

(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.

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§ 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: