ACO's first agreement period.* For agreement periods beginning on July 1, 2019, 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 § 425.400(a)(4)(ii). CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service 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 paragraphs (c) and (d) 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.

(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, 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. CMS does all of the following:

(i) Calculates an average per capita amount of expenditures for the ACO's regional service area as follows:

(A) Determines the counties included in the ACO's regional service area based on the ACO's BY3 assigned beneficiary population.

(B) Determines the ACO's regional expenditures as specified under paragraphs (c) and (d) of this section for BY3.

(C) Adjusts for differences in severity and case mix between the ACO's assigned beneficiary population and the assignable beneficiary population for the ACO's regional service area identified for the 12-month calendar year that corresponds to BY3.

(ii) Calculates the adjustment as follows:

(A) Determines the difference between the average per capita amount of expenditures for the ACO's regional service area as specified under paragraph (a)(8)(i) of this section and the average per capita amount of the ACO's historical benchmark determined under paragraphs (a)(1) through (7) of this section, for each of the following populations of beneficiaries:

- (1) ESRD.
- (2) Disabled.
- (3) Aged/dual eligible for Medicare and Medicaid.
- (4) Aged/non-dual eligible for Medicare and Medicaid.

(B) Applies a percentage, as determined in paragraph (f) of this section.

(C) 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 (a)(8)(ii)(B) of this section at a dollar amount 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 in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary.

(1) 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.

(2) For negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at negative 5 percent of the national per capita expenditure amount for the enrollment type for BY3.

(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 paragraph (a)(8) of this section, according to the ACO's assigned beneficiaries for BY3.

(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), 425.609(c), and 425.610(a).

(b) *Updating the benchmark.* For all agreement periods beginning on July 1,

2019, and in subsequent years, CMS updates the historical benchmark annually for each year of the agreement period using a blend of national and regional growth rates.

(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) National growth rates are computed 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.

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

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

(ii) Determine the ACO's regional expenditures as specified under paragraphs (c) and (d) of this section.

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

(i) 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 (a)(5)(v) of this section; and

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

(c) *Calculating county expenditures.* For all agreement periods beginning on July 1, 2019, 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,

where assignable beneficiaries are identified for the 12-month calendar year corresponding to the relevant benchmark or performance year.

(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.

(d) *Calculating regional expenditures.* For all agreement periods beginning on July 1, 2019, 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 (c) 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 (d)(1) of this section for each population of beneficiaries (according to Medicare enrollment type) across all counties within the ACO's regional service area.

(e) *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 July 1, 2019, and in subsequent years, CMS establishes, adjusts, and updates the rebased historical benchmark in accordance with paragraphs (a) through (d) of this section with the following modifications:

(i) 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.

(ii) For a renewing ACO or re-entering ACO whose prior agreement period benchmark was calculated according to § 425.603(c), to determine the weight used in the regional adjustment calculation described in paragraph (f) of this section, CMS considers the agreement period the ACO is entering into according to § 425.600(f) in combination with either of the following—

(A) 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

(B) 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.

(f) *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 either paragraph (a)(8)(ii)(A) or (e) of this section by the applicable proportion of 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 (f)(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 paragraph (a)(9) of this section, 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 (f)(1) through (3) of this section used in calculating the adjustment under either paragraph (a)(8) or (e) of this section.

(g) *July 1, 2019 through December 31, 2019 performance year.* In determining performance for the July 1, 2019 through December 31, 2019 performance year described in § 425.609(c), CMS does all of the following:

(1) When adjusting the benchmark using the methodology set forth in paragraph (a)(10) of this section and § 425.609(c), CMS adjusts for severity and case mix between BY3 and CY 2019.

(2) When updating the benchmark using the methodology set forth in paragraph (b) of this section and § 425.609(c), CMS updates the benchmark based on growth between BY3 and CY 2019.

[83 FR 68071, Dec. 31, 2018, as amended at 85 FR 85042, Dec. 28, 2020; 87 FR 70237, Nov. 18, 2022; 88 FR 79547, Nov. 16, 2023]

**§ 425.602 Establishing, adjusting, and updating the benchmark for an ACO's first agreement period beginning on or before January 1, 2018.**

(a) *Computing per capita Medicare Part A and Part B benchmark expenditures.* For agreement periods beginning on or before January 1, 2018, in computing an ACO's fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, 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 agreement period using the ACO participants' TINs identified at the start of the agreement period. CMS does all of the following:

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

(ii) This calculation considers individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(A) For agreement periods beginning before 2018, this calculation considers all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For agreement periods beginning in 2018, this calculation considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(C) For the 2018 performance year and subsequent performance years in agreement periods beginning in 2015, 2016 and 2017, the benchmark is adjusted to reflect only 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) Truncation of expenditures:

(i) For agreement periods beginning before 2017—

(A) 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 as determined for each benchmark year in order to minimize variation from catastrophically large claims; and

(B) For the 2017 performance year and any subsequent performance years in agreement periods beginning in 2014, 2015 and 2016, the benchmark is adjusted to reflect the use of assignable beneficiaries in determining the 99th percentile of Medicare fee-for-service expenditures for purposes of truncating

expenditures for assigned beneficiaries during each benchmark year as specified in paragraph (a)(4)(ii) of this section.

(ii) For agreement periods beginning in 2017 and 2018, 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) Trending expenditures:

(i) For agreement periods beginning before 2017—

(A) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates and trends expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

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

(1) ESRD.

(2) Disabled.

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

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

(C) For the 2017 performance year and any subsequent performance years in agreement periods beginning in 2014, 2015 and 2016, the benchmark is adjusted to reflect the use of assignable beneficiaries to perform each of these calculations as specified in paragraph (a)(5)(ii) of this section.

(ii) For agreement periods beginning in 2017 and 2018—

(A) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates for assignable beneficiaries identified for the 12-month calendar year corresponding to each benchmark year, and trends expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

(B) To trend forward the benchmark, CMS makes separate calculations for

expenditure categories for each of the following populations of beneficiaries:

- (1) ESRD.
- (2) Disabled.
- (3) Aged/dual eligible Medicare and Medicaid beneficiaries.
- (4) Aged/non-dual eligible Medicare and Medicaid beneficiaries.
- (6) Restates BY1 and BY2 trended and risk adjusted expenditures in 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 the initial agreement period using the following percentages:
  - (i) BY3 at 60 percent.
  - (ii) BY2 at 30 percent.
  - (iii) BY1 at 10 percent.
- (8) The ACO's benchmark is adjusted for the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b) and for a change to the beneficiary assignment methodology specified in subpart E of this part, as applicable, to take into account the expenditures for 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.
- (9) The historical benchmark is further adjusted at the time of reconciliation for a performance year to account for changes in severity and case mix for newly and continuously assigned beneficiaries using prospective HCC risk scores and demographic factors as described under §§ 425.604(a)(1) through (3), 425.606(a)(1) through (3), and 425.610(a)(1) through (3).
- (b) *Updating the benchmark.* CMS updates the historical benchmark annually for each year of the agreement period based on the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program.
  - (1) For performance years before 2017, CMS updates the historical benchmark annually for each year of the agreement period based on the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B

services under the original Medicare fee-for-service program.

- (i) CMS updates the fixed benchmark by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program using data from CMS' Office of the Actuary.
- (ii) To update the benchmark, CMS makes expenditure calculations for separate 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.
- (2) For the 2017 performance year and subsequent performance years, CMS updates the historical benchmark annually for each year of the agreement period based on the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries identified for the 12-month calendar year corresponding to the year for which the update is calculated.
  - (i) CMS updates the fixed benchmark by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries identified for the 12-month calendar year corresponding to the year for which the update is being calculated using data from CMS' Office of the Actuary.
  - (ii) To update the benchmark, CMS makes expenditure calculations for separate 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.
  - (c) *January 1, 2019 through June 30, 2019 performance year.* In determining performance for the January 1, 2019 through June 30, 2019 performance year described in § 425.609(b) CMS does all of the following:

(1) When adjusting the benchmark using the methodology set forth in paragraph (a)(9) of this section and § 425.609(b), CMS adjusts for severity and case mix between BY3 and CY 2019.

(2) When updating the benchmark using the methodology set forth in paragraph (b) of this section and § 425.609(b), CMS updates the benchmark based on growth between BY3 and CY 2019.

[76 FR 67973, Nov. 2, 2011, as amended at 80 FR 32842, June 9, 2015; 81 FR 38014, June 10, 2016; 82 FR 53370, Nov. 15, 2017; 83 FR 60094, Nov. 23, 2018; 83 FR 68074, Dec. 31, 2018; 85 FR 85042, Dec. 28, 2020]

**§ 425.603 Resetting, adjusting, and updating the benchmark for a subsequent agreement period beginning on or before January 1, 2019.**

(a) An ACO's benchmark is reset at the start of each subsequent agreement period.

(b) For second agreement periods beginning in 2016, CMS establishes, adjusts, and updates the rebased historical benchmark in accordance with § 425.602(a) and (b) with the following modifications:

(1) Rather than weighting each year of the benchmark using the percentages provided at § 425.602(a)(7), each benchmark year is weighted equally.

(2) An additional adjustment is made to account for the average per capita amount of savings generated during the ACO's previous agreement period. The adjustment is limited to the average number of assigned beneficiaries (expressed as person years) under the ACO's first agreement period.

(c) For second or subsequent agreement periods beginning in 2017, 2018 and on January 1, 2019, CMS establishes the rebased historical benchmark by determining the per capita Parts A and B fee-for-service expenditures for beneficiaries who would have been assigned to the ACO in any of the 3 most recent years before the agreement period using the certified ACO participant list submitted before the start of the agreement period as required under § 425.118. CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service claims using a 3-month claims run

out with a completion factor. The calculation—

(i) Excludes IME and DSH payments; and

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

(A) For agreement periods beginning before 2018, considers all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For agreement periods beginning in 2018 and on January 1, 2019, considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(C) For the 2018 and 2019 performance years in agreement periods beginning in 2017, the benchmark is adjusted to reflect only 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:

(i) ESRD.

(ii) Disabled.

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

(iv) 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 regional growth rates based on expenditures for the ACO's regional service area as determined under paragraphs (e) and (f) of this section, making separate expenditure calculations 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.
- (6) Restates BY1 and BY2 trended and risk-adjusted expenditures in BY3 proportions 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.
- (7) Weights each benchmark year equally.
- (8) 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), 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 for 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 paragraph (c)(9) of this section, according to the ACO's assigned beneficiaries for BY3.
  - (9) Adjusts 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. CMS does all of the following:
    - (i) Calculates an average per capita amount of expenditures for the ACO's regional service area as follows:
      - (A) Determines the counties included in the ACO's regional service area based on the ACO's BY3 assigned beneficiary population.
      - (B) Determines the ACO's regional expenditures as specified under paragraphs (e) and (f) of this section for BY3.
      - (C) Adjusts for differences in severity and case mix between the ACO's as-

signed beneficiary population and the assignable beneficiary population for the ACO's regional service area identified for the 12-month calendar year that corresponds to BY3.

- (ii) Calculates the adjustment as follows:

- (A) Determines the difference between the average per capita amount of expenditures for the ACO's regional service area as specified under paragraph (c)(9)(i) of this section and the average per capita amount of the ACO's rebased historical benchmark determined under paragraphs (c)(1) through (8) of this section, for each of the following populations of beneficiaries:
  - (1) ESRD.
  - (2) Disabled.
  - (3) Aged/dual eligible Medicare and Medicaid beneficiaries.
  - (4) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

- (B) Applies a percentage, determined as follows:
  - (1) The first time an ACO's benchmark is rebased using the methodology described under paragraph (c) of this section, 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 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.
  - (2) The second time that an ACO's benchmark is rebased using the methodology described under paragraph (c) of this section, CMS calculates the regional adjustment to the historical benchmark as follows:
    - (i) Using 70 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, unless the Secretary determines a lower weight should be applied, if the ACO is determined to have lower spending than the ACO's regional service area;

(ii) 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 higher spending than the ACO's regional service area.

(3) The third or subsequent time that an ACO's benchmark is rebased using the methodology described under paragraph (c) of this section, CMS calculates the regional adjustment to the historical benchmark using 70 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, unless the Secretary determines a lower weight should be applied.

(4) 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 rebased 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)(9)(ii)(A) of this section by the applicable proportion of the ACO's assigned beneficiary population (ESRD, Disabled, Aged/dual eligible Medicare and Medicaid beneficiaries, Aged/non-dual eligible Medicare and Medicaid beneficiaries) for benchmark year 3 of the rebased historical benchmark.

(ii) Sums the amounts determined in paragraph (c)(9)(ii)(B)(4)(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 CMS adjusts the ACO's benchmark, as specified in paragraph (c)(8) of this section, 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 used in calculating the adjustment in paragraphs (c)(9)(ii)(B)(i) and (2) of this section.

(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 for newly and continuously assigned beneficiaries using prospective HCC risk scores and demographic factors as described under §§ 425.604(a)(1) through (3), 425.606(a)(1) through (3), and 425.610(a)(1) through (3).

(d) For second or subsequent agreement periods beginning in 2017, 2018 and on January 1, 2019, CMS updates the rebased historical benchmark under paragraph (c) of this section, annually for each year of the agreement period by the growth in risk adjusted regional per beneficiary FFS spending for the ACO's regional service area by doing all of the following:

(1) Determining the counties included in the ACO's regional service area based on the ACO's assigned beneficiary population used to determine financial reconciliation for the relevant performance year.

(2) Determining growth rates based on expenditures for counties in the ACO's regional service area calculated under paragraphs (e) and (f) of this section, for the performance year compared to BY3 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.

(3) Updating the benchmark by making separate calculations 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.

(e) For second or subsequent agreement periods beginning in 2017, 2018 and on January 1, 2019, 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, where assignable beneficiaries are identified for the 12-month calendar year corresponding to the relevant benchmark or performance year.

(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

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

(A) For agreement periods beginning before 2018, considers all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For agreement periods beginning in 2018 and on January 1, 2019, considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(C) For the 2018 and 2019 performance years in agreement periods beginning in 2017, risk adjusted county fee-for-

service expenditures are adjusted to reflect only 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 CMS-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.

