
42 C.F.R. § 425.605

Calculation of shared savings and losses under the BASIC track.

(a) *General rules.* For each performance year, CMS determines whether the estimated average per capita Medicare Parts A and B fee-for-service expenditures for Medicare fee-for-service beneficiaries assigned to the ACO are above or below the updated benchmark determined under § 425.601 or § 425.652, as applicable. In order to qualify for a shared savings payment under the BASIC track, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiary population for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate under paragraph (b) of this section except as provided in paragraph (h) of this section.

(1) CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year.

(i) For agreement periods beginning before January 1, 2024:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent.

(B) This cap is the maximum increase in risk scores for each agreement period, such that any positive adjustment between BY3 and any performance year in the agreement period cannot be larger than 3 percent.

(ii) For agreement periods beginning on January 1, 2024, and in subsequent years:

(A) Positive adjustments in prospective HCC risk scores are subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year (positive or negative) plus 3 percentage points.

(B) The cap described in paragraph (a)(1)(ii)(A) of this section will apply to prospective HCC risk score growth for a population described in paragraph (a)(2) of this section only if the ACO's aggregate growth in prospective HCC risk scores between BY3 and the performance year across all of the populations described in paragraph (a)(2) of this section exceeds this cap. If the cap described in paragraph (a)(1)(ii)(A) of this section is determined to apply, the value of the cap is the maximum increase in risk scores for the applicable performance year, such that any positive adjustment between BY3 and the performance year cannot be larger than the value of the cap for any of the populations described in paragraph (a)(2) of this section.

(C) The aggregate growth in demographic risk scores for purposes of paragraph (a)(1)(ii)(A) of this section and the aggregate growth in prospective HCC risk scores for purposes of paragraph (a)(1)(ii)(B) of this section is calculated by taking a weighted average of the growth in demographic risk scores or prospective HCC risk scores, as applicable, across the populations described in paragraph (a)(2) of this section. When calculating the weighted average growth in demographic risk scores or prospective HCC risk scores, as applicable, the weight applied to the growth in risk scores (expressed as a ratio of the ACO's performance year risk score to the ACO's BY3 risk score) for each Medicare enrollment type is equal to the product of the historical benchmark expenditures for

that enrollment type and the performance year person years for that enrollment type.

(2) In risk adjusting the benchmark as described in §§ 425.601(a)(10) and 425.652(a)(10), CMS makes separate adjustments 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) To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Medicare Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare Parts A and B fee-for-service expenditures as determined for the applicable performance year for assignable beneficiaries identified for the 12-month calendar year corresponding to the performance year.

(4) CMS uses a 3-month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(5) Calculations of the ACO's expenditures include the payment amounts included in Medicare Parts A and B fee-for-service claims.

(i) These calculations exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals.

(ii) These calculations take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(6) In order to qualify for a shared savings payment, the ACO's average per capita Medicare Parts A and B fee-for-service expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section except as provided in paragraph (h) of this section.

(b) *Minimum savings or loss rate.* (1) For ACOs under a one-sided model of the BASIC track's glide path, as specified under paragraphs (d)(1)(i) and (ii) of this section, CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for the ACO as follows:

Number of Beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
1 – 499	≥12.2	
500 – 999	12.2	8.7
1,000 – 2,999	8.7	5.0
3,000 – 4,999	5.0	3.9
5,000 – 5,999	3.9	3.6
6,000 – 6,999	3.6	3.4
7,000 – 7,999	3.4	3.2
8,000 – 8,999	3.2	3.1
9,000 – 9,999	3.1	3.0
10,000 – 14,999	3.0	2.7
15,000 – 19,999	2.7	2.5
20,000 – 49,999	2.5	2.2
50,000 – 59,999	2.2	2.0
60,000 +	2.0	2.0

(2) Prior to entering a two-sided model of the BASIC track, the ACO must select the MSR/MLR. For an ACO making this selection as part of an application for, or renewal of, participation in a two-sided model of the BASIC track, the selection applies for the duration of the agreement period under the BASIC track. For an ACO making this selection during an agreement period, as part of the application cycle prior to entering a two-sided model of the BASIC track, the selection applies for the remaining duration of the applicable agreement period under the BASIC track.

(i) The ACO must choose from the following options for establishing the MSR/MLR:

(A) Zero percent MSR/MLR.

(B) Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0 percent.

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