

(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

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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