(f) For second or subsequent agreement periods beginning in 2017, 2018, and on January 1, 2019, CMS calculates an ACO's risk adjusted regional expenditures by—

(1) Weighting the risk-adjusted county-level fee-for-service expenditures determined under paragraph (e) 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 (f)(1) of this

section for each population of beneficiaries (according to Medicare enrollment type) across all counties within the ACO's regional service area; and

(3) Weighting the aggregate expenditure values determined for each population of beneficiaries (according to Medicare enrollment type) under paragraph (f)(2) of this section by a weight reflecting the proportion of the ACO's overall beneficiary population in the applicable Medicare enrollment type for the relevant benchmark or performance year.

(g) In determining performance for the January 1, 2019 through June 30, 2019 performance year described in § 425.609(b) CMS does all of the following:

(1) When adjusting the benchmark using the methodology set forth in paragraph (c)(10) of this section and § 425.609(b), CMS adjusts for severity and case mix between BY3 and CY 2019.

(2) When updating the benchmark using the methodology set forth in paragraph (d) of this section and § 425.609(b), CMS updates the benchmark based on growth between BY3 and CY 2019.

[81 FR 38014, June 10, 2016, as amended at 82 FR 53370, Nov. 15, 2017; 83 FR 60094, Nov. 23, 2018; 83 FR 68074, Dec. 31, 2018; 85 FR 85042, Dec. 28, 2020]

**§ 425.604 Calculation of savings under the one-sided model.**

(a) *Savings determination.* For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark determined under § 425.602 or § 425.603.

(1) *Newly assigned beneficiaries.* CMS uses an ACO's HCC prospective risk score to adjust the benchmark for changes in severity and case mix in this population.

(2) *Continuously assigned beneficiaries.* (i) CMS uses demographic factors to adjust the benchmark for changes in the continuously assigned population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust the benchmark for changes in severity and

case mix in this population using this lower prospective HCC risk score.

(3) Assigned beneficiary changes in demographics and health status are used to adjust benchmark expenditures as described in § 425.602(a) or § 425.603(c). In adjusting the benchmark for health status and demographic changes CMS makes adjustments for separate 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.

(4)(i) For performance years before 2017 to minimize variation from catastrophically large claims, CMS 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 as determined for each performance year.

(ii) For the 2017 performance year and subsequent performance years, to minimize variation from catastrophically large claims, CMS 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 as determined for the applicable performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to the performance year.

(5) CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(A) For performance years beginning before 2018, these calculations will take

§ 425.604

42 CFR Ch. IV (10–1–24 Edition)

into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for

the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings rate (MSR)*. CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for an ACO participating under the one-sided model. The MSR under the one-sided model for an ACO based on the number of assigned beneficiaries is as follows:

Number of Beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
1 – 499	≥12.2	
500 – 999	12.2	8.7
1,000 – 2,999	8.7	5.0
3,000 – 4,999	5.0	3.9
5,000 – 5,999	3.9	3.6
6,000 – 6,999	3.6	3.4
7,000 – 7,999	3.4	3.2
8,000 – 8,999	3.2	3.1
9,000 – 9,999	3.1	3.0
10,000 – 14,999	3.0	2.7
15,000 – 19,999	2.7	2.5
20,000 – 49,999	2.5	2.2
50,000 – 59,999	2.2	2.0
60,000 +	2.0	2.0

(c) *Qualification for shared savings payment*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020*. In order to qualify for shared savings, an ACO must meet or exceed its minimum savings rate determined under paragraph (b) of this section, meet the minimum quality performance standards established under § 425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(2) *For the performance year beginning on January 1, 2021*. To qualify for shared savings, an ACO must meet or exceed

its minimum savings rate determined under paragraph (b) of this section, meet the quality performance standard established under § 425.512, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020*. An ACO that meets all the requirements for receiving shared savings payments under the one-sided model will receive a shared savings payment of up to 50 percent of all savings under the updated benchmark, as determined on the

basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (e)(2) of this section).

(2) *For the performance year beginning on January 1, 2021.* An ACO that meets all the requirements for receiving shared savings payments under Track 1 will receive a shared savings payment of 50 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (e)(2) of this section).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the one-sided model may not exceed 10 percent of its updated benchmark.

(f) *Notification of savings.* CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(g) *January 1, 2019 through June 30, 2019 performance year.* Shared savings for the January 1, 2019 through June 30, 2019 performance year are calculated as described in § 425.609.

[76 FR 67973, Nov. 2, 2011, as amended at 81 FR 38016, June 10, 2016; 82 FR 53370, Nov. 15, 2017; 83 FR 60094, Nov. 23, 2018; 83 FR 68074, Dec. 31, 2018; 85 FR 85042, Dec. 28, 2020]

**§ 425.605 Calculation of shared savings and losses under the BASIC track.**

(a) *General rules.* For each performance year, CMS determines whether the estimated average per capita Medicare Parts A and B fee-for-service expenditures for Medicare fee-for-service beneficiaries assigned to the ACO are above or below the updated benchmark determined under § 425.601 or § 425.652, as applicable. In order to qualify for a shared savings payment under the BASIC track, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate under paragraph (b) of

this section except as provided in paragraph (h) of this section.

(1) CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year.

(i) For agreement periods beginning before January 1, 2024:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent.

(B) This cap is the maximum increase in risk scores for each agreement period, such that any positive adjustment between BY3 and any performance year in the agreement period cannot be larger than 3 percent.

(ii) For agreement periods beginning on January 1, 2024, and in subsequent years:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year (positive or negative) plus 3 percentage points.

(B) The cap described in paragraph (a)(1)(ii)(A) of this section will apply to prospective HCC risk score growth for a population described in paragraph (a)(2) of this section only if the ACO's aggregate growth in prospective HCC risk scores between BY3 and the performance year across all of the populations described in paragraph (a)(2) of this section exceeds this cap. If the cap described in paragraph (a)(1)(ii)(A) of this section is determined to apply, the value of the cap is the maximum increase in risk scores for the applicable performance year, such that any positive adjustment between BY3 and the performance year cannot be larger than the value of the cap for any of the populations described in paragraph (a)(2) of this section.

(C) The aggregate growth in demographic risk scores for purposes of paragraph (a)(1)(ii)(A) of this section and the aggregate growth in prospective HCC risk scores for purposes of paragraph (a)(1)(ii)(B) of this section is calculated by taking a weighted average of the growth in demographic risk scores or prospective HCC risk scores, as applicable, across the populations

**§ 425.605**

**42 CFR Ch. IV (10–1–24 Edition)**

described in paragraph (a)(2) of this section. When calculating the weighted average growth in demographic risk scores or prospective HCC risk scores, as applicable, the weight applied to the growth in risk scores (expressed as a ratio of the ACO's performance year risk score to the ACO's BY3 risk score) for each Medicare enrollment type is equal to the product of the historical benchmark expenditures for that enrollment type and the performance year person years for that enrollment type.

(2) In risk adjusting the benchmark as described in §§ 425.601(a)(10) and 425.652(a)(10), CMS makes separate adjustments 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.

(3) To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Medicare Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare Parts A and B fee-for-service expenditures as determined for the applicable performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to the performance year.

(4) CMS uses a 3-month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(5) Calculations of the ACO's expenditures include the payment amounts included in Medicare Parts A and B fee-for-service claims.

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

(ii) These calculations take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(6) In order to qualify for a shared savings payment, the ACO's average per capita Medicare Parts A and B fee-for-service expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section except as provided in paragraph (h) of this section.

(b) *Minimum savings or loss rate.* (1) For ACOs under a one-sided model of the BASIC track's glide path, as specified under paragraphs (d)(1)(i) and (ii) of this section, CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for the ACO as follows:

Number of Beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
1 – 499	≥12.2	
500 – 999	12.2	8.7
1,000 – 2,999	8.7	5.0
3,000 – 4,999	5.0	3.9
5,000 – 5,999	3.9	3.6
6,000 – 6,999	3.6	3.4
7,000 – 7,999	3.4	3.2
8,000 – 8,999	3.2	3.1
9,000 – 9,999	3.1	3.0
10,000 – 14,999	3.0	2.7
15,000 – 19,999	2.7	2.5
20,000 – 49,999	2.5	2.2
50,000 – 59,999	2.2	2.0
60,000 +	2.0	2.0

(2) Prior to entering a two-sided model of the BASIC track, the ACO must select the MSR/MLR. For an ACO making this selection as part of an application for, or renewal of, participation in a two-sided model of the BASIC track, the selection applies for the duration of the agreement period under the BASIC track. For an ACO making this selection during an agreement period, as part of the application cycle prior to entering a two-sided model of the BASIC track, the selection applies for the remaining duration of the applicable agreement period under the BASIC track.

(i) The ACO must choose from the following options for establishing the MSR/MLR:

(A) Zero percent MSR/MLR.

(B) Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0 percent.

(C) Symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO under subpart E of this part. The MSR is the same as the MSR that would apply under paragraph (b)(1) of this section for an ACO under a one-sided model of the BASIC track's glide path, and is based on the number of assigned beneficiaries. The MLR under the BASIC track is equal to the negative MSR.

(ii) The ACO selects its MSR/MLR as part of one the following:

(A) Application for, or renewal of, program participation in a two-sided model of the BASIC track.

(B) Election to participate in a two-sided model of the BASIC track during an agreement period under § 425.226.

(C) Automatic transition from Level B to Level C of the BASIC track's glide path under § 425.600(a)(4)(i).

(D) Automatic transition from Level B to Level E of the BASIC track's glide path under § 425.600(a)(4)(i)(B)(2)(ii).

(E) Automatic transition from Level A to Level E of the BASIC track's glide path under § 425.600(h)(2).

(3) Except as provided in paragraph (h) of this section, in order to qualify for a shared savings payment, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for the performance year must be below its updated benchmark by at least the MSR established for the ACO.

(4) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for the performance year must be above its updated benchmark costs for the year by at least the MLR established for the ACO.

(c) *Qualification for shared savings payment*—(1) *For performance years beginning on or before January 1, 2020.* To



**§ 425.605**

**42 CFR Ch. IV (10–1–24 Edition)**

qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the minimum quality performance standards established under § 425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(2) *For performance years beginning on or after January 1, 2021.* To qualify for shared savings, an ACO must—

(i) Meet either the minimum savings rate requirement established under paragraph (b) of this section, or the criteria described in paragraph (h) of this section;

(ii) Meet either the quality performance standard or alternative quality performance standard established under § 425.512; and

(iii) Otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Levels of risk and potential reward.*

(1) The following levels of risk and potential reward apply to an ACO in the BASIC track, as permitted under § 425.600(d) or § 425.600(g).

(i) *Level A (one-sided model)—(A) Final sharing rate—(1) For performance years beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level A, receives a shared savings payment of up to 40 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (d)(1)(i)(B) of this section).

(2) *For performance years beginning on January 1, 2021, or January 1, 2022.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level A, receives a shared savings payment of 40 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(i)(B) of this section).

(3) *For the performance year beginning on January 1, 2023.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level A, receives a shared savings payment equal to a per-

centage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(i)(B) of this section). The percentage is as follows:

(i) 40 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i).

(ii) 40 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(4) *For performance years beginning on or after January 1, 2024.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level A, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(i)(B) of this section). Except as provided in paragraph (h) of this section, the percentage is as follows:

(i) 40 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(ii) 40 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(B) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, or as provided in paragraph (h) of this section, the final sharing rate specified in paragraph (d)(1)(i)(A) of this section applies to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the BASIC track, Level A, may not exceed 10 percent of its updated benchmark.

(ii) *Level B (one-sided model)—(A) Final sharing rate—(1) For performance years beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track,

Level B, receives a shared savings payment of up to 40 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (d)(1)(ii)(B) of this section).

(2) (2) *For performance years beginning on January 1, 2021, or January 1, 2022.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level B, receives a shared savings payment of 40 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(ii)(B) of this section).

(3) *For the performance year beginning on January 1, 2023.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level B, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(ii)(B) of this section). The percentage is as follows:

(i) 40 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i).

(ii) 40 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(4) *For performance years beginning on or after January 1, 2024.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level B, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(ii)(B) of this section). Except as provided in paragraph (h) of this section, the percentage is as follows:

(i) 40 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(ii) 40 percent multiplied by the ACO's health equity adjusted quality

performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(B) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, or as provided in paragraph (h) of this section, the final sharing rate specified in paragraph (d)(1)(ii)(A) of this section applies to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the BASIC track, Level B, may not exceed 10 percent of its updated benchmark.

(iii) *Level C (two-sided model)*—(A) *Final sharing rate*—(1) *For performance years beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level C, receives a shared savings payment of up to 50 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (d)(1)(iii)(B) of this section).

(2) *For performance years beginning on January 1, 2021, or January 1, 2022.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level C, receives a shared savings payment of 50 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(iii)(B) of this section).

(3) *For the performance year beginning on January 1, 2023.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level C, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(iii)(B) of this section). The percentage is as follows:

(i) 50 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i).

(ii) 50 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets

the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(4) *For performance years beginning on or after January 1, 2024.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level C, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(iii)(B) of this section). Except as provided in paragraph (h) of this section, the percentage is as follows:

(i) 50 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(ii) 50 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(B) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, or as provided in paragraph (h) of this section, the final sharing rate specified in paragraph (d)(1)(iii)(A) of this section applies to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the BASIC track, Level C may not exceed 10 percent of its updated benchmark.

(C) *Shared loss rate.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on a fixed 30 percent loss sharing rate.

(D) *Loss recoupment limit.* (1) Except as provided in paragraph (d)(1)(iii)(D)(2) of this section, the amount of shared losses for which an eligible ACO is liable may not exceed 2 percent of total Medicare Parts A and B fee-for-service revenue of the ACO participants in the ACO.

