



Medicare Shared Savings Program

SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY

Specifications

May 2018 Version #6
Applicable Beginning Performance Year 2018



MEDICARE
SHARED SAVINGS
PROGRAM

REVISION HISTORY

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
6		Revised to add descriptions of the Track 1+ Model	Executive Summary ; and throughout
6		Revised to add descriptions of voluntary alignment, which was introduced in 2018 and involves prospectively identifying beneficiaries who designate an ACO professional as being responsible for coordinating their overall care, regardless of ACO track	Executive Summary ; Section 1 , Section 2 , Section 3 , Section 7
6		Revised descriptions of use of individually identifiable final payments made for beneficiaries under a demonstration, pilot, or time-limited program, based on changes finalized in the CY 2018 PFS Final Rule that exclude payments that will be reconciled outside the three-month run-out window	Section 2 , Section 4
6		Added clarifying section titles to Section 3 on beneficiary assignment to distinguish claims-based assignment and voluntary alignment	Section 3 , and cross-references

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EXECUTIVE SUMMARY

This document describes the specifications for beneficiary assignment and the shared savings and losses calculations under the Medicare Shared Savings Program (Shared Savings Program) codified at 42 CFR part 425, and the Medicare Accountable Care Organization (ACO) Track 1+ Model (Track 1+ Model) implemented under the authority of the Center for Medicare and Medicaid Innovation (Innovation Center). These specifications are pursuant to policies established by the Centers for Medicare & Medicaid Services (CMS) for the Shared Savings Program through notice and comment rulemaking and for the Track 1+ Model (detailed in [Section 1.1](#)).

Within the Shared Savings Program, CMS enters into agreements with ACOs. CMS rewards ACOs when they are able to lower growth in Medicare Parts A and B fee-for-service (FFS) costs (relative to their unique target), while at the same time, meeting performance standards on quality of care. ACOs have the option to participate under a Track 1 shared savings only model (one-sided model), or under Track 2 or Track 3 models, which are shared savings and losses models (two-sided models). ACOs that choose to become accountable for shared losses under Track 2 or Track 3 will have the opportunity to receive a greater portion of shared savings. In 2018, CMS accepted 55 ACOs into the Track 1 + Model. The new Track 1+ Model is a two-sided model that includes features of both Track 1 and Track 3, but with lower downside risk than Track 2 and Track 3. The Track 1+ Model is a time-limited Innovation Center model.

BENEFICIARY ASSIGNMENT

For Tracks 1 and 2, CMS uses preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. For the Track 1+ Model and Track 3, CMS uses prospective beneficiary assignment. However, CMS will remove beneficiaries who meet a limited set of exclusion criteria from Track 1+ Model and Track 3 ACOs' prospective assignment lists. This occurs on a quarterly basis throughout the performance year and annually at the end of each benchmark and performance year.

As described in the June 2015 Final Rule, if a beneficiary receives at least one primary care service from a physician utilized in assignment¹ within a specific ACO, the beneficiary may be assigned to that ACO based on a two-step process. Note that for beneficiaries who receive primary care services at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), the physician National Provider Identifier (NPI) must be included on the ACO Participant List's Attestation List for the beneficiary to be eligible for assignment.² The assignment methodology, detailed below, is consistent for all tracks.

¹ As defined in the Shared Savings Program's regulations under § 425.20 and § 425.402(c).

² ACOs that include FQHCs and RHCs are required to identify, through an attestation process (refer to § 425.404(a)), the physicians (MD/DO) who provide direct patient primary care services in their ACO participant FQHCs or RHCs. The attestation list refers to the reporting mechanism used to identify these providers.

- The first step assigns a beneficiary to an ACO if he or she receives a plurality³ of primary care services from primary care practitioners (i.e., primary care physicians, nurse practitioners, clinical nurse specialists, physician assistants, or ACO professionals providing services at a FQHC/RHC) within the ACO. CMS defines primary care physicians as physicians with one of the five following specialty designations: internal medicine, general practice, family practice, pediatric medicine, or geriatric medicine.
- The second step only considers beneficiaries who have not received primary care services from a primary care physician, non-physician, or ACO professional providing services at a FQHC/RHC inside or outside the ACO. Under this second step, CMS assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from a specialist physician used in assignment within the ACO.

For Performance Year (PY) 2018 and subsequent performance years, beneficiaries have the opportunity to designate a primary clinician as responsible for coordinating their overall care. Beneficiaries may make this voluntary alignment through MyMedicare.gov at any time during the year. For PY 2018, CMS will use designations made through October 31 of the prior year to supplement the claims-based assignment methodology described above. This process is referred to as voluntary alignment. Voluntary alignment will be determined prospectively, prior to the start of the performance year for all tracks. Beneficiaries who designate an ACO professional in an ACO participant TIN who is a physician used in assignment, a nurse practitioner, a physician assistant, or a clinical nurse specialist will be assigned to the ACO, assuming they meet other eligibility criteria. Voluntary alignment supersedes claims-based assignment.

CALCULATING THE BENCHMARK

CMS establishes, adjusts, updates, and resets an ACO's historical benchmark. There are differences in the methodology used to establish the ACO's first agreement period historical benchmark, which uses national update and trend factors, compared to the methodology for resetting (or rebasing) the ACO's historical benchmark in its second or subsequent agreement period, which uses regional update and trend factors. At the start of the agreement period, CMS provides ACOs with information on their benchmark values by issuing preliminary benchmark reports. After completion of the three-month claims run-out of the most recent benchmark year, CMS provides final benchmark reports to ACOs in the first performance year of an agreement period. This occurs

³ A plurality refers to a greater proportion of primary care services as measured in allowed charges within the ACO than from services outside the ACO (such as from other ACOs, individual providers, or provider organizations). The plurality is determined by the total allowed charges for primary care services and can be less than a majority of the total number of primary care services provided.

approximately six months into the performance year in order to allow time for claims run-out and production. Each performance year, shortly after the beginning of the year, CMS will recalculate the historical benchmark to account for changes in an ACO's certified ACO Participant List finalized prior to the start of the year.

FIRST AGREEMENT PERIOD

For each ACO in its first agreement period, CMS will calculate a historical benchmark using risk-adjusted average per capita expenditures for Parts A and B services under the original Medicare FFS program. The benchmark includes beneficiaries who would have been assigned to the ACO in each of the three calendar years prior to the start of the agreement period.

For each benchmark year, CMS calculates average per capita, risk-adjusted, truncated expenditures for the population that would have been assigned to the ACO in that year. CMS trends forward each of the first two benchmark year (BY1 and BY2) per capita risk-adjusted expenditures to third benchmark year (BY3) dollars based on the national average growth rate in Parts A and B per capita FFS expenditures for assignable beneficiaries (a subset of FFS Medicare beneficiaries). These national growth rates are verified by the CMS Office of the Actuary (OACT). In calculating the three-year average per capita benchmark, the first benchmark year is weighted 10 percent, the second benchmark year is weighted 30 percent, and the third benchmark year is weighted 60 percent.

For each performance year, as part of determining financial reconciliation, CMS risk adjusts the historical benchmark for changes in demographics and health status of the ACO's assigned beneficiary population and updates the benchmark by an OACT-verified projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original FFS program for assignable beneficiaries.

In trending forward the historical benchmark, accounting for changes in performance year assigned beneficiary characteristics, and updating the benchmark, CMS will make calculations for populations of beneficiaries in each of the following Medicare enrollment types: end-stage renal disease (ESRD), disabled, aged/dual eligible, and aged/non-dual eligible. Further, to minimize variation from catastrophically large claims, CMS will truncate an assigned beneficiary's total annual Parts A and B FFS per capita expenditures at a threshold.

SECOND AND SUBSEQUENT AGREEMENT PERIODS

For each ACO in its second and subsequent agreement period, CMS will calculate a rebased benchmark according to the methodology used to calculate the first agreement period benchmark, with the following adjustments.

Second agreement periods beginning in 2016 only: The methodology used to calculate the rebased benchmark includes the following differences from the methodology used for the first agreement period:

- Equally weight the three benchmark years used to calculate the rebased benchmark.
- Account for savings generated under the ACO's prior agreement period if CMS determines the ACO generated net savings across the three performance years under its first agreement period. For an ACO determined to have generated net savings, CMS makes an adjustment to its rebased benchmark to reflect the average per capita amount of savings earned by the ACO in its prior agreement period, reflecting the ACO's financial and quality performance, as well as number of assigned beneficiaries, during that prior agreement period.

Second or subsequent agreement periods beginning in 2017 and subsequent years: The methodology used to calculate the rebased benchmark includes the following differences from the methodology used for the first agreement period:

- Equally weight the three benchmark years used to calculate the rebased benchmark.
- Use regional instead of national trend factors to trend BY1 and BY2 expenditures to BY3.
- Adjust the rebased benchmark by adding a percentage of the difference between risk-adjusted regional expenditures and the ACO's rebased benchmark expenditures. The percentage applied in the calculation of the adjustment will depend on (1) whether the ACO's historical expenditures are higher or lower relative to its region and (2) the ACO's agreement period.
- Annually update the rebased benchmark to account for changes in regional FFS spending (by calculating regional growth rates) instead of using the absolute amount of projected growth in national FFS spending for assignable beneficiaries.

RISK ADJUSTMENT

CMS will use the CMS Hierarchical Condition Category (CMS-HCC) prospective risk adjustment models to calculate beneficiary risk scores, adjust the benchmark years used for the historical benchmark, and compute the rebased historical benchmark. CMS will not risk-adjust the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original FFS program used to update the benchmark during the ACO's first agreement period. CMS will add this flat dollar amount of growth to the risk-adjusted benchmark expenditures. However, in updating benchmarks for second or subsequent agreement periods beginning in 2017 and onward, CMS will risk-adjust the county-level expenditures used in calculating the regional growth rates.

Each year, CMS will adjust the benchmark for changes during the performance period in health status and demographic factors of assigned beneficiaries. An ACO's updated CMS-HCC prospective risk scores will take into account changes in severity and case mix for newly assigned beneficiaries. CMS will use demographic factors to adjust for these changes in severity and case mix for beneficiaries continuously assigned to the

ACO's population. However, if the continuously assigned population shows a decline in its CMS-HCC prospective risk scores, CMS will lower the risk score for this population.

CALCULATING SHARED SAVINGS AND LOSSES

The shared savings methodologies used under the one- and two-sided models are largely the same. CMS will compare the updated historical benchmark to an ACO's assigned beneficiaries' per capita expenditures during the performance year to determine whether the ACO may share in savings or losses. To qualify for shared savings, an ACO must meet or exceed a prescribed minimum savings rate (MSR), fulfill the minimum quality performance standards, and otherwise maintain eligibility to participate in the Shared Savings Program. ACOs that meet these requirements may share in savings at a rate determined by their quality performance up to a performance payment limit. The structure and features of the shared losses and shared savings methodologies are similar to each other. To be liable for shared losses, an ACO must meet or exceed a prescribed minimum loss rate (MLR). Once this MLR is met or exceeded, the ACO will share in losses at a rate determined by its quality performance up to a loss recoupment limit (also referred to as a loss-sharing limit). The MSR and MLR are expressed as a percentage of the ACO's updated historical benchmark and serve as thresholds the ACO must meet or exceed before sharing in savings or losses (respectively).

SHARED SAVINGS

Under the one-sided model, Track 1 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 50 percent based on their quality performance. The one-sided model MSR is a percentage of the ACO's updated historical benchmark calculated on a sliding scale based on the size of its assigned beneficiary population. Savings are calculated as the difference between the updated historical benchmark and actual expenditures, with savings payments capped at 10 percent of the total updated historical benchmark expenditures each year.

Under the two-sided models, ACOs must choose from one of the following options for the MSR/MLR:

- Zero percent MSR/MLR,
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 – 2 percent, or
- Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO, as used for Track 1.

Like Track 1 ACOs, Track 1+ Model ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 50 percent based on their quality performance. Savings are calculated as the difference between the updated historical benchmark and actual expenditures, with savings payments for Track 1+ Model ACOs also capped at 10 percent of total updated historical benchmark expenditures each year.

Track 2 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 60 percent based on their quality performance. Savings are calculated as the difference between the updated historical benchmark and actual expenditures, with payments for Track 2 ACOs capped at 15 percent of total updated historical benchmark expenditures each year.

Track 3 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 75 percent based on their quality performance. Savings are calculated as the difference between the updated historical benchmark and actual expenditures, with payments for Track 3 ACOs capped at 20 percent of total updated historical benchmark expenditures each year.

Shared savings payments made through the Shared Savings Program are subject, until further notice, to the mandatory reductions in federal budgetary resources—known as sequestration—required by the Budget Control Act of 2011. Under these mandatory reductions, shared savings payments made to ACOs will be reduced by two percent. When performing ACO expenditure calculations, CMS will account for the impact of sequestration by adjusting the following to include the amount of payment withheld due to sequestration: benchmark and performance year expenditures, national expenditures used to calculate the national trend factors and update amount, regional expenditures used to calculate the regional FFS adjustment, and growth rates for the trend and update factors for ACOs starting a second or subsequent agreement period in 2017 or beyond. This approach ensures that sequestration applies only once to ACO shared savings payments. In determining performance year expenditures for ACOs, CMS will adjust Part A and B expenditures from April 1, 2013, onward to include the amount of payment withheld due to sequestration.

SHARED LOSSES

Under the two-sided models, ACOs may also incur losses if actual expenditures exceed the updated historical benchmark equal to or greater than the MLR. Track 1+ Model ACOs will share losses, on a first dollar basis, at a fixed rate of 30 percent. In 2018, 2019, and 2020, losses under the Track 1+ Model are capped at either 8 percent of ACO participant Medicare Part A and Part B FFS revenue (revenue-based loss sharing limit) or at 4 percent of the ACO's updated historical benchmark (benchmark-based loss sharing limit), depending on the ACO's composition.

Track 2 or Track 3 ACOs will share losses, on a first dollar basis, at a rate of one minus its final sharing rate. For Track 2 ACOs, the shared loss rate may not be less than 40 percent or exceed 60 percent. For Track 3 ACOs, the shared loss rate may not be less than 40 percent or exceed 75 percent. An ACO will owe a payment equal to its loss rate multiplied by the difference between its updated historical benchmark and its actual expenditures. Losses under Track 2 are capped at 5 percent of the ACO's updated historical benchmark in the first performance year, 7.5 percent in the second

performance year, and 10 percent in the third or subsequent performance year. Under Track 3, losses are capped at 15 percent of the ACO's updated historical benchmark.

REPAYMENT MECHANISM

ACOs choosing a two-sided model (Track 1+ Model, Track 2, or Track 3) must show they have an adequate repayment mechanism in place to assure CMS that they can repay losses for which they may be liable upon reconciliation for each performance year of an agreement period under which they accept performance-based risk.

For Track 2 and Track 3 ACOs, the amount of the ACO's repayment mechanism must be equal to at least one percent of its total per capita Medicare Parts A and B FFS expenditures for its assigned beneficiaries, as determined based on expenditures used to establish the ACO's historical benchmark. CMS will determine whether this repayment mechanism is adequate when looking at an ACO's application to participate in the program. ACOs participating in Track 2 or Track 3 must show that this repayment mechanism is adequate once at the beginning of a three-year agreement period and provide for timely replenishment of repayment mechanism funds used to repay CMS shared losses.

For Track 1+ Model ACOs, a bifurcated approach will be used to determine the estimated amount of the repayment mechanism for consistency with the bifurcated approach to determining the loss-sharing limit. Consistent with Track 2 and Track 3, a Track 1+ Model ACO under the benchmark-based loss-sharing limit must establish a repayment mechanism equal to at least 1 percent of its total per capita Medicare Parts A and B FFS expenditures for its assigned beneficiaries, as determined based on expenditures used to establish the ACO's benchmark. Track 1+ Model ACOs under the revenue-based loss-sharing limit must establish a repayment mechanism equal to at least 2 percent of ACO participant Medicare FFS revenue (total Parts A and B FFS revenue). The repayment mechanism amount for these ACOs will be capped at 1 percent of the ACO's total per capita Medicare Parts A and B FFS expenditures for its assigned beneficiaries, as determined based on expenditures used to establish the ACO's benchmark. Unlike for Track 2 and Track 3 ACOs, the repayment mechanism amount will be re-determined each performance year in an agreement period and may change if the ACO's composition changes, which could impact the ACO's loss sharing limit (either benchmark-based or revenue-based). The Track 1+ Model ACO's repayment mechanism amount could be adjusted up or down on this basis.

DATA SHARING/REPORTS

CMS will provide ACOs aggregate information on their assigned populations and financial performance at the start of the agreement period, quarterly during the performance year, and following the conclusion of each performance year (refer to Table 12).

1 INTRODUCTION

This document is subject to periodic change. Any substantive changes to this document will be noted in a section on revision history.

1.1 STATUTORY AND REGULATORY BACKGROUND

The Shared Savings Program rewards ACOs that lower growth in health care expenditures while meeting performance standards on quality of care. The Shared Savings Program was mandated by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. Section 1899 of the Social Security Act (the Act), added by Section 3022 of the ACA, established the Shared Savings Program. More recently, the requirements for assignment under the program were amended by the 21st Century Cures Act (December 2016). The 21st Century Cures Act amended the Act to require the Secretary to assign beneficiaries to ACOs participating in the Shared Savings Program based not only on their utilization of primary care services furnished by physicians but also on their utilization of services furnished by RHCs and FQHCs, effective for performance years beginning on or after January 1, 2019.

CMS published a notice of proposed rulemaking for the program on April 7, 2011, followed by a public comment period. A final rule was published on November 2, 2011, (76 FR 67802). In subsequent rulemaking for the program, CMS finalized modifications to the program's policies, including:

- Shared Savings Program Final Rule, published June 9, 2015, (80 FR 32692).
- Calendar Year (CY) 2016 Physician Fee Schedule Final Rule with comment period, published November 16, 2015, (80 FR 70886).
- Shared Savings Program Final Rule, published June 10, 2016, (81 FR 37950).
- CY 2017 Physician Fee Schedule Final Rule, published November 15, 2016, (81 FR 80170).
- CY 2018 Physician Fee Schedule Final Rule, published November 15, 2017, (82 FR 52976).
- Shared Savings Program, Interim Final Rule with comment period, published December 26, 2017 (82 FR 60912).

CMS developed the Track 1+ Model for testing by the Innovation Center under section 1115A of the Act. Information about the Track 1+ Model is available through the model's fact sheet⁴ and the Medicare ACO Track 1+ Model Participation Agreement.⁵

⁴ Refer to the CMS fact sheet, [New Accountable Care Organization Model Opportunity: Medicare ACO Track 1+ Model](#).

⁵ The [Medicare Accountable Care Organization Track 1+ Model Participation Agreement](#) is available on the CMS website.

1.2 OVERVIEW OF FINANCIAL MODELS

The Shared Savings Program provides financial incentives to ACOs that proactively coordinate beneficiary care, invest in new care management programs, and redesign care processes to improve the quality, efficiency, and effectiveness of care delivered to Medicare beneficiaries in the FFS program. If these investments generate savings for the Medicare program, ACOs may share in a portion of the savings based on financial and quality performance. However, ACOs may also be required to repay Medicare for shared losses.

For the first agreement period, ACOs will have an option between three tracks. Track 1 ACOs follow a one-sided model. Track 2 and Track 3 ACOs follow a two-sided model. If Track 1 ACOs meet eligibility requirements for continued participation, they can enter one additional three-year agreement under Track 1. ACOs may operate under the one-sided model for a maximum of two agreement periods. ACOs that begin the program in Track 1 also have the option to extend their first agreement period by one year if they apply for and are approved to enter a two-sided risk arrangement in their second agreement period. ACOs that enter an agreement with the Shared Savings Program under a two-sided model (Track 2 or Track 3) must remain under a two-sided model for the term of their agreement and any subsequent agreements. Although the three models share many common features, such as eligibility requirements, quality measures, and shared savings methodology, two-sided model ACOs are accountable for shared losses but also have the opportunity for a greater percentage of shared savings.

The Track 1+ Model, a time-limited Innovation Center model, is available to Track 1 ACOs within their current agreement period, new applicants, and Track 1 ACOs renewing their participation agreements. The Track 1+ Model is based on Track 1, but incorporates elements of Track 3, including: prospective beneficiary assignment, asymmetrical levels of risk and reward (upside based on Track 1 and downside with lower level of risk than Track 2 or Track 3), and the option to request a Skilled Nursing Facility (SNF) 3-Day Rule Waiver. An ACO that enters the Track 1+ Model must continue to participate under a two-sided model in a subsequent agreement period.

1.3 AGREEMENT PERIOD AND BENCHMARK DATA

CMS accepts applications annually for the agreement period start date of January 1 of each year. The term of the agreement is three calendar years, though ACOs entering the program in Track 1 may extend their first agreement period by one year under certain circumstances described above, or may transition to the Track 1+ Model within their Track 1 agreement period. Regardless of an ACO's start date, CMS determines the benchmark based on the three calendar years prior to the ACO's agreement period start date. Table 1 presents the relevant dates for both the assignment periods and expenditures periods for Track 1, Track 2, and Track 3, and Track 1+ ACOs, with a performance year in CY 2018. The benchmark years remain the same for all

performance years during the agreement period. When an ACO renews its agreement for a second or subsequent agreement period, the benchmark is reset based on the three calendar years immediately preceding the start of the new agreement period. For ACOs that move to the Track 1+ Model within their Track 1 agreement period, their benchmark will be recalculated to reflect prospective assignment, but will still be based on the same benchmark years.

For example, the timeline for the program for organizations that start on January 1, 2018, is as follows:

- Three benchmark years: Calendar years for January 1, 2015 – December 31, 2017
- PY 1: January 1, 2018 – December 31, 2018
- PY 2: January 1, 2019 – December 31, 2019
- PY 3: January 1, 2020 – December 31, 2020
- PY 4 (deferred renewals only): January 1, 2021 – December 31, 2021

The subsequent sections of this document describe program procedures and the underlying programming methods in more detail. [Section 2](#) describes the Medicare data files used to calculate shared savings and shared losses. [Section 3](#) explains the method for assigning beneficiaries to an ACO. [Section 4](#) explains how per capita expenditures are calculated and how CMS uses risk adjustment to account for case mix changes from year to year. [Section 5](#) describes the MSR for the one- and two-sided models. [Section 6](#) gives details on how CMS calculates shared savings and shared losses. Finally, [Section 7](#) describes aggregate reports provided to ACOs.

Table 1. Relevant assignment window and expenditures period dates for Track 1, Track 1+ Model, Track 2, and Track 3 ACOs with an agreement period that includes PY 2018

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR (BY) or PERFORMANCE YEAR (PY)	TRACKS 1 & 2 ASSIGNMENT WINDOW[^]	TRACK 1+ MODEL & TRACK 3 ASSIGNMENT WINDOW[^]	EXPENDITURES PERIOD (ALL ACOS)
2015 (Deferred Renewals*)	PY4: CY 2018	Jan 1, 2018 – Dec 31, 2018	N/A	Jan 1, 2018 – Dec 31, 2018
2015 (Deferred Renewals*)	BY3: CY 2014	Jan 1, 2014 – Dec 31, 2014	N/A	Jan 1, 2014 – Dec 31, 2014
2015 (Deferred Renewals*)	BY2: CY 2013	Jan 1, 2013 – Dec 31, 2013	N/A	Jan 1, 2013 – Dec 31, 2013
2015 (Deferred Renewals*)	BY1: CY 2012	Jan 1, 2012 – Dec 31, 2012	N/A	Jan 1, 2012 – Dec 31, 2012
2016 (New Starters and Renewals)	PY3: CY 2018	Jan 1, 2018 – Dec 31, 2018	Oct 1, 2016 – Sep 30, 2017	Jan 1, 2018 – Dec 31, 2018
2016 (New Starters and Renewals)	BY3: CY 2015	Jan 1, 2015 – Dec 31, 2015	Oct 1, 2013 – Sep 30, 2014	Jan 1, 2015 – Dec 31, 2015
2016 (New Starters and Renewals)	BY2: CY 2014	Jan 1, 2014 – Dec 31, 2014	Oct 1, 2012 – Sep 30, 2013	Jan 1, 2014 – Dec 31, 2014
2016 New Starters and Renewals)	BY1: CY 2013	Jan 1, 2013 – Dec 31, 2013	Oct 1, 2011 – Sep 30, 2012	Jan 1, 2013 – Dec 31, 2013
2017 (New Starters and Renewals)	PY2: CY 2018	Jan 1, 2018 – Dec 31, 2018	Oct 1, 2016 – Sep 30, 2017	Jan 1, 2018 – Dec 31, 2018
2017 (New Starters and Renewals)	BY3: CY 2016	Jan 1, 2016 – Dec 31, 2016	Oct 1, 2014 – Sep 30, 2015	Jan 1, 2016 – Dec 31, 2016
2017 (New Starters and Renewals)	BY2: CY 2015	Jan 1, 2015 – Dec 31, 2015	Oct 1, 2013 – Sep 30, 2014	Jan 1, 2015 – Dec 31, 2015
2017 New Starters and Renewals)	BY1: CY 2014	Jan 1, 2014 – Dec 31, 2014	Oct 1, 2012 – Sep 30, 2013	Jan 1, 2014 – Dec 31, 2014
2018 (New Starters and Renewals**)	PY1: CY 2018	Jan 1, 2018 – Dec 31, 2018	Oct 1, 2016 – Sep 30, 2017	Jan 1, 2018 – Dec 31, 2018

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR (BY) or PERFORMANCE YEAR (PY)	TRACKS 1 & 2 ASSIGNMENT WINDOW [^]	TRACK 1+ MODEL & TRACK 3 ASSIGNMENT WINDOW [^]	EXPENDITURES PERIOD (ALL ACOS)
2018 (New Starters and Renewals ^{**})	BY3: CY 2017	Jan 1, 2017 – Dec 31, 2017	Oct 1, 2015 – Sep 30, 2016	Jan 1, 2017 – Dec 31, 2017
2018 (New Starters and Renewals ^{**})	BY2: CY 2016	Jan 1, 2016 – Dec 31, 2016	Oct 1, 2014 – Sep 30, 2015	Jan 1, 2016 – Dec 31, 2016
2018 (New Starters and Renewals ^{**})	BY1: CY 2015	Jan 1, 2015 – Dec 31, 2015	Oct 1, 2013 – Sep 30, 2014	Jan 1, 2015 – Dec 31, 2015

* ACOs that began in Track 1 and were approved to defer by one year entering a two-sided risk arrangement for their second agreement period and, as a result, are participating under their first agreement period for a fourth performance year.

