

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).