

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