(2) Instead of the revenue-based loss recoupment limit determined under paragraph (d)(1)(iii)(D)(1) of this section, the loss recoupment limit for the ACO is 1 percent of the ACO's updated benchmark as determined under

§ 425.601 or § 425.652, if the amount determined under paragraph (d)(1)(iii)(D)(1) of this section exceeds the amount that is 1 percent of the ACO's updated benchmark as determined under § 425.601 or § 425.652.

(iv) *Level D (two-sided model)*—(A) *Final sharing rate*—(1) *For performance years beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level D, receives a shared savings payment of up to 50 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (d)(1)(iv)(B) of this section).

(2) *For performance years beginning on January 1, 2021, or January 1, 2022.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level D, receives a shared savings payment of 50 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(iv)(B) of this section).

(3) *For the performance year beginning on January 1, 2023.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level D, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(iv)(B) of this section). The percentage is as follows:

(i) 50 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i).

(ii) 50 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(4) *For performance years beginning on or after January 1, 2024.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level D, receives a

shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(iv)(B) of this section). Except as provided in paragraph (h) of this section, the percentage is as follows:

(i) 50 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(ii) 50 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(B) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, or as provided in paragraph (h) of this section, the final sharing rate specified in paragraph (d)(1)(iv)(A) of this section applies to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the BASIC track, Level D, may not exceed 10 percent of its updated benchmark.

(C) *Shared loss rate.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on a fixed 30 percent loss sharing rate.

(D) *Loss recoupment limit.* (1) Except as provided in paragraph (d)(1)(iv)(D)(2) of this section, the amount of shared losses for which an eligible ACO is liable may not exceed 4 percent of total Medicare Parts A and B fee-for-service revenue of the ACO participants in the ACO.

(2) Instead of the revenue-based loss recoupment limit determined under paragraph (d)(1)(iv)(D)(1) of this section, the loss recoupment limit for the ACO is 2 percent of the ACO's updated benchmark as determined under § 425.601 or § 425.652, if the amount determined under paragraph (d)(1)(iv)(D)(1) of this section exceeds the amount that is 2 percent of the ACO's updated benchmark as determined under § 425.601 or § 425.652.

(v) *Level E (two-sided model)—(A) Final sharing rate—(1) For performance*

*years beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level E, receives a shared savings payment of up to 50 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (d)(1)(v)(B) of this section).

(2) *For performance years beginning on January 1, 2021, or January 1, 2022.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level E, receives a shared savings payment of 50 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(v)(B) of this section).

(3) *For the performance year beginning on January 1, 2023.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level E, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(v)(B) of this section). The percentage is as follows:

(i) 50 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i).

(ii) 50 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(4) *For performance years beginning on or after January 1, 2024.* An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level E, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(v)(B) of this section). Except as provided in paragraph (h) of this section, the percentage is as follows:

(i) 50 percent for an ACO that that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(ii) 50 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(B) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, or as provided in paragraph (h) of this section, the final sharing rate specified in paragraph (d)(1)(v)(A) of this section applies to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the BASIC track, Level E, may not exceed 10 percent of its updated benchmark.

(C) *Shared loss rate.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on a fixed 30 percent loss sharing rate.

(D) *Loss recoupment limit.* (1) Except as provided in paragraph (d)(1)(v)(D)(2) of this section, the amount of shared losses for which an eligible ACO is liable may not exceed the percentage, as specified in § 414.1415(c)(3)(i)(A) of this chapter, of total Medicare Parts A and B fee-for-service revenue of the ACO participants in the ACO.

(2) Instead of the revenue-based loss recoupment limit determined under paragraph (d)(1)(v)(D)(1) of this section, the loss recoupment limit for the ACO is 1 percentage point higher than the percentage, as specified in § 414.1415(c)(3)(i)(B) of this chapter, based on the ACO's updated benchmark as determined under § 425.601 or § 425.652, if the amount determined under paragraph (d)(1)(v)(D)(1) of this section exceeds this percentage of the ACO's updated benchmark as determined under § 425.601 or § 425.652.

(2) Level E risk and reward as specified in paragraph (d)(1)(v) of this section applies to an ACO eligible to enter the BASIC track that is determined to be experienced with performance-based risk Medicare ACO initiatives as specified under § 425.600(d) or § 425.600(g).

(e) *Notification of savings and losses.*

(1) CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(2) CMS provides written notification to an ACO of the amount of shared losses, if any, that it must repay to the program.

(3) If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification.

(f) *Extreme and uncontrollable circumstances.* The following adjustment is made in calculating the amount of shared losses, after the application of the shared loss rate and the loss recoupment limit.

(1) CMS determines the percentage of the ACO's performance year assigned beneficiary population affected by an extreme and uncontrollable circumstance.

(2) CMS reduces the amount of the ACO's shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.

(i) For an ACO that is liable for a pro-rated share of losses under § 425.221(b)(2)(ii), the amount of shared losses determined for the performance year during which the termination becomes effective is adjusted according to this paragraph (f)(2).

(ii) [Reserved]

(3) CMS applies determinations made under the Quality Payment Program with respect to—

(i) Whether an extreme and uncontrollable circumstance has occurred; and

(ii) The affected areas.

(4) CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's assigned beneficiaries residing in the affected areas.

(g) *July 1, 2019 through December 31, 2019 performance year.* Shared savings or shared losses for the July 1, 2019

through December 31, 2019 performance year are calculated as described in § 425.609.

(h) *Calculation of shared savings for certain BASIC track ACOs not meeting MSR requirement.* An ACO that does not meet the minimum savings rate requirement established under paragraph (b) of this section but meets the other criteria described in paragraphs (c)(2)(ii) and (iii) of this section may qualify for a shared savings payment as provided in this paragraph.

(1) To qualify for a shared savings payment under this paragraph, an ACO must meet all of the following criteria:

(i) The ACO has average per capita Medicare Parts A and B fee-for-service expenditures for the performance year below the updated benchmark determined under § 425.652.

(ii) The ACO is a low revenue ACO as defined in § 425.20 as determined at the time of financial reconciliation for the performance year.

(iii) The ACO has at least 5,000 assigned beneficiaries for the relevant performance year as determined at the time of financial reconciliation for the performance year.

(iv) The ACO is participating in an agreement period beginning on January 1, 2024, or in subsequent years.

(2) The ACO's shared savings payment will be calculated as described in paragraph (d) of this section according to the ACO's applicable level of the BASIC track with the exception that the final sharing rate applied will equal one-half of the applicable percentage described in paragraph (d)(1)(i)(A)(4), (d)(1)(ii)(A)(4), (d)(1)(iii)(A)(4), (d)(1)(iv)(A)(4), or (d)(1)(v)(A)(4) of this section.

[83 FR 68075, Dec. 31, 2018, as amended at 85 FR 85042, Dec. 28, 2020; 87 FR 70237, Nov. 18, 2022]

**§ 425.606 Calculation of shared savings and losses under Track 2.**

(a) *General rule.* For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are above or below the updated benchmark determined under § 425.602 or § 425.603. In order to qualify for a shared savings

payment under Track 2, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate under paragraph (b) of this section.

(1) *Newly assigned beneficiaries.* CMS uses an ACO's HCC prospective risk score to adjust the benchmark for changes in severity and case mix in this population.

(2) *Continuously assigned beneficiaries.*

(i) CMS uses demographic factors to adjust the benchmark for changes in the continuously assigned beneficiary population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust the benchmark for changes in severity and case mix for this population using this lower prospective HCC risk score.

(3) Assigned beneficiary changes in demographics and health status are used to adjust benchmark expenditures as described in § 425.602(a) or § 425.603(c). In adjusting the benchmark for health status and demographic changes CMS makes separate adjustments 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.

(4)(i) For performance years before 2017 to minimize variation from catastrophically large claims, CMS 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 as determined for each performance year.

(ii) For the 2017 performance year and subsequent performance years, to minimize variation from catastrophically large claims, CMS 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 as determined for the applicable performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to the performance year.

(5) CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(A) For performance years beginning before 2018, these calculations will take into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings or loss rate.* (1)(i) For agreement periods beginning in 2012 through 2015, the ACO's MSR and MLR are set at 2 percent.

(ii) For agreement periods beginning in 2016 and subsequent years, as part of the ACO's application for, or renewal of, program participation, the ACO must choose from the following options for establishing the MSR/MLR for the duration of the agreement period:

(A) Zero percent MSR/MLR.

(B) Symmetrical MSR/MLR in a 0.5 percent increment between 0.5–2.0 percent.

(C) Symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO under subpart E of this part. The MSR for an ACO under Track 2 is the same as the MSR that would apply in the one-sided model under § 425.604(b) and is based on the number of assigned beneficiaries. The MLR under Track 2 is equal to the negative MSR.

(2) To qualify for shared savings under Track 2, an ACO's average per capita Medicare expenditures for the performance year must be below its updated benchmark costs for the year by at least the MSR established for the ACO.

(3) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare expenditures for the performance year must be above its updated benchmark costs for the year by at least the MLR established for the ACO.

(c) *Qualification for shared savings payment—*(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* To qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the minimum quality performance standards established under § 425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(2) *For the performance year beginning on January 1, 2021.* To qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the quality performance standard established under § 425.512, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate—*(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under Track 2 will receive a shared savings payment of up to 60 percent of all the savings under the updated benchmark, as determined on the basis of its

quality performance under § 425.502 (up to the performance payment limit described in paragraph (e)(2) of this section).

(2) *For the performance year beginning on January 1, 2021.* An ACO that meets all the requirements for receiving shared savings payments under Track 2 will receive a shared savings payment of 60 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (e)(2) of this section).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under Track 2 may not exceed 15 percent of its updated benchmark.

(f) *Shared loss rate—*(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on the inverse of its final sharing rate described in paragraph (d)(1) of this section (that is, 1 minus the final shared savings rate determined under paragraph (d)(1) of this section). The shared loss rate—

(i) May not exceed 60 percent; and

(ii) May not be less than 40 percent.

(2) *For the performance year beginning on January 1, 2021.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined as follows:

(i) If the ACO meets the quality performance standard established in § 425.512, CMS determines the shared loss rate as follows:

(A) Calculate the quotient of the MIPS Quality performance category points earned divided by the total MIPS Quality performance category points available.

(B) Calculate the product of the quotient determined in paragraph (f)(2)(i)(A) of this section and 60 percent.

(C) Calculate the shared loss rate as 1 minus the product determined in

paragraph (f)(2)(i)(B) of this section. The shared loss rate—

(1) May not exceed 60 percent; and

(2) May not be less than 40 percent.

(ii) If the ACO fails to meet the quality performance standard established in § 425.512, the shared loss rate is 60 percent.

(g) *Loss recoupment limit.* The amount of shared losses for which an eligible ACO is liable may not exceed the following percentages of its updated benchmark as determined under § 425.602 or § 425.603:

(1) 5 percent in the first performance year of participation in Track 2 under the Shared Savings Program.

(2) 7.5 percent in the second performance year.

(3) 10 percent in the third and any subsequent performance year.

(h) *Notification of savings and losses.*

(1) CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(2) CMS provides written notification to an ACO of the amount of shared losses, if any, that it must repay to the program.

(3) If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification.

(i) *Extreme and uncontrollable circumstances.* For performance year 2017 and subsequent performance years, the following adjustment is made in calculating the amount of shared losses, after the application of the shared loss rate in paragraph (f) of this section and the loss recoupment limit in paragraph (g) of this section.

(1) CMS determines the percentage of the ACO's performance year assigned beneficiary population affected by an extreme and uncontrollable circumstance.

(2) CMS reduces the amount of the ACO's shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.



**§ 425.608**

**42 CFR Ch. IV (10–1–24 Edition)**

(i) For an ACO that is liable for a pro-rated share of losses under § 425.221(b)(2)(ii) or (b)(3)(i), the amount of shared losses determined for the performance year during which the termination becomes effective is adjusted according to this paragraph (i)(2).

(ii) [Reserved]

(3) CMS applies determinations made under the Quality Payment Program with respect to—

(i) Whether an extreme and uncontrollable circumstance has occurred; and

(ii) The affected areas.

(4) CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's assigned beneficiaries residing in the affected areas.

(j) *January 1, 2019 through June 30, 2019.* Shared savings or shared losses for the January 1, 2019 through June 30, 2019 performance year are calculated as described in § 425.609.

[76 FR 67973, Nov. 2, 2011, as amended at 80 FR 32842, June 9, 2015; 81 FR 38017, June 10, 2016; 82 FR 53370, Nov. 15, 2017; 82 FR 60918, Dec. 26, 2017; 83 FR 60094, Nov. 23, 2018; 83 FR 68077, Dec. 31, 2018; 85 FR 85043, Dec. 28, 2020]

**§ 425.608 Determining first year performance for ACOs beginning April 1 or July 1, 2012.**

(a) For April 1 and July 1, 2012 starters, first year (defined as 21 and 18 months respectively) performance will be based on an optional interim payment calculation (based on the ACO's first 12 months of participation) and a final reconciliation at the end of the ACO's first performance year. Unless stated otherwise, for purposes of the interim payment calculation and first year reconciliation, the methodology under subpart E of this part for assigning beneficiaries and the methodology described in § 425.602 through § 425.606 for calculating shared savings and losses will apply, and quality performance will be assessed as described in subpart F of this part.

(b) In the interim payment calculation, based on the ACO's first 12 months of performance—

(1) CMS compares the first 12 months of per capita beneficiary expenditures to a historical benchmark updated for

the period which includes the ACO's first 12 months of participation, taking into account changes in health status and demographics; and

(2) Quality performance is based on GPRO quality data reported for CY 2012.

(c)(1) The interim payment calculation is reconciled with the ACO's performance for its complete first performance year, defined as 21 months for April 1, 2012 starters and 18 months for July 1, 2012 starters.

(2) The first year reconciliation takes into account expenditures spanning the entire 21 or 18 months of the first performance year.

(3) First performance year expenditures are summed over beneficiaries assigned in two overlapping 12 month assignment windows.

(i) The first window will be the first 12 months used for interim payment calculation.

(ii) The second window will be CY2013.