** Includes 2014 starters that deferred renewal by one year to 2018.

[^] Note that voluntary alignment was incorporated into the assignment methodology for PY 2018. Voluntary alignment is applied prospectively for all tracks and uses the same offset window as the Track 1+ Model and Track 3 assignment window, with beneficiary designations through October 31 of the previous year. For PY 2018, voluntarily aligned beneficiaries are only included in assigned beneficiary lists for the performance year. In future performance years, for which 2018 and subsequent years will be a benchmark year, voluntarily aligned beneficiaries will also be included in assigned beneficiary lists for benchmark years.

2 MEDICARE DATA USED TO CALCULATE SHARED SAVINGS AND LOSSES

This section describes the Medicare data used to calculate the shared savings and losses for each ACO participating in the program. Acquiring and processing program data for shared savings and losses calculations are discussed in [Section 2.2](#).

2.1 DATA USED IN PROGRAM

CMS primarily uses Medicare enrollment information ([Section 2.1.1](#)) and claims data ([Section 2.1.2](#)) to assign beneficiaries and calculate shared savings and losses for the program.

2.1.1 MEDICARE ENROLLMENT INFORMATION

CMS uses Medicare enrollment information for beneficiaries entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare-managed care enrollment.

2.1.2 CLAIMS DATA

CMS uses Medicare FFS claims data to make benchmark and performance year financial calculations.

Claims have seven components:

- Inpatient
- Outpatient
- Carrier (physician/supplier Part B)
- SNF
- Home Health Agency (HHA)
- Durable Medical Equipment (DME)
- Hospice Claims

Based on historical trends, CMS expects generally to have between 98 – 99 percent of complete claims data three months after the end of the calendar year. CMS will calculate the payment amounts included in Parts A and B FFS claims using a three-month claims run-out⁶ with a completion factor provided by the OACT. CMS will also use these claims data and other sources to find individually identifiable final payments made from the Medicare Trust Funds for beneficiaries under a demonstration, pilot, or time-limited program, such as care coordination fees.

For the annual reports, CMS uses a three-month claims run-out when determining assigned beneficiaries. For the quarterly reports for Track 1 and Track 2 ACOs, CMS runs assignment data in the month following every calendar year quarter using a rolling 12 months of data and, at most, a seven-day claims run-out. For the Track 1+ Model and Track 3 ACO quarterly reports, CMS determines exclusions on a year-to-date basis following every calendar quarter using, at most, a seven-day claims run-out. To control for claim variability, CMS sets the claims effective date and an Integrated Data Repository (IDR) load date when calculating expenditures. For annual reports, the claims effective date is generally set as the last Friday of the three-month run-out period whereas for quarterly reports the effective date is generally set as the first Friday following the end of the quarter. The IDR load date is generally set as the Monday following the claims effective date.

2.2 ACQUIRING AND PROCESSING PROGRAM DATA

Before CMS can start analyzing the data, claims files used to calculate beneficiary expenditures must accumulate at the CMS data center. Therefore, for each benchmark and performance year in the program, CMS will gather and process final program data starting three months after the end of the calendar year. Note that CMS will use a three-month claims run-out both for benchmark and performance years to make sure Shared Savings Program financial calculations stay consistent internally. After waiting these

⁶ As explained in the April 2011 proposed rule, the claims run-out period is the time between when a Medicare-covered service has been furnished to a beneficiary and when the final payment is actually issued for the respective service (76 FR 19554). For example, CMS determines expenditures for a calendar year by accounting for claims with dates of service during the 12-month period paid up to three months following the end of the year (e.g., paid no later than end of March of the following year).

three months, CMS will start the steps to gather and process data for calculating benchmarks or shared savings payments, and OACT will provide a completion factor to estimate the expenditures that would result if claims data were 100 percent complete. CMS may use data based on less than a complete three-month run-out for quarterly and other preliminary reports (including the initial prospective assignment lists for Track 1+ Model and Track 3 ACOs).

2.2.1 DATA STEPS TO ESTABLISH THE HISTORICAL BENCHMARK

There are many data steps involved in calculating the historical benchmarks, including:

- Assigning beneficiaries to each ACO in each benchmark year for purposes of establishing the historical benchmark;⁷
 - Retrospectively assigning beneficiaries to a Track 1 or Track 2 ACO in each benchmark year
 - Prospectively assigning beneficiaries to a Track 1+ Model or Track 3 ACO in each benchmark year (excluding certain beneficiaries ineligible for assignment)
- Calculating annualized, truncated, weighted Part A and B FFS per capita expenditures in each benchmark year;⁸
- Applying a completion factor to all benchmark year expenditures;
- Risk-adjusting and trending forward ACO historical benchmark years BY1 and BY2 to BY3, using trend factors based on the national average growth rate in Parts A and B per capita FFS expenditures for assignable beneficiaries (for ACOs in their first agreement period and ACOs that started a second agreement period in 2016) or regional growth rates (for ACOs that start a second or subsequent agreement period in 2017 or after); and then applying benchmark year weights.

2.2.2 ADDITIONAL DATA STEPS TO CALCULATE THE REBASED HISTORICAL BENCHMARK

- For ACOs with second agreement periods beginning in 2016 only:
 - Adjust the rebased historical benchmark to account for the average per capita amount of savings generated during the ACO's previous agreement period, considering the ACO's financial and quality performance as well as the size of its assigned patient population during that prior agreement period.
- For ACOs with second or subsequent agreement periods beginning in 2017 or after:

⁷ In determining historical benchmarks for future performance years, voluntary alignment will be utilized in determining the assigned beneficiary population for each calendar year in the benchmark period in which voluntary alignment was in effect.

⁸ Annualization and weighting adjust for months of beneficiary eligibility.

- Adjust the rebased historical benchmark based on the ACO's regional service area expenditures, accounting for whether the ACO has lower or higher spending than the ACO's regional service area.

2.2.3 DATA STEPS TO ESTABLISH THE PERFORMANCE YEAR SHARED SAVINGS AND LOSSES

There are several data steps involved in calculating shared savings and losses, including:

- Retrospectively assigning beneficiaries to Track 1 and Track 2 ACOs at the end of each performance year for purposes of determining shared savings and losses;
- Prospectively assigning beneficiaries to the Track 1+ Model and Track 3 ACOs at the beginning of each performance year for purposes of determining shared savings and losses (excluding certain beneficiaries ineligible for assignment);
- Supplementing claims-based assignment lists for all tracks with prospectively voluntarily aligned beneficiaries (excluding certain beneficiaries ineligible for assignment);
- Annualizing and truncating performance year expenditures;
- Applying a completion factor to all performance year expenditures;
- Adjusting the benchmark each performance year for changes in the risk profile of assigned beneficiaries;
- Updating the benchmark each performance year based on the national flat dollar update amount (for ACOs in their first agreement period and ACOs starting a second agreement period in 2016) or regional update factors (for ACOs starting a second or subsequent agreement period in 2017 and beyond); and
- Determining eligibility for and the amount of shared savings or losses.
- Calculating performance year ACO participant Medicare Part A and Part B FFS revenue for purposes of calculating revenue-based loss sharing limit used for eligible Track 1+ Model ACOs.

2.2.4 DETERMINING REGIONAL FFS EXPENDITURES

Benchmark calculations for second and subsequent agreement periods beginning in 2017 and later years include factors based on regional FFS expenditures calculated for the ACO's regional service area. The ACO's regional service area is defined as all counties where one or more beneficiaries assigned to the ACO reside (§ 425.20). These data are used to determine the following:

- Regional growth rates based on expenditures for the ACO's regional service area to trend forward BY1 and BY2 to BY3 in calculating the rebased historical benchmark;

- Regional adjustment to the ACO's rebased historical benchmark; and
- Regional growth rates for updating the rebased historical benchmark each performance year.

To determine factors based on regional FFS expenditures used in benchmark calculations for second or subsequent agreement periods beginning in 2017 and subsequent years, CMS does the following:

1. Determine truncated, risk-adjusted county level Parts A and B expenditures for assignable beneficiaries.

CMS determines county FFS expenditures based on the expenditures of the assignable population of beneficiaries in each county, where assignable beneficiaries are identified for the 12-month period corresponding to the applicable calendar year (refer to [Section 2.2.5](#)). In calculating expenditures for the assignable population, CMS will allow three months after the end of the calendar year for claims to run out, and will apply a completion factor provided by OACT to complete claims to 100 percent.

For each assignable beneficiary in a county, CMS will compute annualized, truncated expenditures for each enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) following the steps laid out in [Sections 4.1 to 4.4](#). CMS will then calculate the weighted average of the truncated annualized expenditures for the county, weighting by the fraction of the year that each assignable beneficiary is enrolled in each Medicare enrollment type.

CMS adjusts county FFS expenditures for severity and case mix of assignable beneficiaries in the county using CMS-HCC prospective risk scores (as described below). Therefore, CMS will determine the CMS-HCC prospective risk score for each assignable beneficiary for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) and compute weighted average CMS-HCC prospective risk scores for each county for each Medicare enrollment type, again using beneficiary eligibility fractions as weights. Note that risk scores for assignable beneficiaries for a given enrollment type for a given year are renormalized to ensure that the mean national assignable FFS risk score for that enrollment type for that year equals 1.0.

When calculating assignable beneficiary annualized truncated expenditures, CMS-HCC risk scores, and Medicare enrollment type eligibility fractions, CMS will only consider months in which the beneficiary is enrolled in both Part A and Part B and is not enrolled in a Medicare Group Health Plan. For example, if a beneficiary with disabled status is enrolled in both Part A and Part B and not enrolled in a Medicare Group Health plan for the first six months of the year but enrolled in a Medicare Group Health plan for the second six months of the year, his/her disability eligibility fraction would be equal to 0.5 (6/12) and his/her annualized truncated expenditures and CMS-HCC risk score would be computed based only on the first six months of the year.

Note, county-level expenditure and risk score data will be publicly released by CMS annually, in the summer following the conclusion of the calendar year to which the data relates.

2. Determine the counties of residence for the ACO's assigned population to establish the ACO's regional service area.

As previously stated, the ACO's regional service area is defined as all counties where one or more beneficiaries assigned to the ACO reside (§ 425.20). CMS will determine the ACO's regional service area using beneficiary assignment for the relevant benchmark or performance year.

Note, ACO-specific aggregate data on counties of residence for the ACO's assigned population for each performance year will be publicly released by CMS annually following the public announcement of results for the relevant performance year.

3. Calculate risk-adjusted regional per capita FFS expenditures for the ACO's regional service area.

For each county and Medicare enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) in the ACO's regional service area, CMS will divide county per capita expenditures by the county average CMS-HCC risk score to obtain risk-adjusted county expenditures.

CMS will weight these expenditures by the ACO's proportion of assigned beneficiary person years in the county for the applicable Medicare enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible). CMS will then aggregate these values, across counties within the ACO's regional service area, for each population by Medicare enrollment type. This will result in a separate value for each of the four populations identified by Medicare enrollment type, representing county weighted regional FFS expenditures for that Medicare enrollment type.

2.2.5 DETERMINING ASSIGNABLE FFS BENEFICIARIES IN CALCULATING FACTORS BASED ON NATIONAL AND REGIONAL FFS EXPENDITURES

Assignable FFS beneficiaries are a subset of the broader FFS population and include any beneficiary receiving a primary care service from a primary care physician or from a physician with one of the primary specialty designations included in § 425.402(c) (refer to [Section 3](#), Table 3). This primary care service must be one that is billed for under traditional FFS Medicare (refer to [Section 3](#), Table 2-5) with a date of service during the 12-month assignment window as defined under § 425.20 (refer to [Section 1](#), Table 1). CMS uses a three-month claims run-out when determining assignable beneficiaries.

Using only assignable beneficiaries in expenditure calculations avoids biases that could result from including Medicare FFS beneficiaries who have not utilized services, among

other factors, that would be present in calculations based on the larger Medicare FFS population.

3 BENEFICIARY ASSIGNMENT

The first step in calculating ACO shared savings or losses is to assign beneficiaries to the ACO based on their utilization of primary care services. For Track 1 and Track 2 ACOs, beneficiary assignment is determined retrospectively at the end of the year for each benchmark and performance year based on Medicare FFS claims. For Track 1+ Model and Track 3 ACOs, beneficiary assignment is determined prospectively prior to the start of each benchmark and performance year based on Medicare FFS claims. Although beneficiaries will be assigned prospectively to Track 1+ Model and Track 3 ACOs, the claims-based assignment methodology itself will be the same as is used to assign beneficiaries to ACOs participating under Track 1 and Track 2, with limited exceptions that are described below. A beneficiary assigned to an ACO in one year may not have been assigned to that ACO for the preceding years.

