

(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: