

(iii) Calculates the average prospective HCC risk score by Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries).

[88 FR 79551, Nov. 16, 2023]

**§ 425.660 Accountable Care Prospective Trend (ACPT).**

(a) *General.* For agreement periods beginning on January 1, 2024, and in subsequent years, CMS incorporates a fixed projected growth rate determined at the beginning of the ACO's agreement period called the Accountable Care Prospective Trend (ACPT) into the blended update factor described in § 425.652(b) when updating an ACO's benchmark for each performance year of the agreement period.

(b) *Determination of ACPT.* An ACPT is a flat dollar amount calculated using one or more annualized growth rates based on national fee-for-service Medicare expenditures projected by the CMS Office of the Actuary. In determining the ACPT for an enrollment type for each performance year, CMS does all of the following:

(1) Projects per capita growth in Parts A and B fee-for-service expenditures for benchmark year 3 (BY3) and each performance year of the ACO's agreement period. The calculation—

(i) Excludes IME and DSH payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals; and

(ii) Makes separate expenditure calculations for each of the following populations of beneficiaries:

(A) ESRD.

(B) Aged/Disabled.

(2) Calculates one or more annualized growth rates for the population of beneficiaries described in paragraph (b)(1)(ii)(A) of this section (the ESRD ACPT) and one or more annualized growth rates for the population of beneficiaries described in paragraph (b)(1)(ii)(B) of this section (the Aged/Disabled ACPT). These annualized growth rates will remain fixed over the ACO's agreement period. The annualized growth rate is an annual rate of growth in projected expenditures during the ACO's 5-year agree-

ment period relative to BY3, calculated as follows—

(i) Using a uniform annualized projected rate of growth over each of the 5 performance years of the 5-year agreement period; or

(ii) If annualization as specified in paragraph (b)(2)(i) of this section is determined not to reasonably fit the anticipated growth curve, CMS will apply an alternative annualization technique using two or more annualized growth rates reflecting the projected rates of growth during the 5 performance years comprising the 5-year agreement period.

(3) For each performance year, multiplies the applicable annualized growth rate described in paragraph (b)(2) of this section by BY3 truncated national per capita fee-for-service Medicare expenditures for assignable beneficiaries for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries) identified for the 12-month calendar year corresponding to BY3 to express the annualized growth rate as a flat dollar amount as follows:

(i) The ESRD ACPT is used for the ESRD population.

(ii) The Aged/Disabled ACPT is used for the following populations: disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(4) Adjusts the flat dollar amounts described in paragraph (b)(3) of this section for each performance year for differences in severity and case mix between the ACO's BY3 assigned beneficiary population and the national assignable FFS population for each Medicare enrollment type identified for the 12-month calendar year corresponding to BY3.

(5) Divides the risk adjusted flat dollar amounts described in paragraph (b)(4) of this section by the ACO's historical benchmark expenditures described in § 425.652(a) for each Medicare enrollment type to calculate the percent increase to be included in the blended update factor described in § 425.652(b)(4).

[87 FR 70248, Nov. 18, 2022]

**§§ 425.661–425.669 [Reserved]**

EFFECTIVE DATE NOTE: At 89 FR 79171, Sept. 27, 2024, §§ 425.661 through 425.669 were added and reserved, effective Oct. 15, 2024.

**§ 425.670 Adjustments to mitigate the impact of significant, anomalous, and highly suspect billing activity on Shared Savings Program financial calculations involving calendar year 2023.**

(a) *General.* This section describes adjustments CMS makes to Shared Savings Program calculations to mitigate the impact of significant, anomalous, and highly suspect billing activity occurring in calendar year 2023.

(b) *Significant, anomalous, and highly suspect billing activity for a HCPCS or CPT code impacting Shared Savings Program calculations.* CMS has determined that the billing of the following HCPCS codes represents significant, anomalous, and highly suspect billing activity for calendar year 2023 that warrants adjustment—

(1) A4352 (Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each); and

(2) A4353 (Intermittent urinary catheter, with insertion supplies).

(c) *Applicability of adjustments to performance year and benchmark year calculations.* Notwithstanding any other provision in this part, CMS adjusts the following Shared Savings Program calculations, as applicable, to exclude all Medicare Parts A and B fee-for-service payment amounts on DMEPOS claims (claim types 72 and 82) associated with a HCPCS code specified in paragraph (b) of this section for the period specified in paragraph (d) of this section:

(1) Calculation of Medicare Parts A and B fee-for-service expenditures for an ACO's assigned beneficiaries for all purposes including the following: Establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures.

(2) Calculation of fee-for-service expenditures for assignable beneficiaries as used in determining county-level fee-for-service expenditures and national Medicare fee-for-service expendi-

tures, including the following calculations:

(i) Determining 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 according to §§ 425.601(c) and 425.654(a) for purposes of calculating the ACO's regional fee-for-service expenditures.

(ii) Determining the 99th percentile of national Medicare fee-for-service expenditures for assignable beneficiaries for purposes of the following:

(A) Truncating assigned beneficiary expenditures used in calculating benchmark expenditures under § 425.652(a)(4), and performance year expenditures under §§ 425.605(a)(3) and 425.610(a)(4).

(B) Truncating expenditures for assignable beneficiaries in each county for purposes of determining county fee-for-service expenditures according to §§ 425.601(c)(3) and 425.654(a)(3).

(C) Truncating expenditures for assignable beneficiaries for purposes of determining truncated national per capita fee-for service expenditures for purposes of calculating the ACPT according to § 425.660(b)(3).

(iii) Determining truncated national per capita fee-for-service Medicare expenditures for assignable beneficiaries for purposes of calculating the ACPT according to § 425.660(b)(3).

(iv) Determining national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries for purposes of capping the regional adjustment to the ACO's historical benchmark according to § 425.656(c)(3) and capping the prior savings adjustment according to § 425.658(c)(1)(ii).

(v) Determining national growth rates that are used as part of the blended growth rates used to trend forward BY1 and BY2 expenditures to BY3 according to § 425.652(a)(5)(ii) and as part of the blended growth rates used to update the benchmark according to §§ 425.601(b)(2) and 425.652(b)(2)(i).

(3) Calculation of Medicare Parts A and B fee-for-service revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track as specified in § 425.605(d).