Beginning in PY 2018, beneficiaries will also have the opportunity to voluntarily align themselves to an ACO at any time during the year by designating a primary clinician who they believe to be responsible for coordinating their overall care at [MyMedicare.gov](https://www.medicare.gov). Voluntary alignment, which will occur prospectively before the start of the performance year (regardless of ACO track), will supplement claims-based assignment. Voluntary alignment will also be in effect for future benchmarks in which 2018 or subsequent years are benchmark years.

3.1 OVERVIEW OF ASSIGNMENT

3.1.1 TIMING OF ASSIGNMENT AND EXCLUSIONS

CMS provides all ACOs with an assignment list prior to the start of the performance year. Track 1 and Track 2 ACOs receive a list that includes preliminary prospective beneficiaries assigned via claims and prospective voluntarily aligned beneficiaries. CMS will run claims-based assignment each quarter, generating a new preliminary prospective list for Track 1 and Track 2 ACOs. This list will also include the prospective voluntarily aligned beneficiaries, indicating which beneficiaries are no longer eligible to be assigned to the ACO. CMS provides Track 1+ Model and Track 3 ACOs with a prospective assignment list prior to the start of the performance year that includes beneficiaries prospectively assigned via claims and beneficiaries who voluntarily aligned to the ACO. Each quarter, CMS will update the prospective lists for Track 1+ Model and Track 3 ACOs to identify beneficiaries who are no longer eligible to be assigned to the ACO. Note that quality measure samples for all tracks are based on the most recent quarterly assignment list available at the time the samples are determined.

Prospective assignment to Track 1+ Model and Track 3 ACOs uses an offset assignment window (refer to Table 1) to generate the list of prospectively assigned beneficiaries prior to the start of the year. Once a beneficiary is prospectively assigned

to a Track 1+ Model or Track 3 ACO for a benchmark or performance year, the beneficiary will not be eligible for assignment to a different ACO, even if the beneficiary obtains a plurality of his or her primary care services from ACO professionals in that ACO during the relevant benchmark or performance year.

While a beneficiary who is prospectively assigned to a Track 1+ Model or Track 3 ACO for a benchmark or performance year via claims-based assignment or voluntary alignment is not eligible for assignment to another ACO, prospectively assigned beneficiaries who meet exclusion criteria at the end of a performance or benchmark year will be excluded from the prospective assignment list prior to calculating the historical benchmark or financial reconciliation. In addition, CMS will perform this exclusion on a quarterly basis during each performance year and incorporate these exclusions into quarterly reports provided to Track 1+ Model and Track 3 ACOs. The remaining exclusion criteria applied to prospectively assigned beneficiaries match the assignment criteria B, C, D, and E included in [Section 3.2](#) below. Also note that in determining prospective assignment for a Track 1+ Model or Track 3 ACO's benchmark and performance years, CMS will identify beneficiaries who, although assigned using the offset assignment window (October – September), died prior to the start of the benchmark or performance year. CMS will exclude these deceased beneficiaries from use in determining financial reconciliation for the Track 1+ Model or Track 3 ACO for the performance year and make a similar exclusion for deceased beneficiaries in determining benchmark year assignments for Track 1+ Model and Track 3 ACOs. ACOs are accountable for the cost and quality of care for prospectively assigned beneficiaries who die during the performance year.

Similar to the prospective assignment exclusion process described above, beneficiaries voluntarily aligned to Track 1 and Track 2 ACOs before the start of the benchmark or performance year who meet exclusion criteria B, C, or E, identified in [Section 3.2](#) below, at the end of the year will be excluded from historical benchmarks or financial reconciliation. Voluntarily aligned beneficiaries with a date of death prior to the start of the benchmark or performance year will also be excluded.

The amount of claims run-out used in determining assignment will vary. Table 10 (Track 1 and Track 2) and Table 11 (Track 1+ Model and Track 3) summarize the run-out periods.

3.1.2 ROLE OF ACO PARTICIPANT LIST IN ASSIGNMENT

In performing claims-based assignment, CMS determines whether ACO professionals participating in an ACO have provided the plurality of a beneficiary's primary care services as compared to ACO professionals in all other ACOs and individual practitioners or groups of practitioners identified by taxpayer identification numbers (TINs) that are not participating in an ACO. CMS treats ACOs as a collection of TINs for the purpose of determining whether the ACO provided the plurality of a beneficiary's primary care services. The ACO's Participant List that identifies these TINs is therefore

important to beneficiary assignment and all related program operations. An ACO participant must agree to participate in the ACO and comply with program regulations in order for the ACO to include the entity on its ACO Participant List. As part of the application cycle, an ACO submits its ACO Participant List and certifies a finalized ACO Participant List as part of entering the program. CMS engages in a process of screening ACO Participant Lists to confirm the eligibility of Medicare-enrolled TINs to participate in the program. An ACO participant TIN that provides primary care services (and, therefore, is used in assignment) may only be included on a single ACO's Participant List.

Under the participation agreement, an ACO is required to inform CMS of changes in the composition of its ACO participants and ACO providers/suppliers. The ACO must report to CMS within 30 days of removing ACO participants and adding or removing ACO providers/suppliers and must certify its ACO Participant and ACO Provider/Supplier Lists at the beginning of each performance year and at other such times as CMS specifies. Annually, an ACO may add TINs vetted through CMS' screening process or delete participants, which results in a certified ACO Participant List that is the basis for beneficiary assignment used in program operations for the ACO's next performance year. Specifically, the ACO's updated certified ACO Participant List is used to:

- Recalculate the ACO's historical benchmark based on the three years prior to the start of its agreement period (herein referred to as "adjusted historical benchmark");
- Determine the ACO's quality sample;
- Determine performance year expenditures and ACO participant Medicare Part A and Part B FFS revenue for calculating revenue-based loss sharing limit for eligible Track 1+ Model ACOs; and
- Produce quarterly and annual feedback reports.

As a result, an ACO may have up to three historical benchmarks for a three-year agreement period if it makes revisions to its ACO Participant List prior to the start of its second and third performance years. A Track 1 ACO that extends its first agreement period by one year before moving to a risk-based track may have up to four historical benchmarks for its first agreement period if it makes revisions to its ACO Participant List prior to the start of its second, third, and fourth performance years. A Track 1 ACO that moves to the Track 1+ Model within an agreement period will receive a new historical benchmark based on prospective assignment for its first performance year participating in the Track 1+ Model regardless of whether the ACO has also made an ACO Participant List change.

3.2 CLAIMS-BASED ASSIGNMENT CRITERIA

Using Medicare claims, CMS will assign beneficiaries to an ACO using a two-step process if they receive at least one primary care service from a physician utilized in

assignment within the ACO (refer to criterion F below). For each year, a beneficiary will be assigned to a participating ACO if the following criteria are met:

A. Beneficiary must have a record of enrollment.

Medicare must have information about the beneficiary's Medicare enrollment status and other information that is required to determine if the beneficiary meets other criteria below.⁹

B. Beneficiary must have at least one month of Part A and Part B enrollment, and cannot have any months of Part A only or Part B only enrollment.

Because the purpose of this program is to align incentives between Part A and Part B, beneficiaries who have coverage under only one of these parts are not included.

C. Beneficiary cannot have any months of Medicare group (private) health plan enrollment.

Only beneficiaries enrolled in original Medicare FFS under Parts A and B are eligible to be assigned to an ACO participating in the Shared Savings Program. Those enrolled in a group health plan, including beneficiaries enrolled in Medicare Advantage (MA) plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All-Inclusive Care for the Elderly (PACE) programs under section 1894 are not eligible.

D. Beneficiaries will be assigned to only one Medicare shared savings initiative.

Beneficiaries cannot be assigned to more than one Medicare shared savings initiative. For example, beneficiaries cannot be assigned to a Shared Savings Program ACO if they are associated with another Medicare shared savings initiative before the start of the Shared Savings Program ACO's performance year. Consequently, CMS will also exclude beneficiaries from each of the benchmark years if they are aligned to another Medicare shared savings initiative prior to establishment of the historical benchmark.

E. Beneficiary must live in the United States or U.S. territories and possessions.

CMS excludes beneficiaries who permanently reside outside of the United States or U.S. territories and possessions in the last available month of the benchmark or performance year assignment window. As these beneficiaries may have received care outside of the U.S., Medicare claims may not be available. If a beneficiary was a U.S. resident in the last available month of the benchmark or performance year assignment window, CMS considers the beneficiary to be a U.S. resident for the entire period. CMS uses the same method (residency in the last available month of the assignment window) for quarterly preliminary prospective assignments for Tracks 1 and 2 ACOs. Similarly, CMS looks at residency in the last available month of the quarter when performing quarterly exclusions for Track 1+ Model and Track 3 ACOs. U.S. residence includes the

⁹ Medicare Secondary Payer (MSP) status does not exclude a beneficiary from assignment to an ACO.

50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas.

F. Beneficiary must have a primary care service with a physician at the ACO.

To be eligible for assignment to an ACO, a beneficiary must have had at least one primary care service furnished by a physician included in the definition of an ACO professional and utilized in assignment.¹⁰ Note that for beneficiaries receiving primary care services at a FQHC or RHC, the physician NPI must be included on an attestation as part of the ACO Participant List. These and other special cases are described below. Tables 2 through 5 below define key terms for the assignment process, such as “primary care service.”

G. Beneficiary must have received the largest share of his/her primary care services from the participating ACO.

If a beneficiary meets the screening criteria in A through F, he or she is eligible to be assigned to an ACO. There are up to two steps in this process:

- **Assignment Policy Step 1:** CMS will assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care practitioner (primary care physician, nurse practitioner, physician assistant, clinical nurse specialist at the participating ACO, or an ACO professional providing services at a FQHC/RHC) within the ACO (refer to Tables 3, 4, and 5), and more primary care services (measured by Medicare-allowed charges) furnished by primary care practitioners at the participating ACO than from the same types of providers at any other Shared Savings Program ACO or non-ACO individual or group TIN.¹¹
- **Assignment Policy Step 2:** This step applies only to beneficiaries who have not received any primary care services from a primary care practitioner and were therefore not assigned in Assignment Policy Step 1. CMS will assign a beneficiary to a participating ACO in this step if the beneficiary received at least one primary care service from a specialist physician utilized in assignment (refer to § 425.402(c)) at the participating ACO, and more primary care services (measured by Medicare-allowed charges) from specialist physicians utilized in assignment at a participating ACO than from any other ACO or non-ACO individual or group TIN.

¹⁰ Physicians utilized in assignment include primary care physicians specified under § 425.20 (internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine) and physicians with primary specialty designations specified under § 425.402(c). These specialty designations include: (1) Cardiology, (2) Osteopathic manipulative medicine, (3) Neurology, (4) Obstetrics/gynecology, (5) Sports medicine, (6) Physical medicine and rehabilitation, (7) Psychiatry, (8) Geriatric psychiatry, (9) Pulmonary disease, (10) Nephrology, (11) Endocrinology, (12) Multispecialty clinic or group practice, (13) Addiction medicine, (14) Hematology, (15) Hematology/oncology, (16) Preventive medicine, (17) Neuro-psychiatry, (18) Medical oncology, and (19) Gynecology/oncology.

¹¹ As assigned by the U.S. Internal Revenue Service. There are two types of TINs: Social Security numbers and Employer Identification Numbers.

CMS will include TINs from the physician/supplier carrier claims file and other identifiers discussed below for Method II Critical Access Hospitals (CAHs), FQHCs, RHCs, and Electing Teaching Amendment (ETA) hospitals in the assignment algorithm in both Assignment Policy Steps 1 and 2 using claims from the outpatient (institutional) file loaded in the IDR. [Sections 3.3.2](#), [3.3.3](#), and [3.3.4](#) contain details on how these other organization types will be identified in outpatient claims. These organizations may include either a participant in an ACO or a non-ACO organization.

3.3 PROGRAMMING STEPS AND SPECIAL RULES IN ASSIGNING BENEFICIARIES TO ACOs VIA CLAIMS-BASED ASSIGNMENT

There are five programming steps involved in assigning beneficiaries to an ACO via claims-based assignment. These are described in [Section 3.3.1](#). [Sections 3.3.2](#), [3.3.3](#), and [3.3.4](#) explain special policies or rules used for processing Method II CAH, FQHC/RHC, or ETA hospital claims, respectively.

3.3.1 PROGRAMMING STEPS FOR CLAIMS-BASED ASSIGNMENT

Programming Step 1: Identify only those beneficiaries who have a primary care service with a physician at the ACO (3.2 F).

CMS identifies all Part B claims that have at least one line item with a primary care service code furnished by an ACO professional billing under an ACO participant TIN. CMS will use an ACO participant's TIN to identify beneficiaries who had a Part B claim that includes at least one primary care service (identified by the Healthcare Common Procedure Coding System (HCPCS) and/or revenue center codes listed in Table 2) furnished by a physician utilized in assignment at the ACO (refer to Table 3) within the year—this includes RHC, FQHC, and Method II CAH professional services claims, which are Part B claims billed on institutional forms. Note that RHCs, FQHCs, and Method II CAHs will be identified on claims by their CMS Certification Numbers (CCNs). For claims for services provided by an ACO's FQHC/RHC participants, beneficiaries are identified if they had at least one primary care service at the ACO from a physician NPI (Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO)) listed on an attestation as part of the ACO Participant List. As noted in Table 2, beginning in 2017, CMS will not consider certain HCPCS codes in physician claims with SNFs as the place of service (POS = 31) to be primary care services for purposes of assignment.

Programming Step 2: Create finder file for beneficiaries identified in Step 1.

CMS will create a “finder file” of the beneficiaries identified in Programming Step 1 for each ACO. The finder file includes the beneficiary identifier for each beneficiary who received at least one primary care service from the ACO's physicians utilized in assignment within the assignment window. Beneficiaries who meet these criteria are also known as “assignable.”

Programming Step 3: Obtain selected claims, enrollment, and demographic information for beneficiaries.

CMS will use the finder file from Step 2 to obtain enrollment information for each beneficiary who had a primary care service from physicians utilized in assignment at the ACO. Eligibility information includes Medicare Parts A and B enrollment, enrollment in a group health plan, and other enrollment information for these beneficiaries. CMS will ultimately drop beneficiaries who do not meet general eligibility requirements described in [Section 3.2](#).

Programming Step 4: Assign beneficiaries to ACOs using Assignment Policy Step 1 (3.2 G).

For beneficiaries identified in the finder file in Step 3, CMS will identify their primary care services from a primary care practitioner at the participating ACO during the assignment window. CMS will assign beneficiaries who meet this condition to an ACO if the allowed charges for primary care services given to the beneficiary by primary care practitioners at the participating ACO are greater than the allowed charges for primary care services furnished by primary care practitioners in any other ACO, and greater than the allowed charges for primary care services from the same types of providers in each non-ACO individual or group TIN or CCN for FQHC, RHC, or Method II CAH, as noted in [Sections 3.3.2](#) and [3.3.3](#) below.

For each ACO, CMS will sum allowed charges for primary care services by the beneficiary identifier. CMS includes the primary care-allowed charges for each beneficiary at each ACO participant (TINs and CCNs) identified as associated with the ACO's organizational ID.¹² Note that the CCN is used for FQHC, RHC, Method II CAH and ETA hospital claims as indicated in [Sections 3.3.2](#), [3.3.3](#), and [3.3.4](#) below. CMS will sum primary care-allowed charges by the "Line HCPCS Code" on Part B, FQHC,¹³ and method II CAH claims, and by revenue codes on claims from RHCs. Refer to Table 2 for a list of the primary care HCPCS and revenue codes CMS includes in beneficiary assignment. CMS will use allowed charges for assignment because unlike expenditures, they include the Medicare deductible—the first dollars of Medicare Part B payments by a beneficiary within the year (for example, \$147 in 2014). By using allowed charges rather than a simple service count, CMS also reduces the likelihood of ties. To determine where a beneficiary received the plurality of his or her primary care services, CMS compares the allowed charges for each beneficiary for primary care services provided by the ACO (in total for all ACO participants) to the allowed charges for primary care services provided by other ACOs and non-ACO providers.

CMS has established the following policy in the event of a tie: the tiebreaker will be the ACO or non-ACO individual or group TIN or other organizational identifier (for FQHCs,

¹² All ACOs will have special identifiers (ACO IDs) in the form of Axxxx (with the x's signifying a four-digit number).

¹³ For claims prior to January 1, 2011, revenue center codes on FQHC claims were used to identify primary care services. For FQHC claims on or after January 1, 2011, the "line HCPCS codes" are used.

RHCs, Method II CAHs, and ETA hospitals) that provided the most recent primary care service through a primary care physician. If there is still a tie, then the tiebreaker will be the ACO or non-ACO individual or group TIN or other organizational identifier (for FQHCs, RHCs, Method II CAHs and ETA hospitals) that provided the most recent primary care service through a physician utilized in assignment. If there is still a tie, the beneficiary is randomly assigned.

Programming Step 5: Apply Assignment Policy Step 2 to beneficiaries who were not assigned in Assignment Policy Step 1.

This step applies only to beneficiaries who have not received any primary care services from a primary care physician, nurse practitioner, physician assistant, clinical nurse specialist or ACO professional providing services at an FQHC/RHC at the participating ACO, or the same type of providers outside of the ACO. In other words, it applies to beneficiaries in the finder file from Step 2 who, after Step 4, remain unassigned to any ACO, or non-ACO individual or group TIN or FQHC, RHC, Method II CAH or ETA hospitals. CMS will assign each of these beneficiaries to an ACO if:

- The allowed charges for primary care services given to the beneficiary by all other ACO physicians utilized in assignment (including physician specialists as indicated in Table 3) are greater than the allowed charges for primary care services furnished by all ACO physician specialists used in assignment in each other ACO, and
- The allowed charges are greater than the allowed charges for primary care services furnished by physician specialists used in assignment in each non-ACO individual or group TIN or Method II CAH or ETA hospitals.

Table 3 lists all specialty codes included in the definition of a physician utilized in assignment. Note that the definition of a physician for purposes of the Shared Savings Program includes only MD/DO physicians. Table 4 lists specialty codes for ACO non-physician practitioners (nurse practitioners, clinical nurse specialists, or physician assistants) included in the definition of ACO professional under § 425.20.

3.3.2 SPECIAL POLICY FOR PROCESSING METHOD II CAH CLAIMS FOR PROFESSIONAL SERVICES

Method II CAH professional services are billed on institutional claim form 1450, bill type 85X, with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x. These services require special processing for purposes of the Shared Savings Program. In general, ACOs are identified by TINs. However, the TINs for method II CAHs are not included in the National Claims History (NCH) and IDR claims files. These CAHs submit line item bills using HCPCS. The rendering physician/practitioner is not reported for each line item. In addition, unlike for FQHCs and RHCs, no attestation (as required for processing FQHC and RHC claims under [Section 3.3.3](#) below) is required for CAH services.

- CMS will use the CCN as the unique identifier for an individual method II CAH.

- To obtain the rendering physician/practitioner for method II CAH claims, CMS will use the “rendering NPI” field. In the event the rendering NPI field is blank, CMS will use the “other provider” NPI field. If the other provider NPI field is also blank on a claim, CMS will use the attending NPI field.
- CMS uses the Provider Enrollment, Chain, and Ownership System (PECOS) to obtain the CMS specialty for Method II CAH claims.

3.3.3 SPECIAL RULES FOR PROCESSING FQHC AND RHC CLAIMS

FQHC and RHC services are billed on an institutional claim form (refer to Table 5 for bill types) and require special handling to incorporate them into the beneficiary assignment process. In general, ACO participants are identified through their TINs. However, the TINs for FQHCs and RHCs are not included in the NCH and IDR claims files. Note that the definition of a primary care service or a primary care physician depends on the bill type and date of service.

- A primary care physician is any physician NPI included in an attestation by the FQHC or RHC as part of the ACO Participant List. CMS will use FQHC/RHC physician attestation information only for purposes of determining whether a beneficiary is eligible for assignment to an ACO. If a beneficiary is identified as being eligible for assignment to the ACO, then CMS will use claims for primary care services furnished by all FQHC/RHC ACO professionals submitted by the FQHC or RHC to determine whether the beneficiary received a plurality of his or her primary care services from the ACO under Step 1.
- For FQHCs/RHCs that are participants in an ACO, CMS treats a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service.
- For FQHCs/RHCs that are NOT participants in an ACO, CMS treats a FQHC or RHC service reported on an institutional claim as a primary care service if the claim includes a HCPCS or revenue center code that meets the definition of a primary care service. That is, for these non-ACO FQHCs and RHCs, CMS assumes a primary care physician performed all primary care services. This will help make sure CMS does not disrupt established relationships between beneficiaries and FQHCs/RHCs.
- CMS uses the CCN as the unique identifier for an individual FQHC/RHC.

The ACO Participant List includes the CCN, TIN, and individual NPIs for the FQHC/RHC providers affiliated with the ACO.

3.3.4 SPECIAL RULES FOR PROCESSING ETA INSTITUTIONAL CLAIMS

ETA hospitals are hospitals that have voluntarily elected to receive payment on a reasonable cost basis for the direct medical and surgical services of their physicians in lieu of the Medicare fee schedule payments that might otherwise be made.

ETA institutional claims are identified with claim type code equal to 40, bill type equal to 13, and require that the CCN on the claim be on a list of CMS-recognized ETA hospitals. The line item HCPCS codes on the ETA institutional claims are used to identify whether a primary care service was provided. The reason for this is that physician services provided at ETA hospitals do not otherwise appear in either outpatient or physician claims.¹⁴ ETA hospitals, however, do bill CMS to recover facility costs incurred when ETA hospital physicians provide services. The HCPCS code, thus, will provide identification that a primary care service was provided to a beneficiary. However, CMS will not scan revenue center codes. Table 2 lists the HCPCS codes that will be used to identify primary care services for ETA institutional claims, except for two: G0438 and G0439 are not included in the list of HCPCS codes for ETA hospitals in 2009 and 2010.

- To obtain the rendering physician/practitioner for ETA institutional claims, CMS will use the “other provider” NPI field. If this field is blank on a claim, CMS will use the attending NPI field.
- CMS uses PECOS to obtain the CMS specialty for ETA institutional claims.
- Allowed charges for ETA claims are imputed using the formula used by Medicare’s Physician Fee Schedule for calculating allowed charges for each HCPCS code.

3.4 VOLUNTARY ALIGNMENT

For PY 2018 and subsequent performance years, beneficiaries have the opportunity to designate a clinician as responsible for coordinating their overall care. Beneficiary designations can be made throughout the year using the MyMedicare.gov website. CMS uses these designations to supplement the claims-based assignment methodology described above. This process is referred to as voluntary alignment.

Beneficiaries who designate an ACO professional participating in an ACO as responsible for coordinating their overall care are prospectively assigned to that ACO, regardless of track, annually at the beginning of each benchmark and performance year based on designations made as of October 31 of the year preceding the benchmark or performance year. Note that any changes in designation made by a beneficiary after that date will not go into effect until the following year.

¹⁴ The physician services, per se, are reimbursed during settlement of the annual Medicare Cost Report for ETA hospitals.

Beneficiaries will be added to an ACO's list of assigned beneficiaries if they meet criteria A through F in [Section 3.2](#) and if they have designated an ACO professional who is a physician used in assignment (refer to [Section 3.1.2](#)), or a nurse practitioner, physician assistant, or clinical nurse specialist as responsible for coordinating their overall care (sometimes referred to as the primary clinician). Note that voluntarily aligned beneficiaries who die before the start of the performance year or become ineligible during the year will be excluded from an ACO's final assigned beneficiary population used to compute performance year expenditures.

If a beneficiary has designated a primary clinician outside the ACO, the beneficiary will be excluded from claims-based assignment. For example, if a beneficiary is assigned to ACO A via claims-based assignment, but designates a primary clinician in ACO B (and meets other criteria for voluntary alignment), the beneficiary will be assigned to ACO B.

3.5 TABLES FOR SECTION 3

- Table 2 lists the primary care codes (HCPCS and Revenue Center Codes) included in beneficiary assignment criteria.
- Table 3 lists specialty codes used to identify physicians who are the basis for beneficiary assignment. Physician specialty is identified by the specialty code associated with each line item on a claim. The table includes the specialty codes used to define a primary care physician (used in Assignment Step 1 and specified under § 425.20), and specialists (used in Assignment Step 2 and specified under § 425.402(c)). Note that the definition of a physician, for purposes of the Shared Savings Program, includes only MD/DO physicians.
- Table 4 lists specialty codes for non-physician practitioners included in the definition of an ACO professional.
- Table 5 lists the bill types for selecting carrier (physician/supplier Part B), Method II CAH, FQHC, RHC, and ETA institutional claims.

Table 2. Primary care codes included in beneficiary assignment criteria

PRIMARY CARE CODES AND SERVICES
For services billed under the physician fee schedule (including method II CAHs), and for FQHC services furnished after 1/1/2011, primary care services include services identified by the following HCPCS/CPT¹⁵ codes:
Office or Other Outpatient Services
99201 New Patient, brief
99202 New Patient, limited
99203 New Patient, moderate
99204 New Patient, comprehensive
99205 New Patient, extensive
99211 Established Patient, brief
99212 Established Patient, limited
99213 Established Patient, moderate
99214 Established Patient, comprehensive
99215 Established Patient, extensive
Initial Nursing Facility Care
99304 New or Established Patient, brief (use except when POS = 31)
99305 New or Established Patient, moderate (use except when POS = 31)
99306 New or Established Patient, comprehensive (use except when POS = 31)
Subsequent Nursing Facility Care
99307 New or Established Patient, brief (use except when POS = 31)
99308 New or Established Patient, limited (use except when POS = 31)
99309 New or Established Patient, comprehensive (use except when POS = 31)
99310 New or Established Patient, extensive (use except when POS = 31)
Nursing Facility Discharge Services
99315 New or Established Patient, brief (use except when POS = 31)
99316 New or Established Patient, comprehensive (use except when POS = 31)
Other Nursing Facility Services
99318 New or Established Patient (use except when POS = 31)
Domiciliary, Rest Home, or Custodial Care Services
99324 New Patient, brief
99325 New Patient, limited

¹⁵ CPT is copyright 2011 American Medical Association. All rights reserved.

