
42 C.F.R. § 425.601

Establishing, adjusting, and updating the benchmark for agreement periods beginning on or after July 1, 2019, and before January 1, 2024.

- (a) *Computing per capita Medicare Part A and Part B benchmark expenditures for an ACO's first agreement period.*
For agreement periods beginning on July 1, 2019, 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 paragraphs (c) and (d) 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.

(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.

This document is only available to subscribers. Please log in or purchase access.

[Purchase Login](#)