(4) Expenditures for the first performance year are the sum of aggregate expenditure dollars accounting for the ACO's first 6 or 9 months of performance within CY 2012 for beneficiaries assigned for the interim payment calculation and aggregate dollars calculated for CY2013 for beneficiaries assigned for CY 2013.

(5) Adjustments for health status and demographic changes are performed as described in § 425.604 through § 425.606 with the following exceptions:

(i) Beneficiaries from the CY2013 assignment window are identified as continuously assigned or newly assigned relative to the previous calendar year.

(ii) The adjustment factor identified for purposes of the interim payment calculation is applied to the 6 months or 9 months of the ACO's first performance year that lie within CY2012.

(6) The updated benchmark, stated in aggregate dollars, is the sum of the interim updated benchmark for the average fraction of expenditures incurred in the latter 6 or 9 months of CY 2012 and an updated aggregate benchmark representing CY 2013.

(7) A savings percentage (based on a comparison of summed expenditures to summed updated benchmark dollars)

for the ACO's 18 or 21 month performance year is compared to the ACO's MSR or MLR. The reconciled amount of the shared savings or losses owed to or by the ACO for the performance year is net of any interim payments of shared savings or losses.

(8) Quality performance for the first year reconciliation is based on complete and accurate reporting, of all required quality measures, for CYs 2012 and 2013.

(d) An ACO with a start date of April 1, 2012 or July 1, 2012 has the option to request an interim payment calculation based on quality and financial performance for its first 12 months of program participation. As required under § 425.204(f), the ACO requesting an interim payment calculation must have a mechanism in place to pay back the interim payment if final reconciliation determines an overpayment.

(e) Unless otherwise stated, program requirements which apply in the course of a performance year apply to the interim payment calculation and first year reconciliation.

**§ 425.609 Determining performance for 6-month performance years during CY 2019.**

(a) *General.* An ACO's financial and quality performance for a 6-month performance year during 2019 are determined as described in this section.

(b) *January 2019 through June 2019.* For ACOs participating in a 6-month performance year from January 1, 2019, through June 30, 2019, under § 425.200(b)(2)(ii)(B) and for ACOs eligible for pro-rated shared savings or liable for pro-rated shared losses in accordance with § 425.221(b)(3)(i) for the performance period from January 1, 2019, through June 30, 2019, CMS reconciles the ACO for the period from January 1, 2019, through June 30, 2019, after the conclusion of CY 2019, based on the 12-month calendar year and pro-rates shared savings or shared losses to reflect the ACO's participation from January 1, 2019, through June 30, 2019. CMS does all of the following to determine financial and quality performance:

(1) Uses the ACO participant list in effect for the performance year beginning January 1, 2019, to determine ben-

eficiary assignment, using claims for the entire calendar year, as specified in §§ 425.402 and 425.404, and according to the ACO's track as specified in § 425.400.

(i) For ACOs under preliminary prospective assignment with retrospective reconciliation the assignment window is CY 2019.

(ii) For ACOs under prospective assignment—

(A) Medicare fee-for-service beneficiaries are prospectively assigned to the ACO based on the beneficiary's use of primary care services in the most recent 12 months for which data are available; and

(B) Beneficiaries remain prospectively assigned to the ACO at the end of CY 2019 if they do not meet any of the exclusion criteria under § 425.401(b) during the calendar year.

(2) Uses the ACO's quality performance for the 2019 reporting period to determine the ACO's quality performance score as specified in § 425.502.

(i) The ACO participant list finalized for the first performance year of the ACO's agreement period beginning on July 1, 2019, is used to determine the quality reporting samples for the 2019 reporting year for the following ACOs:

(A) An ACO that extends its participation agreement for a 6-month performance year from January 1, 2019, through June 30, 2019, under § 425.200(b)(2)(ii)(B), and enters a new agreement period beginning on July 1, 2019.

(B) An ACO that participates in the program for the first 6 months of a 12-month performance year during 2019 and is eligible for pro-rated shared savings or liable for pro-rated shared losses in accordance with § 425.221(b)(3)(i).

(ii) The ACO's latest certified ACO participant list is used to determine the quality reporting samples for the 2019 reporting year for an ACO that extends its participation agreement for the 6-month performance year from January 1, 2019, through June 30, 2019, under § 425.200(b)(2)(ii)(B), and does not enter a new agreement period beginning on July 1, 2019.

(3) Uses the methodology for calculating shared savings or shared losses applicable to the ACO under the terms

## § 425.609

## 42 CFR Ch. IV (10–1–24 Edition)

of the participation agreement that was in effect on January 1, 2019.

(i) The ACO's historical benchmark is determined according to either § 425.602 (first agreement period) or § 425.603 (second agreement period) except as follows:

(A) The benchmark is adjusted for changes in severity and case mix between BY3 and CY 2019 using the methodology that accounts separately for newly and continuously assigned beneficiaries using prospective HCC risk scores and demographic factors as described under §§ 425.604(a)(1) through (3), 425.606(a)(1) through (3), and 425.610(a)(1) through (3).

(B) The benchmark is updated to CY 2019 according to the methodology described under § 425.602(b), § 425.603(b), or § 425.603(d), based on whether the ACO is in its first or second agreement period, and for an ACO in a second agreement period, the date on which that agreement period began.

(ii) The ACO's financial performance is determined based on the track the ACO is participating under during the performance year starting on January 1, 2019 (§ 425.604, § 425.606 or § 425.610), unless otherwise specified. In determining ACO financial performance, CMS does all of the following:

(A) Average per capita Medicare Parts A and B fee-for-service expenditures for CY 2019 are calculated for the ACO's performance year assigned beneficiary population identified in paragraph (b)(1) of this section.

(B) Expenditures calculated in paragraph (b)(3)(ii)(A) of this section are compared to the ACO's updated benchmark determined according to paragraph (b)(3)(i) of this section.

(C)(1) The ACO's performance year assigned beneficiary population identified in paragraph (b)(1) of this section is used to determine the MSR for Track 1 ACOs and the variable MSR/MLR for ACOs in a two-sided model that selected this option at the start of their agreement period. For two-sided model ACOs that selected a fixed MSR/MLR at the start of the ACO's agreement period, this fixed MSR/MLR is applied. In the event an ACO's performance year assigned population identified in paragraph (b)(1) of this section is below 5,000 beneficiaries, the MSR/

MLR is determined according to § 425.110(b).

(2) To qualify for shared savings an ACO must do all of the following:

(i) Have average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for CY 2019 below its updated benchmark costs for the year by at least the MSR established for the ACO based on the track the ACO is participating under during the performance year starting on January 1, 2019 (§ 425.604, § 425.606 or § 425.610) and paragraph (b)(3)(ii)(C)(1) of this section.

(ii) Meet the minimum quality performance standards established under § 425.502 and according to paragraph (b)(2) of this section.

(iii) Otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(3) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for CY 2019 must be above its updated benchmark costs for the year by at least the MLR established for the ACO based on the track the ACO is participating under during the performance year starting on January 1, 2019 (§ 425.606 or § 425.610) and paragraph (b)(3)(ii)(C)(1) of this section.

(D) For an ACO that meets all the requirements to receive a shared savings payment under paragraph (b)(3)(ii)(C)(2) of this section—

(1) The final sharing rate, determined based on the track the ACO is participating under during the performance year starting on January 1, 2019 (§ 425.604, § 425.606 or § 425.610), is applied to all savings under the updated benchmark specified under paragraph (b)(3)(i) of this section, not to exceed the performance payment limit for the ACO based on its track; and

(2) After applying the applicable performance payment limit, CMS prorates any shared savings amount determined under paragraph (b)(3)(ii)(D)(1) of this section by multiplying the amount by one-half, which represents the fraction of the calendar year covered by the period from January 1, 2019, through June 30, 2019.

(E) For an ACO responsible for shared losses under paragraph (b)(3)(ii)(C)(3) of this section—

(I) The shared loss rate, determined based on the track the ACO is participating under during the performance year starting on January 1, 2019 (§ 425.606 or § 425.610), is applied to all losses under the updated benchmark specified under paragraph (b)(3)(i) of this section, not to exceed the loss recoupment limit for the ACO based on its track; and

(2) After applying the applicable loss recoupment limit, CMS pro-rates any shared losses amount determined under paragraph (b)(3)(ii)(E)(I) of this section by multiplying the amount by one-half, which represents the fraction of the calendar year covered by the period from January 1, 2019, through June 30, 2019.

(c) *July 2019 through December 2019.* For ACOs entering an agreement period beginning on July 1, 2019, the ACO's first performance year is from July 1, 2019, through December 31, 2019, as specified in § 425.200(c)(3). CMS reconciles the ACO for the period from July 1, 2019, through December 31, 2019, after the conclusion of CY 2019, based on the 12-month calendar year and pro-rates shared savings or shared losses to reflect the ACO's participation from July 1, 2019, through December 31, 2019. CMS does all of the following to determine financial and quality performance:

(1) Uses the ACO participant list in effect for the performance year beginning on July 1, 2019, to determine beneficiary assignment, using claims for the entire calendar year, consistent with the methodology the ACO selected at the start of its agreement period under § 425.400(a)(4)(ii).

(i) For ACOs under preliminary prospective assignment with retrospective reconciliation the assignment window is CY 2019.

(ii) For ACOs under prospective assignment—

(A) The assignment window is the same as the assignment window that applies under paragraph (b)(1)(ii)(A) of this section for ACOs under prospective assignment for the 6-month performance year from January 1, 2019, through June 30, 2019; and

(B) Beneficiaries remain prospectively assigned to the ACO at the end of CY 2019 if they do not meet any of the exclusion criteria under § 425.401(b) during the calendar year.

(2) Uses the ACO's quality performance for the 2019 reporting period to determine the ACO's quality performance score as specified in § 425.502. The ACO participant list finalized for the first performance year of the ACO's agreement period beginning on July 1, 2019, is used to determine the quality reporting samples for the 2019 reporting year for all ACOs.

(3) Uses the methodology for calculating shared savings or shared losses applicable to the ACO for its first performance year under its agreement period beginning on July 1, 2019.

(i) The ACO's historical benchmark is determined according to § 425.601 except as follows:

(A) The benchmark is adjusted for changes in severity and case mix between BY3 and CY 2019 based on growth in prospective HCC risk scores, subject to a cap of positive 3 percent as described under § 425.605(a)(1) or § 425.610(a)(2).

(B) The benchmark is updated to CY 2019 according to the methodology described under § 425.601(b).

(ii) The ACO's financial performance is determined based on the track the ACO is participating under during the performance year starting on July 1, 2019 (§ 425.605 (BASIC track) or § 425.610 (ENHANCED track)), unless otherwise specified. In determining ACO financial performance, CMS does all of the following:

(A) Average per capita Medicare Parts A and B fee-for-service expenditures for CY 2019 are calculated for the ACO's performance year assigned beneficiary population identified in paragraph (c)(1) of this section.

(B) Expenditures calculated in paragraph (c)(3)(ii)(A) of this section are compared to the ACO's updated benchmark determined according to paragraph (c)(3)(i) of this section.

(C)(I) The ACO's performance year assigned beneficiary population identified in paragraph (c)(1) of this section is used to determine the MSR for ACOs in BASIC track Level A or Level B, and the variable MSR/MLR for ACOs in a

two-sided model that selected this option at the start of their agreement period. In the event a two-sided model ACO selected a fixed MSR/MLR at the start of its agreement period, and the ACO's performance year assigned population identified in paragraph (c)(1) of this section is below 5,000 beneficiaries, the MSR/MLR is determined based on the number of assigned beneficiaries as specified in § 425.110(b)(3)(iii).

(2) To qualify for shared savings an ACO must do all of the following:

(i) Have average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for CY 2019 below its updated benchmark costs for the year by at least the MSR established for the ACO based on the track the ACO is participating under during the performance year starting on July 1, 2019 (§ 425.605 or § 425.610) and paragraph (c)(3)(ii)(C)(1) of this section.

(ii) Meet the minimum quality performance standards established under § 425.502 and according to paragraph (c)(2) of this section.

(iii) Otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(3) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for CY 2019 must be above its updated benchmark costs for the year by at least the MLR established for the ACO based on the track the ACO is participating under during the performance year starting on July 1, 2019 (§ 425.605 or § 425.610) and paragraph (c)(3)(ii)(C)(1) of this section.

(D) For an ACO that meets all the requirements to receive a shared savings payment under paragraph (c)(3)(ii)(C)(2) of this section—

(1) The final sharing rate, determined based on the track the ACO is participating under during the performance year starting on July 1, 2019 (§ 425.605 or § 425.610), is applied to all savings under the updated benchmark specified under paragraph (c)(3)(i) of this section, not to exceed the performance payment limit for the ACO based on its track; and

(2) After applying the applicable performance payment limit, CMS prorates any shared savings amount determined under paragraph (c)(3)(ii)(D)(1) of this section by multiplying the amount by one-half, which represents the fraction of the calendar year covered by the July 1, 2019 through December 31, 2019 performance year.

(E) For an ACO responsible for shared losses under paragraph (c)(3)(ii)(C)(3) of this section—

(1) The shared loss rate, determined based on the track the ACO is participating under during the performance year starting on July 1, 2019 (§ 425.605 or § 425.610), is applied to all losses under the updated benchmark specified under paragraph (c)(3)(i) of this section, not to exceed the loss recoupment limit for the ACO based on its track; and

(2) After applying the applicable loss recoupment limit, CMS prorates any shared losses amount determined under paragraph (c)(3)(ii)(E)(1) of this section by multiplying the amount by one-half, which represents the fraction of the calendar year covered by the July 1, 2019 through December 31, 2019 performance year.

(d) *Extreme and uncontrollable circumstances.* For ACOs affected by extreme and uncontrollable circumstances during CY 2019—

(1) In calculating the amount of shared losses owed, CMS makes adjustments to the amount determined in paragraph (b)(3)(ii)(E)(1) or (c)(3)(ii)(E)(1) of this section, as specified in § 425.605(f), § 425.606(i), or § 425.610(i), as applicable; and

(2) In determining the ACO's quality performance score for the 2019 quality reporting period, CMS uses the alternative scoring methodology specified in § 425.502(f).