PRIMARY CARE CODES AND SERVICES
99326 New Patient, moderate
99327 New Patient, comprehensive
99328 New Patient, extensive
99334 Established Patient, brief
99335 Established Patient, moderate
99336 Established Patient, comprehensive
99337 Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services
99339, brief
99340, comprehensive
Home Services
99341 New Patient, brief
99342 New Patient, limited
99343 New Patient, moderate
99344 New Patient, comprehensive
99345 New Patient, extensive
99347 Established Patient, brief
99348 Established Patient, moderate
99349 Established Patient, comprehensive
99350 Established Patient, extensive
99490 Chronic Care Management Service, 20 minutes
99495 Transitional Care Management Services within 14 days of discharge
99496 Transitional Care Management Services within 7 days of discharge
Wellness Visits
G0402 Welcome to Medicare Visit
G0438 Annual Wellness Visit
G0439 Annual Wellness Visit
New G Code for Outpatient Hospital Claims
G0463 Hospital Outpatient Clinic Visit (refer to note below)
For FQHC services furnished prior to 1/1/2011, primary care services include services identified by HCPCS code G0402 (effective 1/1/2009) or the following revenue center codes:
0521 Clinic Visit by Member to FQHC/RHC

PRIMARY CARE CODES AND SERVICES
0522 Home Visit by FQHC/RHC Practitioner
0524 Visit by FQHC/RHC Practitioner to a Member, in a Covered Part A Stay at the SNF
0525 Visit by FQHC/RHC Practitioner to a Member in an SNF (not in a Covered Part A Stay) or Nursing Facility or ICF MR or Other Residential Facility
For RHC services, primary care services include services identified by HCPCS code G0402 (effective 1/1/2009) or G0438 (effective 1/1/2011), G0439 (effective 1/1/2011) or the following revenue center codes:
0521 Clinic Visit by Member to FQHC/RHC
0522 Home Visit by FQHC/RHC Practitioner
0524 Visit by FQHC/RHC Practitioner to a Member, in a Covered Part A Stay at the SNF
0525 Visit by FQHC/RHC Practitioner to a Member in an SNF (not in a Covered Part A Stay) or Nursing Facility or ICF MR or Other Residential Facility

NOTE: 42 CFR part 425 defines primary care services as the set of services identified by the following HCPCS codes: 99201 through 99215; 99304 through 99340; 99341 through 99350; G0402; G0438; G0439; and G0463 and revenue center codes 0521, 0522, 0524, and 0525. Table 2 contains all codes in that range that are currently in use. When comment indicates “use except when POS = 31,” this refers to physician claims only (Claim Type = 71 or 72). While G0463 is used by hospital outpatient departments covered by Outpatient Prospective Payment System (OPPS) (bill type 13x) since January 1, 2014, for assignment purposes it is used only for ETA hospitals. The Shared Savings Program assignment algorithm ignores claims with bill type 13x except for ETA hospitals. That is, only CCNs belonging to ETA hospitals can use G0463 during the assignment process. The codes in this table will also be used to determine eligibility for voluntary alignment.

Table 3. Use of physician specialty codes in assignment

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	SPECIALIST (STEP 2)
01	General practice	Yes	No
06	Cardiology	No	Yes
08	Family practice	Yes	No
11	Internal medicine	Yes	No
12	Osteopathic manipulative medicine	No	Yes
13	Neurology	No	Yes
16	Obstetrics/gynecology	No	Yes
23	Sports medicine	No	Yes
25	Physical medicine and rehabilitation	No	Yes
26	Psychiatry	No	Yes
27	Geriatric psychiatry	No	Yes
29	Pulmonary disease	No	Yes
37	Pediatric medicine	Yes	No

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	SPECIALIST (STEP 2)
38	Geriatric medicine	Yes	No
39	Nephrology	No	Yes
46	Endocrinology (eff. 5/1992)	No	Yes
70	Multispecialty clinic or group practice	No	Yes
79	Addiction medicine (eff. 5/1992)	No	Yes
82	Hematology (eff. 5/1992)	No	Yes
83	Hematology/oncology (eff. 5/1992)	No	Yes
84	Preventive medicine (eff. 5/1992)	No	Yes
86	Neuropsychiatry (eff. 5/1992)	No	Yes
90	Medical oncology (eff. 5/1992)	No	Yes
98	Gynecologist/oncologist (eff. 10/1994)	No	Yes

NOTE: All specialties listed in this table are used to create the finder file based on non-FQHC/RHC claims. For FQHC/RHCs participating in an ACO, CMS will use any MD/DO included on the FQHC/RHC attestation list, including those with specialties not listed in the table above, when creating the finder file. In Assignment Step 1, CMS includes any MD/DO at an FQHC/RHC, including those with specialties not listed in the above table. The same finder file used for prospective claims-based assignment will be used for determining eligibility for voluntary alignment.

Table 4. Specialty codes for non-physician practitioners included in the definition of an ACO professional

SPECIALTY CODE	DESCRIPTION
50	Nurse practitioner
89	Clinical nurse specialist
97	Physician assistant

Table 5. Bill types used for identifying Method II CAH, FQHC/RHC, and ETA institutional claims

SPECIALTY CODE	SPECIALTY CODE NAME
Method II CAH Claims	Type of bill 85X with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x
RHC Claims	71x bill types
FQHC Claims	73x (for dates of service prior to 4/1/2010) and 77x (for dates of service on or after 4/1/2010)
ETA Claims	13x bill types (from ETA hospitals)

4 ACO PER CAPITA EXPENDITURES AND RISK ADJUSTMENT

This section describes how CMS will calculate per capita expenditures and risk scores for ACOs. This process starts once CMS completes beneficiary assignment, as described in [Section 3](#). CMS performs separate calculations for each benchmark year, quarterly aggregate report, and performance year. Four key steps are reviewed in this section:

1. Calculating total Medicare Part A and Part B expenditures for each beneficiary assigned to the ACO;
2. Calculating the fraction of the year that each assigned beneficiary is enrolled in Medicare in each Medicare enrollment type;
3. Calculating truncated, annualized expenditures and applying a completion factor; and
4. Calculating the weighted average of truncated, annualized expenditures for the ACO by Medicare enrollment type, weighting by the fraction of the year that each beneficiary is enrolled in Medicare enrollment type.

4.1 CALCULATING ACO-ASSIGNED BENEFICIARY EXPENDITURES

After CMS completes ACO beneficiary assignment, it calculates expenditures for ACO-assigned beneficiaries separately for the following populations based on their Medicare enrollment type:

- ESRD eligibility for Medicare as a result of ESRD;
- Disabled eligibility for Medicare by disability;
- Aged/dual eligible Medicare and Medicaid beneficiaries eligibility for Medicare by age, and eligible for both Medicare and Medicaid; or
- Aged/non-dual eligible beneficiaries eligibility for Medicare by age, but not eligible for Medicaid.

CMS will allocate eligible beneficiary months to each of these Medicare enrollment types, applying a hierarchy when determining monthly enrollment categories for each beneficiary. CMS will use Medicare paid amounts to calculate the ACO's benchmark and performance year expenditures. CMS will assign beneficiary expenditures separately in the following hierarchical order of Medicare enrollment type by month: (1) ESRD, (2) disabled, (3) aged/dual eligible Medicare and Medicaid beneficiaries, or (4) aged/non-dual eligible beneficiaries.

The Shared Savings Program identifies ESRD status based on Medicare enrollment/eligibility files. Beneficiaries meet the Medicare ESRD entitlement definition based on long-term dialysis or transplant status. Diagnosis codes on Medicare claims are not used as an indicator of whether a beneficiary is entitled to Medicare ESRD status. CMS does not use the 72x bill types (renal dialysis facilities) to determine whether a beneficiary is an ESRD beneficiary. Beneficiaries on short-term dialysis are not defined as ESRD for Medicare eligibility purposes or in the Shared Savings Program. Additionally, beneficiaries greater than three-months post-graft are not categorized as ESRD beneficiaries under the Shared Savings Program. This aligns with how Medicare Advantage defines ESRD beneficiaries for purposes of HCC risk adjustment and how the CMS OACT defines ESRD beneficiaries. With respect to how the agency designates a beneficiary as ESRD, ESRD facilities are responsible for submitting Form 2728 data to CMS via the Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb).¹⁶ This form must be completed within 45 days of the patient beginning or returning to dialysis treatment. Information in CROWNWeb supports the development of monthly ESRD status flags that are compiled in the final risk score file.

The Shared Savings Program identifies dually eligible beneficiaries as those categorized according to CMS' definitions of Medicare-Medicaid enrollees,¹⁷ including:

- Qualified Medicare Beneficiaries (QMBs) (referred to as having “partial-benefit”) and Qualified Medicare Beneficiaries plus full Medicaid or QMB-plus (referred to as having “full benefits”), identified in CMS data systems by dual status code 01 and 02, respectively.
- Specified Low-Income Medicare Beneficiaries (SLMBs) plus full Medicaid or SLMB-plus, identified by dual status code 04.
- Other full benefit dual eligible/Medicaid only dual eligibles, identified by dual status code 08.

CMS distinguishes between the aged/dual eligible and aged/non-dual eligible populations because CMS' models suggest these populations have significantly different expenditures. However, the ESRD and disabled categories include both dual eligible and non-dual eligible beneficiaries because CMS models suggest these populations do not have significantly different levels of cost.

Step 1: Calculate total Medicare expenditures for each beneficiary assigned to the ACO.

For each beneficiary who CMS assigns to the ACO, CMS will calculate total Medicare Parts A and B FFS expenditures (payments) for Shared Savings Program-eligible months from the inpatient, SNF, outpatient, carrier (physician/supplier Part B), DME,

¹⁶ Refer to [CMS Form 2728](#).

¹⁷ Refer to [“Defining Medicare-Medicaid Enrollees in CMS Data Sources”](#) (Version date: January 9, 2013.)

HHA, and Hospice claims for each Medicare enrollment type. To calculate total Medicare FFS expenditures for each beneficiary for each Medicare enrollment type, CMS will sum expenditures (paid amounts) from all of the beneficiary's inpatient, SNF, outpatient, carrier (Part B), DME, HHA, and hospice claims at any provider. CMS will exclude denied payments and line items from the calculation.

In determining expenditures for quarterly and annual reports, CMS will adjust Part A and B expenditures from April 1, 2013, onward to include the amount of payment withheld due to sequestration. Table 6 contains a list of the variables CMS will use to determine the expenditure amount and denied line items or denied claims for the various claims. CMS will also include individually identifiable payments made for beneficiaries under a demonstration, pilot, or time-limited program (e.g., care coordination payments) that are final and not subject to further reconciliation. CMS will remove Indirect Medical Education (IME) payments and Disproportionate Share Hospital (DSH) payments, including uncompensated care payments, from total expenditures. Since Maryland hospitals receive payment outside the inpatient prospective payment system, these hospitals do not directly receive IME and DSH payments from Medicare. Therefore, the Shared Savings Program does not adjust for IME/DSH payments to Maryland hospitals. Pass-through payments are also excluded from expenditures. Pass-through payments include, but are not limited to, graduate medical education, kidney acquisition costs, and bad debt.

Shared Savings Program expenditure calculations will include Medicare claim payment adjustments resulting from incentive payment programs, including the Value-Based Payment Modifier, Hospital Value-Based Purchasing (VBP), and the Merit-based Incentive Payment System (MIPS). Advanced Alternative Payment Model (APM) lump sum incentive payments to qualified participants participating in Track 1+ Model, Track 2 or Track 3 ACOs or other eligible programs will not be included in ACO expenditures.

In calculating expenditures for annual reports, CMS will allow up to three months after the end of the performance year for claims to run-out. CMS will apply a completion factor, provided by OACT, to complete claims to 100 percent because generally claims will be approximately 98 percent to 99 percent complete at this time. For the quarterly aggregate reports, CMS will use up to a seven-day claims run-out, depending on data availability, and apply a completion factor provided by OACT.

4.2 ANNUALIZING ASSIGNED BENEFICIARY EXPENDITURES

After CMS sums an ACO's assigned beneficiary's expenditures for each Medicare enrollment type, CMS will annualize the expenditures by dividing them by the fraction of months in the year the beneficiary was enrolled in each Medicare enrollment type. All further analyses weight the annualized expenditures by this same fraction.

Annualization and weighting ensure that payments are correctly adjusted for months of beneficiary eligibility, including new Medicare enrollees and beneficiaries who die, and enable CMS to truncate outlier expenditures.

