COSMOS
Navigate the Compliance Universe

42 C.F.R. § 425.603

Resetting, adjusting, and updating the benchmark for a subsequent agreement period beginning on or before January 1, 2019.

(a) An ACO's benchmark is reset at the start of each subsequent agreement period.

(b) For second agreement periods beginning in 2016, CMS establishes, adjusts, and updates the rebased historical benchmark in accordance with § 425.602(a) and (b) with the following modifications:

(1) Rather than weighting each year of the benchmark using the percentages provided at § 425.602(a)(7), each benchmark year is weighted equally.

(2) An additional adjustment is made to account for the average per capita amount of savings generated during the ACO's previous agreement period. The adjustment is limited to the average number of assigned beneficiaries (expressed as person years) under the ACO's first agreement period.

(c) For second or subsequent agreement periods beginning in 2017, 2018 and on January 1, 2019, CMS establishes the rebased historical benchmark by determining the per capita Parts A and B fee-for-service expenditures for beneficiaries who would have been assigned to the ACO in any of the 3 most recent years before the agreement period using the certified ACO participant list submitted before the start of the agreement period as required under § 425.118. 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. 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, the benchmark is adjusted to reflect only 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:

(i) ESRD.

(ii) Disabled.

(iii) Aged/dual eligible Medicare and Medicaid beneficiaries.

(iv) 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 regional growth rates based on expenditures for the ACO's regional service area as determined under paragraphs (e) and (f) of this section, making separate expenditure calculations for each of the following populations of beneficiaries:

(i) ESRD.

(ii) Disabled.

(iii) Aged/dual eligible Medicare and Medicaid beneficiaries.