(e) *Notification of savings and losses.*

(1) CMS notifies the ACO of shared savings or shared losses separately for the January 1, 2019 through June 30, 2019 performance year (or performance period) and the July 1, 2019 through December 31, 2019 performance year, consistent with the notification requirements specified in §§ 425.604(f), 425.605(e), 425.606(h), and 425.610(h), as applicable:

(i) CMS notifies an ACO in writing regarding whether the ACO qualifies

for a shared savings payment, and if so, the amount of the payment due.

(ii) CMS provides written notification to an ACO of the amount of shared losses, if any, that it must repay to the program.

(iii) If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification.

(2) If an ACO is reconciled for both the January 1, 2019 through June 30, 2019 performance year (or performance period) and the July 1, 2019 through December 31, 2019 performance year, CMS issues a separate notice of shared savings or shared losses for each performance year (or performance period), and if the ACO has shared savings for one performance year (or performance period) and shared losses for the other performance year (or performance period), CMS reduces the amount of shared savings by the amount of shared losses.

(i) If any amount of shared savings remains after completely repaying the amount of shared losses owed, the ACO is eligible to receive payment for the remainder of the shared savings.

(ii) If the amount of shared losses owed exceeds the amount of shared savings earned, the ACO is accountable for payment of the remaining balance of shared losses in full.

[83 FR 60094, Nov. 23, 2018, as amended at 83 FR 68078, Dec. 31, 2018]

**§ 425.610 Calculation of shared savings and losses under the ENHANCED track.**

(a) *General rule.* For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are above or below the updated benchmark determined under § 425.601, 425.602, 425.603, or 425.652. In order to qualify for a shared savings payment under the ENHANCED track, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services for the performance year must be below or above the updated benchmark, respectively, by at least the

minimum savings or loss rate under paragraph (b) of this section.

(1) Risk adjustment for ACOs in agreement periods beginning on or before January 1, 2019. CMS does the following to adjust the benchmark each performance year:

(i) *Newly assigned beneficiaries.* CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in this population.

(ii) *Continuously assigned beneficiaries.* (A) CMS uses demographic factors to adjust the benchmark for changes in the continuously assigned beneficiary population.

(B) If the prospective HCC risk score is lower in the performance year for this population, CMS adjusts the benchmark for changes in severity and case mix for this population using this lower prospective HCC risk score.

(2) Risk adjustment for ACOs in agreement periods beginning on July 1, 2019, and in subsequent years. CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year.

(i) For agreement periods beginning before January 1, 2024:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent.

(B) This cap is the maximum increase in risk scores for each agreement period, such that any positive adjustment between BY3 and any performance year in the agreement period cannot be larger than 3 percent.

(ii) For agreement periods beginning on January 1, 2024, and in subsequent years:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year (positive or negative) plus 3 percentage points.

(B) The cap described in paragraph (a)(2)(ii)(A) of this section will apply to prospective HCC risk score growth for a population described in paragraph (a)(3) of this section only if the ACO's aggregate growth in prospective HCC

risk scores between BY3 and the performance year across all of the populations described in paragraph (a)(3) of this section exceeds this cap. If the cap described in paragraph (a)(2)(ii)(A) of this section is determined to apply, the value of the cap is the maximum increase in risk scores for the applicable performance year, such that any positive adjustment between BY3 and the performance year cannot be larger than the value of the cap for any of the populations described in paragraph (a)(3) of this section.

(C) The aggregate growth in demographic risk scores for purposes of paragraph (a)(2)(ii)(A) of this section and the aggregate growth in prospective HCC risk scores for purposes of paragraph (a)(2)(ii)(B) of this section is calculated by taking a weighted average of the growth in demographic risk scores or prospective HCC risk scores, as applicable, across the populations described in paragraph (a)(3) of this section. When calculating the weighted average growth in demographic risk scores or prospective HCC risk scores, as applicable, the weight applied to the growth in risk scores (expressed as a ratio of the ACO's performance year risk score to the ACO's BY3 risk score) for each Medicare enrollment type is equal to the product of the historical benchmark expenditures for that enrollment type and the performance year person years for that enrollment type.

(3) In risk adjusting the benchmark as described in §§ 425.601(a)(10), 425.602(a)(9), 425.603(c)(10), and 425.652(a)(10) CMS makes separate adjustments 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.

(4)(i) For performance years before 2017 to minimize variation from catastrophically large claims, CMS 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 as determined for each performance year.

(ii) For the 2017 performance year and subsequent performance years, to minimize variation from catastrophically large claims, CMS 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 as determined for the applicable performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to the performance year.

(5) CMS uses a 3-month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(A) For performance years beginning before 2018, these calculations will take into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings or loss rate.* (1) As part of the ACO's application for, or renewal of, program participation, the ACO must choose from the following options for establishing the MSR/MLR

for the duration of the agreement period:

- (i) Zero percent MSR/MLR
- (ii) Symmetrical MSR/MLR in a 0.5 percent increment between 0.5–2.0 percent.
- (iii) Symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO under subpart E of this part. The MSR for an ACO under the ENHANCED track is the same as the MSR that would apply in the one-sided model under either § 425.604(b) (for ACOs entering an agreement period on or before January 1, 2019) or § 425.605(b)(1) (for ACOs entering an agreement period on July 1, 2019, and in subsequent years) and is based on the number of assigned beneficiaries. The MLR under the ENHANCED track is equal to the negative MSR.

(2) To qualify for shared savings under the ENHANCED track, an ACO's average per capita Medicare expenditures for the performance year must be below its updated benchmark costs for the year by at least the MSR established for the ACO.

(3) To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare expenditures for the performance year must be above its updated benchmark costs for the year by at least the MLR established for the ACO.

(c) *Qualification for shared savings payment*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* To qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the minimum quality performance standards established under § 425.502, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(2) *For performance years beginning on or after January 1, 2021.* To qualify for shared savings, an ACO must meet the minimum savings rate requirement established under paragraph (b) of this section, meet the quality performance standard established under § 425.512, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

(d) *Final sharing rate*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* An ACO that meets all the requirements for receiving shared savings payments under the ENHANCED track will receive a shared savings payment of up to 75 percent of all the savings under the updated benchmark, as determined on the basis of its quality performance under § 425.502 (up to the performance payment limit described in paragraph (e)(2) of this section).

(2) *For performance years beginning on January 1, 2021, or January 1, 2022.* An ACO that meets all the requirements for receiving shared savings payments under the ENHANCED track will receive a shared savings payment of 75 percent of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (e)(2) of this section).

(3) *For the performance year beginning on January 1, 2023.* An ACO that meets all the requirements for receiving shared savings payments under the ENHANCED track will receive a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (e)(2) of this section). The percentage is as follows:

(i) 75 percent for an ACO that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i).

(ii) 75 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(4) *For performance years beginning on or after January 1, 2024.* An ACO that meets all the requirements for receiving shared savings payments under the ENHANCED track will receive a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (e)(2) of this section). The percentage is as follows:

(i) 75 percent for an ACO that meets the quality performance standard by



**§ 425.610**

**42 CFR Ch. IV (10–1–24 Edition)**

meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(ii) 75 percent multiplied by the ACO's health equity adjusted quality performance score calculated according to § 425.512(b) for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(e) *Performance payment.* (1) If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.

(2) The amount of shared savings an eligible ACO receives under the ENHANCED track may not exceed 20 percent of its updated benchmark.

(f) *Shared loss rate*—(1) *For performance years (or a performance period) beginning on or before January 1, 2020.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on the inverse of its final sharing rate described in paragraph (d)(1) of this section (that is, 1 minus the final shared savings rate determined under paragraph (d)(1) of this section). The shared loss rate—

(i) May not exceed 75 percent; and

(ii) May not be less than 40 percent.

(2) *For performance years beginning on January 1, 2021, or January 1, 2022.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined as follows:

(i) If the ACO meets the quality performance standard established in § 425.512, CMS determines the shared loss rate as follows:

(A) Calculate the quotient of the MIPS Quality performance category points earned divided by the total MIPS Quality performance category points available.

(B) Calculate the product of the quotient determined in paragraph (f)(2)(i)(A) of this section, and 75 percent.

(C) Calculate the shared loss rate as 1 minus the product determined in paragraph (f)(2)(i)(B) of this section. The shared loss rate—

(1) May not exceed 75 percent; and

(2) May not be less than 40 percent.

(ii) If the ACO fails to meet the quality performance standard established in § 425.512, the shared loss rate is 75 percent.

(3) *For the performance year beginning on January 1, 2023.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined as follows:

(i) If the ACO meets either the quality performance standard established in § 425.512 applicable for the performance year by meeting the criteria specified in § 425.512(a)(2) or (a)(4)(i), or the alternative quality performance standard established in § 425.512(a)(4)(ii), CMS determines the shared loss rate as follows:

(A) Calculate the product of 75 percent and the ACO's health equity adjusted quality performance score calculated according to § 425.512(b).

(B) Calculate the shared loss rate as 1 minus the product determined in paragraph (f)(3)(i)(A) of this section. The shared loss rate—

(1) May not exceed 75 percent; and

(2) May not be less than 40 percent.

(ii) If the ACO fails to meet either the quality performance standard or the alternative quality performance standard established in § 425.512 applicable for the performance year, the shared loss rate is 75 percent.

(4) *For performance years beginning on or after January 1, 2024.* For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined as follows:

(i) If the ACO meets either the quality performance standard established in § 425.512 applicable for the performance year by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i), or the alternative quality performance standard established in § 425.512(a)(5)(ii), CMS determines the shared loss rate as follows:

(A) Calculate the product of 75 percent and the ACO's health equity adjusted quality performance score calculated according to § 425.512(b).

(B) Calculate the shared loss rate as 1 minus the product determined in paragraph (f)(4)(i)(A) of this section. The shared loss rate—

(1) May not exceed 75 percent; and

(2) May not be less than 40 percent.

(ii) If the ACO fails to meet either the quality performance standard or the alternative quality performance standard established in § 425.512 for the applicable performance year, the shared loss rate is 75 percent.

(g) *Loss recoupment limit.* The amount of shared losses for which an eligible ACO is liable may not exceed 15 percent of its updated benchmark as determined under § 425.601, 425.602, 425.603 or 425.652.

(h) *Notification of savings and losses.*

(1) CMS notifies an ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.

(2) CMS provides written notification to an ACO of the amount of shared losses, if any, that it must repay to the program.

(3) If an ACO has shared losses, the ACO must make payment in full to CMS within 90 days of receipt of notification.

(i) *Extreme and uncontrollable circumstances.* For performance year 2017 and subsequent performance years, the following adjustment is made in calculating the amount of shared losses, after the application of the shared loss rate in paragraph (f) of this section and the loss recoupment limit in paragraph (g) of this section.

(1) CMS determines the percentage of the ACO's performance year assigned beneficiary population affected by an extreme and uncontrollable circumstance.

(2) CMS reduces the amount of the ACO's shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.

(i) For an ACO that is liable for a pro-rated share of losses under § 425.221(b)(2)(ii) or (b)(3)(i), the amount of shared losses determined for the performance year during which the termination becomes effective is adjusted according to this paragraph (i)(2).

(ii) [Reserved]

(3) CMS applies determinations made under the Quality Payment Program with respect to—

(i) Whether an extreme and uncontrollable circumstance has occurred; and

(ii) The affected areas.

(4) CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's assigned beneficiaries residing in the affected areas.

(j) *January 1, 2019 through June 30, 2019 performance year.* Shared savings or shared losses for the January 1, 2019 through June 30, 2019 performance year are calculated as described in § 425.609.

(k) *July 1, 2019 through December 31, 2019 performance year.* Shared savings or shared losses for the July 1, 2019 through December 31, 2019 performance year are calculated as described in § 425.609.

[80 FR 32842, June 9, 2015, as amended at 81 FR 38017, June 10, 2016; 82 FR 53370, Nov. 15, 2017; 82 FR 60918, Dec. 26, 2017; 83 FR 60096, Nov. 23, 2018; 83 FR 68079, Dec. 31, 2018; 85 FR 85044, Dec. 28, 2020; 87 FR 70240, Nov. 18, 2022]

EDITORIAL NOTE: At 81 FR 38017, June 10, 2016, in § 425.610, paragraph (a)(2)(ii), the phrase "adjust for changes" was removed, and in its place the phrase "adjust the benchmark for changes" was added, however, the phrase "adjust for changes" does not appear in this paragraph, so the amendment could not be incorporated.

#### **§ 425.611 Adjustments to Shared Savings Program calculations to address the COVID-19 pandemic.**

(a) *General.* This section describes adjustments CMS makes to Shared Savings Program calculations to address the impact of the COVID-19 pandemic.

(b) *Episodes of care for treatment of COVID-19.* (1) CMS identifies an episode of care for treatment of COVID-19 based on either of the following:

(i) Discharges for inpatient services eligible for the 20 percent adjustment under section 1886(d)(4)(C) of the Act.

(ii) Discharges for acute care inpatient services for treatment of COVID-19 from facilities that are not paid under the inpatient prospective payment system, such as CAHs, when the date of discharge occurs within the

Public Health Emergency as defined in § 400.200 of this chapter.

(2) CMS defines the episode of care as starting in the month in which the inpatient stay begins as identified by the admission date, all months during the inpatient stay, and the month following the end of the inpatient stay as indicated by the discharge date.

(c) *Applicability of adjustments.* Notwithstanding any other provision in this part, CMS adjusts the following Shared Savings Program calculations to exclude all Parts A and B fee-for-service payment amounts for a beneficiary's episode of care for treatment of COVID-19 as described in paragraph (b) of this section:

(1) Calculation of Medicare Parts A and B fee-for-service expenditures for an ACO's assigned beneficiaries for all purposes including the following: Establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures.

(2) Calculation of fee-for-service expenditures for assignable beneficiaries as used in determining county-level fee-for-service expenditures and national Medicare fee-for-service expenditures, including the following calculations:

(i) Determining 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 according to §§ 425.601(c), 425.603(e), and 425.654(a) for purposes of calculating the ACO's regional fee-for-service expenditures.

(ii) Determining the 99th percentile of national Medicare fee-for-service expenditures for assignable beneficiaries for purposes of the following:

(A) Truncating assigned beneficiary expenditures used in calculating benchmark expenditures under §§ 425.601(a)(4), 425.602(a)(4), 425.603(c)(4), and 425.652(a)(4), and performance year expenditures under §§ 425.604(a)(4), 425.605(a)(3), 425.606(a)(4), and 425.610(a)(4).

(B) Truncating expenditures for assignable beneficiaries in each county for purposes of determining county fee-for-service expenditures according to

§§ 425.601(c)(3), 425.603(e)(3), and 425.654(a)(3).

(iii) Determining national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries for purposes of capping the regional adjustment to the ACO's historical benchmark according to §§ 425.601(a)(8)(ii)(C) and 425.656(c)(3), and capping the prior savings adjustment according to § 425.658(c)(1)(ii).

(iv) Determining the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries, for purposes of updating the ACO's historical benchmark according to § 425.602(b)(2).

(v) Determining national growth rates that are used as part of the blended growth rates used to trend forward BY1 and BY2 expenditures to BY3 according to §§ 425.601(a)(5)(ii) and 425.652(a)(5)(ii) and as part of the blended growth rates used to trend the benchmark and update the benchmark according to §§ 425.601(b)(2) and 425.652(b)(2)(i).

(3) Calculation of Medicare Parts A and B fee-for-service revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track as specified in § 425.605(d).

(4) Calculation of total Medicare Parts A and B fee-for-service revenue of ACO participants and total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries for purposes of identifying whether an ACO is a high revenue ACO or low revenue ACO, as defined under § 425.20, determining an ACO's eligibility for participation options according to § 425.600(d), and determining an ACO's eligibility to receive advance investment payments according to § 425.630.

(5) Calculation or recalculation of the amount of the ACO's repayment mechanism arrangement according to § 425.204(f)(4).

[85 FR 27625, May 8, 2020, as amended at 85 FR 85044, Dec. 28, 2020; 87 FR 70241, Nov. 18, 2022; 88 FR 79548, Nov. 16, 2023]

**§ 425.612 Waivers of payment rules or other Medicare requirements.**

(a) *General.* CMS may waive certain payment rules or other Medicare requirements as determined necessary to carry out the Shared Savings Program under this part.

(1) *SNF 3-day rule.* For performance year 2017 and subsequent performance years, CMS waives the requirement in section 1861(i) of the Act for a 3-day inpatient hospital stay prior to a Medicare-covered post-hospital extended care service for eligible beneficiaries assigned to ACOs participating in a two-sided model and as provided in paragraph (a)(1)(iv) of this section during a grace period for beneficiaries excluded from prospective assignment to an ACO in a two-sided model, who receive otherwise covered post-hospital extended care services furnished by an eligible SNF that has entered into a written agreement to partner with the ACO for purposes of this waiver. Eligible SNFs include providers furnishing SNF services under swing bed agreements. All other provisions of the statute and regulations regarding Medicare Part A post-hospital extended care services continue to apply. ACOs identified under paragraph (a)(1)(vi) of this section may request to use the SNF 3-day rule waiver for performance years beginning on July 1, 2019, and in subsequent years.

(i) ACOs must submit to CMS supplemental application information sufficient to demonstrate the ACO has the capacity to identify and manage beneficiaries who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than 3-days in the form and manner specified by CMS. Application materials include but are not limited to, the following:

(A) An attestation that it has established and will make available to CMS upon request the following narratives describing how the ACO plans to implement the waiver:

(1) A communication plan between the ACO and its SNF affiliates.

(2) A care management plan for beneficiaries admitted to a SNF affiliate.

(3) A beneficiary evaluation and admission plan approved by the ACO medical director and the healthcare

professional responsible for the ACO's quality improvement and assurance processes under § 425.112.

(B) A list of SNFs with whom the ACO will partner along with executed written SNF affiliate agreements between the ACO and each listed SNF.

(ii) In order to be eligible to receive covered SNF services under the waiver, a beneficiary must meet the following requirements:

(A) In the case of a beneficiary who is assigned to an ACO that has selected preliminary prospective assignment with retrospective reconciliation under § 425.400(a)(2), the beneficiary must appear on the list of preliminarily prospectively assigned beneficiaries at the beginning of the performance year or on the first, second, or third quarterly preliminary prospective assignment list for the performance year in which they are admitted to the eligible SNF, and the SNF services must be provided after the beneficiary first appeared on the preliminary prospective assignment list for the performance year.

(B) In the case of a beneficiary who is assigned to an ACO that has selected prospective assignment under § 425.400(a)(3), the beneficiary must be prospectively assigned to the ACO for the performance year in which they are admitted to the eligible SNF.

(C) Does not reside in a SNF or other long-term care setting.

(D) Is medically stable.

(E) Does not require inpatient or further inpatient hospital evaluation or treatment.

(F) Have certain and confirmed diagnoses.

(G) Have an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient.

(H) Have been evaluated and approved for admission to the SNF within 3 days prior to the SNF admission by an ACO provider/supplier who is a physician, consistent with the ACO's beneficiary evaluation and admission plan.

(iii) SNFs eligible to partner and enter into written agreements with ACOs for purposes of this waiver must do the following:

(A) Providers eligible to be included in the CMS 5-star Quality Rating System must have and maintain an overall rating of 3 or higher.

(B) Sign a SNF affiliate agreement with the ACO that includes elements determined by CMS including but not limited to the following:

(1) Agreement to comply with the requirements and conditions of this part, including but not limited to those specified in the participation agreement with CMS.

(2) Effective dates of the SNF affiliate agreement.

(3) Agreement to implement and comply with the ACO's beneficiary evaluation and admission plan and the care management plan.

(4) Agreement to validate the eligibility of a beneficiary to receive covered SNF services in accordance with the waiver prior to admission.

(5) Remedial processes and penalties that will apply for non-compliance.

(iv) For a beneficiary who was included on the ACO's prospective assignment list or preliminary prospective assignment list at the beginning of the performance year or on the first, second, or third quarterly preliminary prospective assignment list for the performance year, for an ACO for which a waiver of the SNF 3-day rule has been approved under paragraph (a)(1) of this section, but who was subsequently removed from the assignment list for the performance year, CMS makes payment for SNF services furnished to the beneficiary by a SNF affiliate if the following conditions are met:

(A)(1) The beneficiary was prospectively assigned to an ACO that selected prospective assignment under § 425.400(a)(3) at the beginning of the applicable performance year, but was excluded in the most recent quarterly update to the assignment list under § 425.401(b), and the beneficiary was admitted to a SNF affiliate within 90 days following the date that CMS delivered the quarterly exclusion list to the ACO; or

(2) The beneficiary was identified as preliminarily prospectively assigned to an ACO that has selected preliminary prospective assignment with retrospective reconciliation under § 425.400(a)(2) in the report provided under § 425.702(c)(1)(ii)(A) at the beginning of the performance year or for the first, second, or third quarter of the performance year, the SNF services were pro-

vided after the beneficiary first appeared on the preliminary prospective assignment list for the performance year, and the beneficiary meets the criteria to be assigned to an ACO under § 425.401(a)(1) and (2).

(B) But for the beneficiary's removal from the ACO's assignment list, CMS would have made payment to the SNF affiliate for such services under the waiver under paragraph (a)(1) of this section.

(v) The following beneficiary protections apply when a beneficiary receives SNF services without a prior 3-day inpatient hospital stay from a SNF affiliate that intended to provide services under a SNF 3-day rule waiver under paragraph (a)(1) of this section, the SNF affiliate services were non-covered only because the SNF affiliate stay was not preceded by a qualifying hospital stay under section 1861(i) of the Act, and in the case of a beneficiary where the ACO selected one of the following:

(A) Prospective assignment under § 425.400(a)(3), the beneficiary was not prospectively assigned to the ACO for the performance year in which they received the SNF services, or was prospectively assigned but was later excluded and the 90-day grace period, described in paragraph (a)(1)(iv)(A) of this section, has lapsed.

(B) Preliminary prospective assignment with retrospective reconciliation under § 425.400(a)(2), the beneficiary was not identified as preliminarily prospectively assigned to the ACO for the performance year in the report provided under § 425.702(c)(1)(ii)(A) at the beginning of the performance year or for the first, second, or third quarter of the performance year before the SNF services were provided to the beneficiary.

(C) A SNF is presumed to intend to provide services pursuant to the SNF 3-day rule waiver under paragraph (a)(1) of this section if the SNF submitting the claim is a SNF affiliate of an ACO for which such a waiver has been approved.

(D) CMS makes no payments for SNF services to a SNF affiliate of an ACO for which a waiver of the SNF 3-day rule has been approved when the SNF affiliate admits a FFS beneficiary who was not prospectively or preliminarily prospectively assigned to the ACO

prior to the SNF admission or was prospectively assigned but was later excluded and the 90-day grace period under paragraph (a)(1)(iv)(A) of this section has lapsed.

(E) In the event that CMS makes no payment for SNF services furnished by a SNF affiliate as a result of paragraph (a)(1)(v)(D) of this section and the only reason the claim was non-covered is due to the lack of a qualifying inpatient stay, the following beneficiary protections will apply:

(1) The SNF must not charge the beneficiary for the expenses incurred for such services; and

(2) The SNF must return to the beneficiary any monies collected for such services; and

(3) The ACO may be required to submit a corrective action plan under § 425.216(b) for CMS approval. If after being given an opportunity to act upon the corrective action plan the ACO fails to come into compliance with the requirements of paragraph (a)(1), approval for the SNF 3-day rule waiver under this section will be terminated as provided under paragraph (d) of this section.

(vi) The following ACOs may request to use the SNF 3-day rule waiver:

(A) An ACO participating in performance-based risk within the BASIC track under § 425.605.

(B) An ACO participating in the ENHANCED track under § 425.610.

(2) [Reserved]

(b) *Review and determination of request to use waivers.* (1) In order to obtain a determination regarding whether the ACO may use waivers under this section, an ACO must submit a waiver request to CMS in the form and manner and by a deadline specified by CMS.

(2) An ACO executive who has the authority to legally bind the ACO must certify to the best of his or her knowledge, information, and belief that the information contained in the waiver request submitted under paragraph (b)(1) of this section is accurate, complete, and truthful.

(3) CMS evaluates an ACO's waiver request to determine whether it satisfies the requirements of this part and approves or denies waiver requests accordingly. Waiver requests are ap-

proved or denied on the basis of the following:

(i) Information contained in and submitted with the waiver request by a deadline specified by CMS.

(ii) Supplemental information submitted by a deadline specified by CMS in response to a CMS request for information.

(iii) Screening of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities providing services to Medicare beneficiaries in accordance with the terms of the waiver.

(iv) Other information available to CMS.

(4) CMS may deny a waiver request if an ACO fails to submit requested information by the deadlines established by CMS.

(c) *Effective and termination date of waivers.* (1) Waivers are effective upon CMS notification of approval for the waiver or the start date of the participation agreement, whichever is later.

(2) Waivers do not extend beyond the end of the participation agreement.

(3) If CMS terminates the participation agreement under § 425.218, the waiver ends on the date specified by CMS in the termination notice.

(4) If the ACO terminates the participation agreement, the waiver ends on the effective date of termination as specified in the written notification required under § 425.220.

(d) *Monitoring and termination of waivers.* (1) ACOs with approved waivers are required to post their use of the waiver as part of public reporting under § 425.308.

(2) CMS monitors and audits the use of such waivers in accordance with § 425.316.

(3) CMS reserves the right to deny or revoke a waiver if an ACO, its ACO participants, ACO providers/suppliers or other individuals or entities providing services to Medicare beneficiaries are not in compliance with the requirements of this part or if any of the following occur:

(i) The waiver is not used as described in the ACO's waiver request under paragraph (b)(1) of this section.

(ii) The ACO does not successfully meet the quality reporting standard under subpart F of this part.

## § 425.613

(iii) CMS identifies a program integrity issue affecting the ACO's use of the waiver.

(4) CMS reserves the right to take compliance action, including termination, against an ACO for noncompliance with program rules, including misuse of a waiver under this section, as specified at §§ 425.216 and 425.218.

(e) *Other rules governing use of waivers.* (1) Waivers under this section do not protect financial or other arrangements between or among ACOs, ACO participants, ACO providers/suppliers, or other individual or entities providing services to Medicare beneficiaries from liability under the fraud and abuse laws or any other applicable laws.

(2) Waivers under this section do not protect any person or entity from liability for any violation of law or regulation for any conduct other than the conduct permitted by a waiver under paragraph (a) of this section.

(3) ACOs must ensure compliance with all claims submission requirements, except those expressly waived under paragraph (a) of this section.

(f) *Waiver for payment for telehealth services.* For performance year 2020 and subsequent performance years, CMS waives the originating site requirements in section 1834(m)(4)(C)(i) and (ii) of the Act and makes payment for telehealth services furnished to a beneficiary, if the following conditions are met:

(1) The beneficiary was prospectively assigned to an ACO that is an applicable ACO for purposes of § 425.613 at the beginning of the applicable performance year, but the beneficiary was excluded in the most recent quarterly update to the prospective assignment list under § 425.401(b).

(2) The telehealth services are provided by a physician or practitioner billing under the TIN of an ACO participant in the ACO within 90 days following the date CMS delivers the quarterly exclusion list to the ACO.

(3) But for the beneficiary's exclusion from the ACO's prospective assignment list, CMS would have made payment to

## 42 CFR Ch. IV (10–1–24 Edition)

the ACO participant for such services under § 425.613.

[80 FR 32843, June 9, 2015, as amended at 81 FR 80561, Nov. 15, 2016; 82 FR 53371, Nov. 15, 2017; 83 FR 68080, Dec. 31, 2018; 84 FR 63204, Nov. 15, 2019; 87 FR 70242, Nov. 18, 2022]

### § 425.613 Telehealth services.

(a) *General.* Payment is available for otherwise covered telehealth services furnished on or after January 1, 2020, by a physician or other practitioner billing through the TIN of an ACO participant in an applicable ACO, without regard to the geographic requirements under section 1834(m)(4)(C)(i) of the Act, in accordance with the requirements of this section.