Table 6. Variables used in total beneficiary expenditure calculations

EXPENDITURE COMPONENT	PAYMENT IS EQUAL TO	CLAIM DENIED IF LEFT JUSTIFIED VALUE IS	LINE ITEM DENIED IF	THROUGH DATE
SNF (Claim type = 20, 30)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code'	N/A	Claim thru date
Inpatient (Claim type = 60)	Claim payment amount (excluding IME and DSH amounts)	Any non-blank value for 'Claim Medicare Non-Payment reason code'	N/A	Claim thru date
Outpatient (Claim type= 40)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code' Claim Billing Facility Type Code in (4, 5)	N/A	Claim thru date
Home Health Agency (Claim type = 10)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code' Claim Billing Facility Type Code in (4, 5)	N/A	Claim thru date
Carrier (physician/ supplier Part B) (Claim type = 71, 72)	Line NCH payment amount	'Carrier Claim Payment Denial Code' = '0' or 'D through Y'	Line processing indicator code ≠ A, R, or S	Line latest expense date
DME (Claim type = 81, 82)	Line NCH payment amount	'Carrier Claim Payment Denial Code' = '0' or 'D through Y'	Line processing indicator code ≠ A, R, or S	Line latest expense date
Hospice (Claim type = 50)	Claim payment amount	Any non-blank value for 'Claim Medicare Non-Payment reason code'	N/A	Claim thru date

NOTE: Details on variables are available on the [Research Data Assistance Center website](#).

Step 2: Calculate the fraction of the year that each assigned beneficiary is enrolled in Medicare in each Medicare enrollment type.

In this step, CMS calculates the number of months the beneficiary was enrolled in Medicare Parts A and B for each Medicare enrollment type. A beneficiary is enrolled in

Medicare Parts A and B when the Medicare entitlement/Buy-in Indicator for the month in the Medicare enrollment files is equal to 3 (3=Medicare Parts A and B both) or C (C=Medicare Parts A and B, and State Buy-In). CMS will then take the number of months the beneficiary is enrolled in each Medicare enrollment type and divide it by 12 (the number of months in a calendar year). CMS will use this fraction to annualize beneficiary expenditures in the next step. When CMS sums the fraction of the year enrolled in Medicare for all the beneficiaries assigned to the ACO, the result is the total person years for the ACO's assigned beneficiaries within the year. Person years are used to calculate the ACO's benchmark expenditures and to determine shared savings or losses.

Step 3: Calculate annualized expenditures.

CMS will calculate annualized expenditures for each beneficiary assigned to the ACO for his or her Shared Savings Program-eligible months in each Medicare enrollment type. To annualize a beneficiary's expenditures, CMS will divide the total expenditures in the applicable months by the fraction of the year the beneficiary is enrolled in each Medicare enrollment type.

4.3 TRUNCATING ASSIGNED BENEFICIARY EXPENDITURES AND APPLYING A COMPLETION FACTOR

Step 4: Truncate annualized expenditures and apply completion factor.

CMS will then truncate all annualized expenditures by setting those expenditures greater than a threshold equal to the threshold. CMS will do this to prevent a small number of extremely costly beneficiaries from significantly affecting the ACO's per capita expenditures. For all beneficiaries, the threshold will be the national un-weighted 99th percentile of annualized expenditures for assignable beneficiaries by Medicare enrollment type, verified by OACT. The 99 percentile for ESRD beneficiaries is typically much higher than that of aged and disabled beneficiaries.

Similarly, CMS will truncate all annualized negative expenditures. A negative payment amount may occur in two situations: when a beneficiary is charged the full Medicare deductible during a short inpatient stay and the deductible exceeds the amount Medicare pays, or when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount plus deductible exceeds the amount Medicare pays. For a relatively low weight diagnosis-related group, the deductible plus coinsurance can exceed the Medicare diagnosis-related group payment amount. Medicare records the payment as a negative number on the claim and deducts the amount from the provider payment at the time it is sent. The beneficiary does not receive the excess. Negative annualized expenditures will be truncated at the applicable negative truncation threshold (i.e., the negative of the national un-weighted 99 percentile of annualized expenditures).

CMS will truncate annualized expenditures and annualized negative expenditures at the 99th percentile of national FFS per capita expenditures for assignable beneficiaries for the applicable enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible).

Once expenditures are annualized and truncated, the appropriate completion factor is applied to expenditures. For example, if an aged/dual beneficiary had annualized expenditures of \$20,000 in 2016, then after adjustment for the completion factor with three-month run-out it would be $(\$20,000) \times (1.013) = \$20,260$. To take another example, if an aged/dual beneficiary had annualized expenditures of \$200,000 in 2016, then since the 2016 applicable nominal expenditure truncation threshold for the aged/dual population is \$188,547.10, the beneficiary's truncated expenditures would be \$188,547.10. Then, after adjustment for the completion factor with three-month run-out, the effective expenditure truncation threshold would be $(\$188,547.10) \times (1.013) = \$190,998.21$.

OACT calculates the nominal annualized expenditure truncation thresholds based on uncompleted claims. To be consistent for annualized expenditures, the uncompleted claims are truncated, and then the truncated claims are completed.

4.4 ACO PER CAPITA EXPENDITURES FOR ASSIGNED BENEFICIARIES

Once CMS has annualized and truncated expenditures for each assigned beneficiary's months in each Medicare enrollment type, CMS calculates weighted mean annualized expenditures. This yields per capita expenditures for the ACO for each Medicare enrollment type. As described in Step 5 below, CMS will weight ACO per capita expenditures for each Medicare enrollment type by the fraction of the year the beneficiary is enrolled in Medicare in each enrollment type. Therefore, beneficiaries for whom CMS has less than a year's worth of expenditures do not contribute equally to ACO per capita expenditures as compared to beneficiaries for whom CMS does have a full year of expenditure data.

Step 5: Calculate weighted average of truncated annualized expenditures for the ACO by Medicare enrollment type, weighting by the fraction of the year that each beneficiary is enrolled in Medicare enrollment type.

CMS will calculate the per capita expenditures for the ACO according to the following methodology. CMS uses truncated annualized Medicare expenditures as determined in Steps 3 and 4 for each beneficiary for their Shared Savings Program-eligible months in each Medicare enrollment type and multiplies by each beneficiary's fraction of the year enrolled in each Medicare enrollment type. For example, CMS would assign a value of \$1,250 to a disabled beneficiary with \$2,500 annualized expenditures enrolled in Medicare on the basis of disability for six months. CMS calculates this value for all beneficiaries in the disabled population assigned to the ACO, and then sums all these values and divides by the total number of person years in the disabled population

assigned to the ACO. The beneficiary above would count as half of a person year for purposes of this calculation. CMS will use these ACO per capita expenditures to calculate shared savings and losses.

4.5 RISK ADJUSTMENT

4.5.1 RISK ADJUSTMENT FOR ESTABLISHING THE HISTORICAL BENCHMARK

When establishing the historical benchmark, CMS will use the CMS-HCC prospective risk adjustment model to calculate beneficiary risk scores to adjust for changes in the health status of the population assigned to the ACO. These adjustments will account for changes in case mix between the first and third benchmark years and between the second and third benchmark years.

CMS maintains the CMS-HCC prospective risk adjustment models for the MA program. CMS calculates CMS-HCC risk scores for all Medicare beneficiaries, including FFS beneficiaries. For the benchmark and performance years, CMS will apply the MA risk adjustment model that exists for the current applicable year. CMS will remove the MA coding intensity adjustment in the applicable years. For each beneficiary, CMS will use the final risk score for each month that the beneficiary is in a particular Medicare enrollment type used in the Shared Savings Program (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) to calculate the beneficiary's average risk score for that enrollment type for a given year.

A beneficiary's final risk score for each month is the risk score determined for that beneficiary based on the beneficiary's risk adjustment model status for that month. There are risk adjustment models for MA subpopulations, which include community versus institutional residence, new versus continuing Medicare enrollee, ESRD versus aged versus disabled entitlement status, ESRD dialysis versus transplant versus functioning graft status, and full benefit dual eligible versus partial benefit dual eligible versus non-dual eligible. Therefore, the risk scores used for beneficiaries in a Shared Savings Program enrollment status (e.g., aged/non-dual eligible) may be derived from more than one risk adjustment model (e.g., community model versus institutional model versus new enrollee model). Also, the risk adjustment models are refined over time by CMS, so these risk adjustment model statuses may not be the same across all years (e.g., aged, disabled, community-residing beneficiary).

A beneficiary's average risk score for a particular Medicare enrollment type for a given year will be renormalized to ensure that the mean national assignable FFS risk score for that enrollment type for that year equals 1.0. This adjustment ensures consistency in the FFS risk score year to year. Note also that data used for the quarterly reports will not be risk-adjusted.

4.5.2 PERFORMANCE YEAR RISK ADJUSTMENT FOR NEWLY AND CONTINUOUSLY ASSIGNED BENEFICIARIES

When determining if a beneficiary is newly or continuously assigned, CMS uses the same claims-based assignment eligibility requirements (as described in [Section 3.2](#)) and uses the ACO's Participant List applicable for the performance year. During the assignment window for the most recent prior benchmark or performance year, if a beneficiary does not meet the eligibility criteria, they would be considered ineligible for assignment and considered newly assigned. The only differences between years are the parameter inputs used that reflect the current performance year, and more specifically, parameter inputs that include dates, the list of HCPCS codes used to define primary care services, the list of physician specialties used in assignment, and the ACO Participant List used to identify ACO participants. We use the current performance year ACO Participant List to determine visits with ACO professionals when identifying primary care services at the ACO in prior benchmark or performance years.

A newly assigned beneficiary is a beneficiary assigned in the current performance year who neither was assigned to nor received a primary care service from any of the ACO's participants during the assignment window for the most recent prior benchmark or performance year. A continuously assigned beneficiary is one assigned to the ACO in the current performance year who either was assigned to or received a primary care service from any of the ACO's participants during the assignment window for the most recent prior benchmark or performance year. CMS will categorize beneficiaries as ESRD, disabled, aged/dual eligible and aged/non-dual eligible based on eligibility on a monthly basis. In each performance year, CMS will adjust the ACO's benchmark to account for changes in health status and demographic factors for newly assigned beneficiaries and for continuously assigned beneficiaries. CMS will make these adjustments separately for each Medicare enrollment type. CMS will restate the ACO's updated historical benchmark in the appropriate performance year risk to recognize changes in the level of risk among the ACO's assigned beneficiaries.

For each performance year, CMS will use separate methodologies to risk-adjust the benchmark for newly assigned and continuously assigned beneficiaries. For newly assigned beneficiaries, CMS will recalculate the ACO's CMS-HCC prospective risk scores to adjust for changes in severity and case mix arising from this population's risk scores. The MA coding intensity adjustment will be removed in the applicable years. CMS will use demographic factors to adjust for changes in severity and case mix for beneficiaries continuously assigned to the ACO's population. CMS will renormalize demographic risk scores by Medicare enrollment type for each year to ensure that the mean national assignable FFS risk score equals 1.0. However, if the continuously assigned population shows a decline in its CMS-HCC prospective risk scores, CMS will lower the risk score for this population.

For the ACO's continuously assigned beneficiaries, CMS will recalculate:

1. CMS-HCC prospective risk scores, and
2. Demographic scores.

CMS will then determine whether a prospective HCC or demographic risk adjustment will be used for the continuously assigned population at the aggregate level (rather than within each Medicare enrollment type). CMS will compare risk ratios for each continuously assigned beneficiary population in each Medicare enrollment type based on their CMS-HCC scores and demographic risk scores for the performance year relative to BY3. CMS will weight the risk ratios for each Medicare enrollment type relative to their respective person years and per capita benchmark dollars to obtain an overall dollar weighted average risk ratio. If the overall HCC risk ratio is less than one—thereby indicating the average HCC score for the continuously assigned beneficiaries has fallen relative to BY3—CMS applies HCC ratios to the continuously assigned population within each Medicare enrollment type. Alternatively, if the overall risk ratio is greater than or equal to one, then the demographic ratios are applied to the continuously assigned population within each Medicare enrollment type.

CMS will then update the ACO's historical benchmark risk scores for the continuously and newly assigned populations within each Medicare enrollment type based on the ratio of HCC or a combination of HCC and demographic scores in the performance period relative to BY3.

On a year-to-year basis, this risk adjustment methodology would account for changes in total risk due to beneficiaries who were assigned in the prior year but not assigned in the current performance year (patients who leave the ACO or “leavers”). However, CMS will monitor HCC scores for leavers to monitor for a trend in how the health status changes for this population.

The demographic risk score is a risk score based on certain demographic attributes that do not vary with the beneficiary's health condition. Demographic risk adjustment categories are based on combinations of age, sex, Medicaid status, and original reason for Medicare entitlement. For both the aged/disabled and ESRD demographic risk adjustment models, CMS uses a calibration sample to predict expenditures for different demographic categories of beneficiaries.

- For years prior to 2013, CMS uses the MA demographic risk adjustment models for aged/disabled and ESRD new Medicare enrollees to determine demographic risk scores used in our risk adjustment methodology.
- Beginning with 2013, the MA program restricted the samples used to calibrate its new Medicare enrollee models to beneficiaries newly enrolled in Medicare. Because the Shared Savings Program's calculation of demographic risk scores is not limited to beneficiaries who are newly enrolled in Medicare, for years 2013 and beyond, CMS uses a modified version of the MA aged/disabled and ESRD demographic

models. The Shared Savings Program's demographic models are calibrated on 100 percent samples of the entire Medicare FFS population.

Normalized risk scores for each demographic category are calculated by dividing predicted expenditures for the category by the weighted mean expenditures of the relevant model's calibration sample.