(1) For purposes of this section:

(i) An applicable ACO is an ACO that is participating under a two-sided model under § 425.600 and has elected prospective assignment under § 425.400(a)(3) for the performance year.

(ii) The home of the beneficiary is treated as an originating site under section 1834(m)(4)(C)(ii) of the Act.

(2) For payment to be made under this section, the following requirements must be met:

(i) The beneficiary is prospectively assigned to the ACO for the performance year in which the beneficiary received the telehealth service.

(ii) The physician or practitioner who furnishes the telehealth service must bill under the TIN of an ACO participant that is included on the certified ACO participant list under § 425.118 for the performance year in which the service is rendered.

(iii) The originating site must comply with applicable State licensing requirements.

(iv) When the originating site is the beneficiary's home, the telehealth services must not be inappropriate to furnish in the home setting. Services that are typically furnished in an inpatient setting may not be furnished as a telehealth service when the originating site is the beneficiary's home.

(v) CMS does not pay a facility fee when the originating site is the beneficiary's home.

(b) *Beneficiary protections.* (1) When a beneficiary who is not prospectively assigned to an applicable ACO or in a 90-

day grace period under § 425.612(f) receives a telehealth service from a physician or practitioner billing through the TIN of an ACO participant participating in an applicable ACO, CMS makes no payment for the telehealth service to the ACO participant.

(2) In the event that CMS makes no payment for a telehealth service furnished by a physician or practitioner billing through the TIN of an ACO participant, and the only reason the claim was non-covered is because the beneficiary is not prospectively assigned to the ACO or in the 90-day grace period under § 425.612(f), all of the following beneficiary protections apply:

(i) The ACO participant must not charge the beneficiary for the expenses incurred for such service.

(ii) The ACO participant must return to the beneficiary any monies collected for such service.

(iii) The ACO may be required to submit a corrective action plan under § 425.216(b) for CMS approval. If the ACO is required to submit a corrective action plan and, after being given an opportunity to act upon the corrective action plan, the ACO fails to implement the corrective action plan or demonstrate improved performance upon completion of the corrective action plan, CMS may terminate the participation agreement as specified under § 425.216(b)(2).

(c) *Termination date for purposes of payment for telehealth services.* (1) Payment for telehealth services under paragraph (a) of this section does not extend beyond the end of the applicable ACO's participation agreement.

(2) If CMS terminates the participation agreement under § 425.218, payment for telehealth services under paragraph (a) of this section is not made with respect to telehealth services furnished beginning on the date specified by CMS in the termination notice.

(3) If the ACO terminates the participation agreement, payment for telehealth services under paragraph (a) of this section is not made with respect to telehealth services furnished beginning on the effective date of termination as specified in the written notification required under § 425.220.

(d) *Monitoring of telehealth services.* (1) CMS monitors and audits the use of telehealth services by the ACO and its ACO participants and ACO providers/suppliers, in accordance with § 425.316.

(2) CMS reserves the right to take compliance action, up to and including termination of the participation agreement, as specified in §§ 425.216 and 425.218, with respect to an applicable ACO for non-compliance with program requirements, including inappropriate use of telehealth services.

[83 FR 68081, Dec. 31, 2018]

#### §§ 425.614–425.629 [Reserved]

#### § 425.630 Option to receive advance investment payments.

(a) *Purpose.* Advance investment payments are intended to encourage low-revenue ACOs that are inexperienced with risk to participate in the Shared Savings Program and to provide additional resources to such ACOs in order to support care improvement for underserved beneficiaries.

(b) *Eligibility.* An ACO is eligible to receive advance investment payments as specified in this section if CMS determines that all of the following criteria are met:

(1) The ACO is not a renewing or a re-entering ACO.

(2) CMS has determined that the ACO is eligible to participate in the Shared Savings Program.

(3) The ACO is inexperienced with performance-based risk Medicare ACO initiatives during its first 2 performance years and participates in the BASIC track's glide path as follows:

(i) For performance year 1, the ACO must participate in Level A of the BASIC track's glide path.

(ii) For performance year 2, the ACO may participate in Level A of the BASIC track's glide path (in accordance with § 425.600(a)(4)(i)(C)(3)) or Level B.

(iii) For performance years 3 through 5, the ACO may participate in Level A of the BASIC track's glide path (in accordance with § 425.600(a)(4)(i)(C)(3)), or Levels B through E.

(4) The ACO is a low revenue ACO.

(c) *Application procedure.* To obtain a determination regarding whether an ACO may receive advance investment



payments, the ACO must submit to CMS complete supplemental information as part of its application to participate in the Shared Savings Program (filed pursuant to § 425.202) in the form and manner and by a deadline specified by CMS.

(d) *Application contents and review.* (1) *General.* An ACO must submit to CMS supplemental application information sufficient for CMS to determine whether the ACO is eligible to receive advance investment payments. In addition, the ACO must submit a proposed spend plan as part of the supplemental application information.

(2) *Spend plan.* The spend plan must:

(i) Describe how the ACO will spend its advance investment payments during the agreement period to build care coordination capabilities (including coordination with community-based organizations, as appropriate), address specific health disparities, and meet other criteria under this section.

(ii) Identify the categories of goods and services that will be purchased with advance investment payment funds (including any allowable uses under paragraph (e) of this section), the dollar amounts to be spent on the various categories, and such other information as may be specified by CMS.

(iii) State that the ACO has established a separate designated account for the deposit and expenditure of all advance investment payments in accordance with paragraph (e)(4) of this section.

(3) *CMS review.* CMS will review the supplemental application information to determine whether an ACO meets the eligibility criteria and other requirements for advance investment payments and will approve or deny the advance investment payment application accordingly. CMS may review an ACO's spend plan at any time and require the ACO to modify its spend plan to comply with the requirements of this paragraph (d) and paragraph (e) of this section.

(e) *Use and management of advance investment payments—*(1) *Allowable uses.* An ACO must use an advance investment payment to improve the quality and efficiency of items and services furnished to beneficiaries by investing in increased staffing, health care infra-

structure, and the provision of accountable care for underserved beneficiaries, which may include addressing social determinants of health. Expenditures of advance investment payments must comply with the beneficiary incentive provision at § 425.304, paragraph (e)(2) of this section, and all other applicable laws and regulations.

(2) *Prohibited uses.* Advance investment payments may not be used for any expense other than allowable uses under paragraph (e)(1) of this section. In the case of an ACO participating in Level E of the BASIC track, the repayment of any shared losses incurred as specified in a written notice in accordance with § 425.605(e)(2).

(3) *Duration for spending payments.* An ACO may spend an advance investment payment over its entire agreement period. An ACO must repay to CMS any unspent funds remaining at the end of the ACO's agreement period, except if the ACO terminated its current participation agreement under § 425.220 at the end of performance year 2 or later and immediately enters a new agreement period to continue its participation in the Shared Savings Program, the ACO must spend its advance investment payments within 5 performance years of when it first received advance investment payments and repay to CMS any unspent funds remaining at the end of that fifth performance year.

(4) *Segregation of advance investment payments.* An ACO must segregate advance investment payments from all other revenues by establishing and maintaining a separate account into which all advance investment payments will be deposited immediately and from which all disbursements of such funds are made only for allowable uses in accordance with this paragraph.

(f) *Payment methodology.* An ACO receives two types of advance investment payments: a one-time payment of \$250,000 and quarterly payments calculated pursuant to the methodology defined in paragraph (f)(2) of this section. CMS notifies in writing each ACO of its determination of the amount of advance investment payment and the notice will inform the ACO of its right to request reconsideration review in accordance with the procedures specified in subpart I of this part. If CMS

does not make any advance investment payment, the notice will specify the reason(s) why and inform the ACO of its right to request reconsideration review in accordance with the procedures specified in subpart I of this part.

(1) *Frequency of payments.* An ACO will receive the one-time payment at the beginning of Performance Year 1 of the ACO's agreement period. An ACO will receive quarterly payments each quarter for the first two performance years of the ACO's agreement period. An ACO may receive no more than eight quarterly payments.

(2) *Quarterly payment amount calculation methodology.* CMS does all of the following in determining the quarterly payment amount prior to the start of the quarter.

(i) Determines the ACO's assigned beneficiary population. The assigned beneficiaries used in determining the quarterly payment amount are the beneficiaries most recently assigned to the ACO under § 425.400(a)(2) (for an ACO under preliminary prospective assignment with retrospective reconciliation) or § 425.400(a)(3) (for an ACO under prospective assignment), based on the certified ACO participant list for the relevant performance year.

(ii) Assigns each beneficiary a risk factors-based score. For each beneficiary in the assigned population identified

in paragraph (f)(2)(i) of this section, CMS applies the following requirements in assigning a risk factors-based score:

(A) The risk factors-based score will be set to 100 if the beneficiary is enrolled in the Medicare Part D LIS or is dually eligible for Medicare and Medicaid.

(B) The risk factors-based score will be set to the Area Deprivation Index national percentile rank matched to the beneficiary's mailing address if the beneficiary is not enrolled in the LIS or is not dually eligible for Medicare and Medicaid and sufficient data is available to match the beneficiary to an Area Deprivation Index national percentile rank.

(C) The risk factors-based score will be set to 50 if the beneficiary is not enrolled in the LIS or is not dually eligible for Medicare and Medicaid and sufficient data is not available to match the beneficiary to an Area Deprivation Index national percentile rank.

(iii) Determines a beneficiary's payment amount. For each beneficiary in the assigned population identified in paragraph (f)(2)(i) of this section, CMS determines the payment amount that corresponds to the beneficiary's risk factors-based score determined in paragraph (f)(2)(ii) of this section. The beneficiary payment amount is as follows:

TABLE 1 TO PARAGRAPH (f)(2)(iii)

Risk factors-based score	1–24	25–34	35–44	45–54	55–64	65–74	75–84	85–100
Payment amount	\$0	\$20	\$24	\$28	\$32	\$36	\$40	\$45

(iv) Calculates the ACO's quarterly payment amount. The ACO's quarterly payment amount is the sum of the beneficiary payment amounts corresponding to each assigned beneficiary's risk factors-based score, specified in paragraph (f)(2)(iii) of this section, capped at 10,000 beneficiaries. If the ACO has more than 10,000 assigned beneficiaries according to paragraph (f)(2)(i) of this section, CMS will calculate the quarterly payment amount based on the 10,000 assigned beneficiaries with the highest risk factors-

based scores determined according to paragraph (f)(2)(ii) of this section.

(g) *Recoupment and recovery of advance investment payments, and notice of bankruptcy.* (1) CMS will recoup advance investment payments made to an ACO from any shared savings the ACO earns until CMS has recouped in full the amount of advance investment payments made to the ACO. For both renewing and re-entering ACOs, CMS will carry forward any remaining balance owed to subsequent performance year(s) in which the ACO achieves

shared savings, including in any performance year(s) in a subsequent agreement period.

(2) If the amount of shared savings earned by the ACO is revised upward by CMS for any reason, CMS will reduce the redetermined amount of shared savings by the amount of advance investment payments made to the ACO as of the date of the redetermination. If the amount of shared savings earned by the ACO is revised downward by CMS for any reason, the ACO will not receive a refund of any portion of the advance investment payments previously recouped or otherwise repaid.

(3) Except as provided for in paragraphs (g)(4) of this section and § 425.316(e)(3), for each performance year, CMS will not recover an amount of advance investment payments greater than the shared savings earned by an ACO in that performance year.

(4) If an ACO terminates its participation agreement during the agreement period in which it received an advance investment payment, the ACO must repay all advance investment payments it received, unless the ACO terminated its current participation agreement under § 425.220 at the end of performance year 2 or later during the agreement period in which it received advance investment payments and immediately enters a new agreement period to continue its participation in the program. CMS will provide written notification to the ACO of the amount due and the ACO must pay such amount no later than 90 days after the receipt of such notification.

(5) In the event of bankruptcy—

(i) If an ACO has filed a bankruptcy petition, whether voluntary or involuntary, the ACO must provide written notice of the bankruptcy to CMS and to the U.S. Attorney's Office in the district where the bankruptcy was filed, unless final payment for the agreement period has been made by either CMS or the ACO and all administrative or judicial review proceedings relating to any payments under the Shared Savings Program have been fully and finally resolved.

(ii) The notice of bankruptcy must be sent by certified mail no later than 5 days after the petition has been filed and must contain a copy of the filed

bankruptcy petition (including its docket number). The notice to CMS must be addressed to the CMS Office of Financial Management at 7500 Security Boulevard, Mailstop C3-01-24, Baltimore, MD 21244 or such other address as may be specified on the CMS website for purposes of receiving such notices.

(h) *Termination of advance investment payments*—(1) *General*. Except as provided in paragraph (h)(2) of this section, CMS may terminate an ACO's advance investment payments if the ACO—

(i) Fails to comply with the requirements of this section;

(ii) Meets any of the grounds for ACO termination set forth in § 425.218(b); or

(iii) Voluntarily terminates its participation agreement in accordance with § 425.220(a).

(2) *Eligibility sanction*. CMS will terminate an ACO's advance investment 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.

(i) *Reporting information on advance investment payments*. The ACO must report information on its receipt of and use of advance investment payments, as follows:

(1) The ACO must publicly report information about the ACO's use of advance investment payments for each performance year, in accordance with § 425.308(b)(8).

(2) In a form and manner and by a deadline specified by CMS, the ACO must report to CMS the same information it is required to publicly report under § 425.308(b)(8).

[87 FR 70242, Nov. 18, 2022, as amended at 88 FR 79548, Nov. 16, 2023]

**§§ 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, 425.603, and 425.659. 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, as amended at 88 FR 79548, Nov. 16, 2023]

**§ 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 § 425.400(a)(4)(ii). CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service 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 BY3 using the assignment window or expanded window for assignment that is consistent with 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) Except as provided in paragraph (a)(8)(iii) of this section, 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 (as specified under § 425.658). CMS does all of the following to determine the adjustment, if any, 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), and the regional adjustment, expressed as a single value as described in § 425.656(d), is positive, the ACO will receive an adjustment to its benchmark equal to 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.

(iii) If an ACO is not eligible to receive a prior savings adjustment under § 425.658(b)(3)(i), and the regional adjustment, expressed as a single value as described in § 425.656(d), is negative or zero, the ACO will not receive an adjustment to its benchmark.

(iv) If an ACO is eligible to receive a prior savings adjustment and the regional adjustment, expressed as a single value as described in § 425.656(d), is positive, the ACO will receive an adjustment to its benchmark equal to the higher of the following:

(A) 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.

(B) The prior savings adjustment. The adjustment will be calculated as described in § 425.658(c) and 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.

(v) If an ACO is eligible to receive a prior savings adjustment and the regional adjustment, expressed as a single value as described in § 425.656(d), is negative or zero, the ACO will receive an adjustment to its benchmark equal to the prior savings adjustment. The adjustment will be calculated as described in § 425.658(c) and 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.

(9) For the first performance year during the term of the agreement period, the ACO's benchmark is adjusted for the following, as applicable: For changes in values used in benchmark calculations in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315. 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), for a change to the beneficiary assignment methodology specified in subpart E of this part, for a change in the CMS-HCC risk adjustment methodology used to calculate prospective HCC risk scores under § 425.659, and for changes in values used in benchmark calculations in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315. 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 BY3 using the assignment window or expanded window for assignment that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).

(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 § 425.226(a)(1), 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).

(vi) Redetermines factors based on prospective HCC risk scores calculated for benchmark years by calculating the prospective HCC risk scores using the CMS-HCC risk adjustment methodology that applies for the calendar year corresponding to the applicable performance year in accordance with § 425.659(b)(1).

(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.

(C) Multiply the growth rate calculated in this paragraph (b)(2)(ii) by a regional risk score growth cap adjustment factor computed as described in § 425.655.

(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 performance year using the assignment window or expanded window for assignment that is consistent with 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, as amended at 88 FR 79548, Nov. 16, 2023]

**§ 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 relevant benchmark or performance year using the assignment window or expanded window for assignment that is consistent with 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:



**§ 425.655**

**42 CFR Ch. IV (10–1–24 Edition)**

- (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, as amended at 88 FR 79549, Nov. 16, 2023]

**§ 425.655 Calculating the regional risk score growth cap adjustment factor.**

(a) *General.* This section describes the methodology for calculating the regional risk score growth cap adjustment factor that will be applied to the regional growth rate component of the three-way blend used to update the historical benchmark as described in § 425.652(b) for agreement periods beginning on January 1, 2024, and in subsequent years.

(b) *Calculating county risk scores.* CMS does all of the following to determine county prospective HCC and demographic risk scores for use in calculating the ACO's regional risk scores:

(1) Determines average county prospective HCC and demographic risk scores 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 relevant benchmark or performance year using the assignment window or expanded window for assignment that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).

(2) Makes separate risk score calculations 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.

(c) *Calculating regional risk scores.* CMS calculates an ACO's regional prospective HCC and demographic risk scores by:

(1) Weighting the county-level risk scores determined under paragraph (b) 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 (c)(1) of this section for each population of beneficiaries (according to Medicare enrollment type) across all counties within the ACO's regional service area.

(d) *Determining aggregate growth in regional risk scores.* CMS determines aggregate growth in regional prospective HCC and demographic risk scores by:

(1) Determining growth in regional prospective HCC and demographic risk scores determined in paragraph (c) of this section (expressed as a ratio of the performance year regional risk score to the BY3 regional risk score) 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) Determines the aggregate growth in regional risk scores by calculating a weighted average of the growth in regional prospective HCC risk scores or demographic risk scores, as applicable, across the populations described in paragraph (d)(1) of this section. When calculating the weighted average growth in prospective HCC risk scores or demographic risk scores, as applicable, the weight applied to the growth in risk scores for each Medicare enrollment type is equal to the product of

the ACO's regionally adjusted historical benchmark expenditures for that enrollment type and the ACO's performance year assigned beneficiary person years for that enrollment type.

(e) *Determining the cap on regional risk score growth.* CMS determines the cap on regional prospective HCC risk score growth by:

(1) Computing the sum of the aggregate growth in regional demographic risk scores as determined in paragraph (d)(2) of this section and 3 percentage points.

(2) Calculating the ACO's aggregate market share by calculating the weighted average of the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO for the performance year as determined in § 425.652(b)(2)(iv) across the populations described in § 425.652(b)(1). In calculating this weighted average, the weight applied to the share for each Medicare enrollment type is equal to the ACO's performance year assigned beneficiary person years for that enrollment type.

(3) Adding to the sum computed in paragraph (e)(1) of this section an amount equal to the product of:

(i) The ACO's aggregate market share as determined in paragraph (e)(2) of this section.

(ii) The difference between the aggregate growth in regional prospective HCC risk scores as determined in paragraph (d)(2) of this section and the sum determined in paragraph (e)(1) of this section. This difference is subject to a floor of zero.

(f) *Determining the regional risk score growth cap adjustment factor.* CMS determines the regional risk score growth cap adjustment factor for each Medicare enrollment type to be applied in calculating the regional growth rate described in § 425.652(b) by comparing the aggregate growth in regional prospective HCC risk scores determined in paragraph (d)(2) of this section and, if applicable, the growth in regional prospective HCC risk scores for individual Medicare enrollment types as determined in paragraph (d)(1) of this section with the cap determined in paragraph (e) of this section.

(1) If the aggregate growth in regional prospective HCC risk scores de-

termined in paragraph (d)(2) of this section does not exceed the cap on regional risk score growth determined in paragraph (e) of this section, CMS will set the regional risk score growth cap adjustment factor equal to 1 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) If the aggregate growth in regional prospective HCC risk scores determined in paragraph (d)(2) of this section exceeds the cap determined in paragraph (e) of this section, CMS will compare the growth in regional prospective HCC risk scores for each Medicare enrollment type as determined in paragraph (d)(1) of this section with the cap on regional risk score growth determined in paragraph (e) of this section.

(i) If the growth in regional prospective HCC risk scores for the enrollment type determined in paragraph (d)(1) of this section does not exceed the cap on regional risk score growth determined in paragraph (e) of this section, CMS will set the regional risk score growth cap adjustment factor for that enrollment type equal to 1.

(ii) If the growth in regional prospective HCC risk scores determined in paragraph (d)(1) for the enrollment type exceeds the cap on regional risk score growth determined in paragraph (e) of this section, CMS will set the regional risk score growth cap adjustment factor for that enrollment type equal to the growth in regional prospective HCC risk scores for the enrollment type determined in paragraph (d)(1) of this section divided by the cap on regional risk score growth determined in paragraph (e) of this section.

[88 FR 79549, Nov. 16, 2023]

**§ 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 for BY3 using the assignment window or expanded window for assignment that is consistent with 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 (e) 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) *Expression of the regional adjustment as a single value.* (1) CMS expresses the regional adjustment as a single

value by taking a person-year weighted average of the Medicare enrollment type-specific regional adjustment values determined in paragraph (c) of this section.

(2) CMS uses the regional adjustment expressed as a single value for purposes of determining the adjustment, if any, that will be applied to the benchmark in accordance with § 425.652(a)(8).

(e) *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 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 (e)(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 (e)(1) through (3) of this section used in calculating the regional adjustment.

(f) *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 (e) 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, as amended at 88 FR 79550, Nov. 16, 2023]

**§ 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.

(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 reconciled for the corresponding performance years in its prior agreement period.

(c) *Calculate the per capita prior savings adjustment.* (1) If an ACO is eligible for the prior savings adjustment as determined in paragraph (b)(3) of this section, the prior savings adjustment will equal the lesser of the following:

(i) 50 percent of the pro-rated average per capita amount computed in paragraph (b)(3)(ii) of this section.

(ii) 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.

(2) [Reserved]

(d) *Applicability of the prior savings adjustment.* CMS compares the per capita prior savings adjustment determined in paragraph (c)(1) of this section with the regional adjustment, expressed as a single value as described in § 425.656(d), to determine the adjustment, if any, that will be applied to the ACO's benchmark in accordance with § 425.652(a)(8).

(e) *Recalculation of the prior savings adjustment during an agreement period.*

(1) The ACO's prior savings adjustment is recalculated for changes to the ACO's savings or losses for a performance year used in the prior savings adjustment calculation in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315.

(2) For a new ACO identified as a re-entering ACO, the prior savings adjustment is recalculated for changes to savings or losses for a performance year used in the prior savings adjustment calculation, if the savings or losses of the ACO in which the majority of the new ACO's participants were participating change in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315.

[87 FR 70248, Nov. 18, 2022, as amended at 88 FR 79551, Nov. 16, 2023]

**§ 425.659 Calculating risk scores used in Shared Savings Program benchmark calculations.**

(a) *General.* CMS accounts for differences in severity and case mix of the

ACO's assigned beneficiaries and assignable beneficiaries (as defined under § 425.20) in calculations used in establishing, adjusting, and updating the ACO's historical benchmark.

(b) *Prospective Hierarchical Condition Category (HCC) risk score calculation.* In determining Medicare FFS beneficiary prospective HCC risk scores for a performance year and each benchmark year of the ACO's agreement period, CMS does the following:

(1) CMS specifies the CMS-HCC risk adjustment methodology used to calculate prospective HCC risk scores for Medicare FFS beneficiaries (as defined under § 425.20) for use in Shared Savings Program calculations as follows:

(i) In calculating risk scores for Medicare FFS beneficiaries for a performance year, CMS applies the CMS-HCC risk adjustment methodology applicable for the corresponding calendar year.

(ii) For agreement periods beginning before January 1, 2024, CMS applies the CMS-HCC risk adjustment methodology for the calendar year corresponding to the benchmark year in calculating risk scores for Medicare FFS beneficiaries for each benchmark year of the agreement period.

(iii) For agreement periods beginning on January 1, 2024, and in subsequent years, CMS applies the CMS-HCC risk adjustment methodology for the calendar year corresponding to the performance year, as specified under paragraph (b)(1)(i) of this section, in calculating risk scores for Medicare FFS beneficiaries for each benchmark year of the agreement period.

(2) CMS does the following to calculate the prospective HCC risk scores identified in paragraph (b)(1) of this section for a benchmark or performance year:

(i) Removes the Medicare Advantage coding intensity adjustment, if applicable.

(ii) Renormalizes prospective HCC risk scores by Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries) based on the national assignable FFS population for the relevant benchmark or performance year.

(iii) Calculates the average prospective HCC risk score by Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries).

[88 FR 79551, Nov. 16, 2023]

**§ 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 agree-

ment 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 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).

[87 FR 70248, Nov. 18, 2022]

**§§ 425.661–425.669 [Reserved]**

EFFECTIVE DATE NOTE: At 89 FR 79171, Sept. 27, 2024, §§ 425.661 through 425.669 were added and reserved, effective Oct. 15, 2024.

**§ 425.670 Adjustments to mitigate the impact of significant, anomalous, and highly suspect billing activity on Shared Savings Program financial calculations involving calendar year 2023.**

(a) *General.* This section describes adjustments CMS makes to Shared Savings Program calculations to mitigate the impact of significant, anomalous, and highly suspect billing activity occurring in calendar year 2023.

(b) *Significant, anomalous, and highly suspect billing activity for a HCPCS or CPT code impacting Shared Savings Program calculations.* CMS has determined that the billing of the following HCPCS codes represents significant, anomalous, and highly suspect billing activity for calendar year 2023 that warrants adjustment—

(1) A4352 (Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each); and

(2) A4353 (Intermittent urinary catheter, with insertion supplies).

(c) *Applicability of adjustments to performance year and benchmark year calculations.* Notwithstanding any other provision in this part, CMS adjusts the following Shared Savings Program calculations, as applicable, to exclude all Medicare Parts A and B fee-for-service payment amounts on DMEPOS claims (claim types 72 and 82) associated with a HCPCS code specified in paragraph (b) of this section for the period specified in paragraph (d) of this section:

(1) Calculation of Medicare Parts A and B fee-for-service expenditures for an ACO's assigned beneficiaries for all purposes including the following: Establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures.

(2) Calculation of fee-for-service expenditures for assignable beneficiaries as used in determining county-level fee-for-service expenditures and national Medicare fee-for-service expendi-

tures, including the following calculations:

(i) Determining 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 according to §§ 425.601(c) and 425.654(a) for purposes of calculating the ACO's regional fee-for-service expenditures.

(ii) Determining the 99th percentile of national Medicare fee-for-service expenditures for assignable beneficiaries for purposes of the following:

(A) Truncating assigned beneficiary expenditures used in calculating benchmark expenditures under § 425.652(a)(4), and performance year expenditures under §§ 425.605(a)(3) and 425.610(a)(4).

(B) Truncating expenditures for assignable beneficiaries in each county for purposes of determining county fee-for-service expenditures according to §§ 425.601(c)(3) and 425.654(a)(3).

(C) Truncating expenditures for assignable beneficiaries for purposes of determining truncated national per capita fee-for service expenditures for purposes of calculating the ACPT according to § 425.660(b)(3).

(iii) Determining truncated national per capita fee-for-service Medicare expenditures for assignable beneficiaries for purposes of calculating the ACPT according to § 425.660(b)(3).

(iv) Determining national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries for purposes of capping the regional adjustment to the ACO's historical benchmark according to § 425.656(c)(3) and capping the prior savings adjustment according to § 425.658(c)(1)(ii).

(v) Determining national growth rates that are used as part of the blended growth rates used to trend forward BY1 and BY2 expenditures to BY3 according to § 425.652(a)(5)(ii) and as part of the blended growth rates used to update the benchmark according to §§ 425.601(b)(2) and 425.652(b)(2)(i).

(3) Calculation of Medicare Parts A and B fee-for-service revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track as specified in § 425.605(d).