For each aged/disabled Medicare enrollment type used in the Shared Savings Program (disabled, aged/dual eligible, aged/non-dual eligible), normalized risk scores are renormalized each year by dividing by the national assignable FFS mean demographic normalized risk score for that year for that enrollment type. ESRD normalized risk scores for each year are renormalized by dividing by the ESRD national assignable FFS mean demographic normalized risk score for that year. These renormalized risk scores are used in financial reconciliation.

5 MINIMUM SAVINGS RATE AND MINIMUM LOSS RATE

Under both the one-sided and two-sided models of the Shared Savings Program, ACOs must meet or exceed an MSR to receive a shared savings payment.

The MSR is designed to provide a level of confidence that Medicare is rewarding true cost savings (efficiency) on the part of the ACO rather than paying for normal expenditure fluctuations. There is "normal" variation in the incidence and severity of illness in patient populations, so variation in medical expenditures does exist. Variation in annual per capita medical care expenditures (claims costs) for the patients assigned to an ACO creates uncertainty in determining savings. The question then arises as to whether observed (measured) savings are the result of the ACO, or the result of normal fluctuations in medical expenditures for the assigned beneficiary population. A similar issue arises with respect to shared losses; therefore, a MLR is applied to protect against losses resulting from random variation.

As described in this section, the MSR and MLR reflect a percent of the ACO's updated historical benchmark.

5.1 ONE-SIDED MODEL (TRACK 1)

Under the one-sided model, CMS will base an ACO's MSR on the ACO's number of assigned beneficiaries in the performance year. Table 7 shows the MSR as a function of the number of beneficiaries annually assigned to the ACO. For example, the minimum (floor) MSR is set at 2 percent for ACOs with 60,000 or more beneficiaries and set at 3.9 percent for ACOs with 5,000 beneficiaries.

MSRs that are in between the stated endpoints are calculated by the below specified equation, which is a weighted average of the stated endpoints in Table 7. For example, if an ACO has 5,333 beneficiaries, its MSR would be 3.8 percent:

$$3.9\% \times (5,999 - 5,333)/(5,999 - 5,000) + 3.6\% \times (5,333 - 5,000)/(5,999 - 5,000)$$

Table 7. Minimum Savings Rate by number of assigned beneficiaries (one-sided model)

NUMBER OF ASSIGNED BENEFICIARIES*	MSR (LOW END OF ASSIGNED BENEFICIARIES)	MSR (HIGH END OF ASSIGNED BENEFICIARIES)
0-499	>12.2%	>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%

* An ACO must have at least 5,000 assigned beneficiaries in each of the three years before the start of its agreement period and during each performance year of its agreement period, as specified under the program's regulation at 42 CFR § 425.110. If an ACO's number of assigned beneficiaries falls below 5,000, the ACO's MSR will be set to a level consistent with the number of assigned beneficiaries, as specified under § 425.110.

If an ACO's number of retrospectively assigned beneficiaries used for performance year reconciliation falls below 5,000, the ACO's MSR will be set to a level consistent with the number of assigned beneficiaries (as specified under § 425.110). In these cases the ACO's MSR will be increased above 3.9 percent, based on its number of assigned beneficiaries.

Since ACOs participating under the one-sided model are not accountable for shared losses, there is no corresponding MLR that is applied.

5.2 TWO-SIDED MODELS (TRACK 1+ MODEL, TRACK 2, AND TRACK 3)

ACOs participating in Track 2, Track 3, or the Track 1+ Model must choose from one of the following options for the MSR/MLR:

- (1) Zero percent MSR/MLR,

- (2) Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 - 2 percent, or
- (3) Symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO, as used for Track 1.

This selection, made at the time of application to the program, applies for the duration of an ACO's agreement period. These MSR/MLR options give ACOs flexibility in setting the threshold they must meet before being eligible to share in savings or being accountable for losses. By selecting a higher MSR/MLR, an ACO will have the protection of a higher threshold before liability for losses. However, they will also have a higher threshold to meet before being eligible to share in savings. By selecting a lower MSR/MLR, an ACO will have less protection against liability for losses, but will benefit from a corresponding lower threshold for sharing in savings. By choosing the option for a MSR/MLR to vary according to the size of the ACO's population, a smaller ACO will have a relatively higher threshold to meet before being accountable for losses and therefore greater protection against performance-based risk. However, they will have a corresponding higher threshold to meet before sharing in savings.

6 SHARED SAVINGS AND LOSSES CALCULATIONS

This section describes how CMS will calculate an ACO's historical benchmark, updated historical benchmark, performance year expenditures, and annual ACO shared savings and shared losses during a Shared Savings Program agreement period.

There are differences in the methodology used to establish the ACO's first agreement period historical benchmark compared to the methodology for establishing the ACO's rebased historical benchmark in its second or subsequent agreement period. For example, for ACOs in their first agreement period, the benchmark years are weighted as follows: BY1 weighted at 10 percent, BY2 weighted at 30 percent, and BY3 weighted at 60 percent. For an ACO's second or subsequent agreement periods, CMS equally weights the ACO's historical benchmark years. Furthermore, the benchmark rebasing methodology differs for ACOs entering second agreement periods in 2016 and those entering second or subsequent agreements periods in 2017 or subsequent years. For 2016 renewals only, the rebased benchmark is adjusted to account for savings generated under the ACO's prior agreement period. For ACOs starting their second or subsequent agreement period on or after January 1, 2017, an adjustment and trend factors based on regional FFS expenditures are applied to the rebased benchmark.

The ACO's historical benchmark (in the case of ACOs in their first agreement period), or rebased historical benchmark (in the case of renewing ACOs), is adjusted annually to account for changes in the ACO's certified ACO Participant List. Under the participation agreement, the ACO is required to inform CMS of changes in the composition of its ACO participants and ACO providers/suppliers. The ACO must report to CMS within 30 days of removing ACO participants and adding or removing ACO providers/suppliers and must certify its ACO participant and ACO Provider/Supplier List prior to the

beginning of each performance year and at other such times as CMS specifies. An ACO may have up to three historical benchmarks for an agreement period if it revises its ACO Participant List prior to the start of its second and third performance years (or up to four historical benchmarks for Track 1 ACOs that are approved to extend their first agreement period by one year before moving to a two-sided risk model for their second agreement period). Throughout the ACO's agreement period, the historical benchmark and adjusted historical benchmark (if any are produced for the ACO) are based on the three years prior to the start of the ACO's agreement period. The adjusted historical benchmark is not based on more current years.

Each performance year, the historical benchmark or rebased historical benchmark is further adjusted for the health status and demographic factors of the ACO's performance year assigned beneficiary population and updated based on either national assignable FFS expenditures or regional FFS expenditures.

Historical benchmarks may be adjusted for all ACOs to account for Shared Savings Program regulatory changes such as changes to the assignment algorithm or the benchmark calculation itself.

[Section 6.1](#) discusses the methodology for determining the historical benchmark for ACOs in their first agreement period, adjusting the historical benchmark, and updating the historical benchmark. [Section 6.2](#) discusses the methodology for determining the rebased historical benchmark for ACOs that entered their second agreement period in 2016, adjusting the rebased historical benchmark, and updating the rebased historical benchmark. [Section 6.3](#) discusses the methodology for determining the rebased historical benchmark for ACOs entering a second or subsequent agreement period in 2017 or later, adjusting the rebased historical benchmark, and updating the rebased historical benchmark. [Sections 6.4 and 6.5](#) focus on the calculation of shared savings and losses for each year within an agreement period for one-sided and two-sided models, respectively. [Section 6.6](#) briefly describes the repayment mechanism requirement for ACOs participating under a two-sided risk model. [Section 6.7](#) describes offsets to performance payments to repay the Innovation Center advance payments, in the case of Shared Savings Program ACOs participating in the Advance Payment ACO Model or ACO Investment Model. [Appendix A](#) summarizes the characteristics of the benchmarking approaches by agreement period.

The methodologies described in these sub-sections apply to both the one-sided and two-sided models. CMS uses PY1, PY2, and PY3 to denote the three performance years of the Shared Savings Program agreement period, and in discussing ACO performance, CMS refers to the corresponding performance period to be clear. For instance, CMS will refer to the performance year ending December 31, 2018, as PY 2018. CMS uses BY1, BY2, and BY3 to denote the three years CMS uses to calculate the ACO's historical benchmark or rebased historical benchmark.

6.1 CALCULATING BENCHMARKS FOR ACOs IN THEIR FIRST AGREEMENT PERIOD

This section describes the methodologies used to calculate the historical benchmark and updated historical benchmark for any ACO in its first agreement period.

6.1.1 CALCULATING THE HISTORICAL BENCHMARK FOR ACOs IN THEIR FIRST AGREEMENT PERIOD

For each ACO, CMS calculates the three-year average per capita benchmark using expenditures for beneficiaries who would have been assigned to the ACO in each of the three calendar years prior to the start of the ACO's agreement period using the steps in [Sections 4.1 – 4.5](#).

First, CMS calculates the ACO's assigned beneficiary annualized per capita expenditures for each of the three benchmark years (BY1-BY3) for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations by summing Parts A and B FFS expenditures for months in each Medicare enrollment type and dividing by the fraction of the year in the Medicare enrollment type. As noted in [Section 2.1.2](#), CMS will include individually identifiable final payments from the Medicare Trust Funds made for beneficiaries under a demonstration, pilot, or time-limited program, such as care coordination fees, in the ACO's benchmark. As noted in [Section 4.3](#), CMS will truncate expenditures at the national un-weighted 99th percentile of annualized expenditures for assignable beneficiaries ([Section 2.2.5](#) summarizes how CMS identifies national assignable beneficiaries).

CMS will trend forward the per capita dollars of expenditures for beneficiaries assigned in the first and second benchmark years (BY1 and BY2) to BY3 dollars based on the national average growth rate in Parts A and B FFS expenditures for assignable beneficiaries in the national FFS population (refer to [Section 2.2.5](#)) verified by OACT. CMS will identify the OACT national assignable FFS expenditures by ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations and will calculate separate growth factors for each Medicare enrollment type.

To risk-adjust the benchmark expenditures, CMS will obtain the mean renormalized CMS-HCC risk scores for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible assigned populations. CMS restates the BY1 and BY2 expenditures in BY3-assigned beneficiary level of risk by calculating and applying risk ratios of the BY3 risk score divided by each year's risk score.

CMS will apply the benchmark year weights to the trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations. BY1 has a weight of 10 percent, BY2 has a weight of 30 percent, and BY3 has a weight of 60 percent. This will give CMS weighted average annual per capita expenditures for each population.

CMS will then weight the final benchmark to reflect the BY3 proportions of the ACO assigned beneficiary populations that are ESRD, disabled, aged/dual eligible, and aged/non-dual eligible beneficiaries. CMS will state the ACO's historical benchmark as a single per capita amount.

6.1.2 CALCULATING THE ADJUSTED BENCHMARK BASED ON PARTICIPANT LIST CHANGES FOR ACOs IN THEIR FIRST AGREEMENT PERIOD

For an ACO in its first agreement period, CMS will recalculate the historical benchmark using the same methodology described in [Section 6.1.1](#) and based on the same three benchmark years (prior to the start of its agreement period) to account for changes in the ACO's Participant List certified prior to the start of each performance year. The result is an adjusted historical benchmark. The finalized historical benchmark, either the benchmark issued during the ACO's first performance year or the adjusted historical benchmark (in the event the ACO finalizes participant list changes effective for the performance year), will be used to produce the updated historical benchmark for determining shared savings/losses for the relevant performance year.

6.1.3 CALCULATING THE UPDATED HISTORICAL BENCHMARK FOR ACOs IN THEIR FIRST AGREEMENT PERIOD

CMS calculates the updated historical benchmark expenditures for each performance year in an ACO's first agreement period as the sum of risk-adjusted historical benchmark expenditures and the flat dollar amount equal to the projected absolute amount of growth in national per capita expenditures for Parts A and B services for assignable beneficiaries under the original FFS program from the benchmark to the performance year.

To calculate the updated historical benchmark, CMS first risk-adjusts the historical benchmark expenditures calculated in [Section 6.1.1 or 6.1.2](#) for each Medicare enrollment type (i.e., ESRD, disabled, aged/dual eligible, aged/non-dual eligible) using the method described in [Section 4.5](#) that accounts separately for newly and continuously assigned beneficiaries. CMS then determines the national projected absolute amount of growth in per capita expenditures among assignable beneficiaries for each Medicare enrollment type. CMS will add this flat dollar amount to the risk-adjusted historical benchmark expenditures from above. For example, CMS would add the aged/dual eligible national amount of growth from historical benchmark to performance year to the aged/dual eligible risk-adjusted portion of the historical benchmark.

The overall updated historical benchmark for a performance year is the weighted average of per capita expenditures for each of the Medicare enrollment types. To obtain the updated historical benchmark for a performance year, CMS will take a weighted average of ESRD, disabled, aged/dual eligible and aged/non-dual eligible updated

benchmark expenditures, using the performance year ACO assigned beneficiary proportions of ESRD, disabled, aged/dual eligible and aged/non-dual eligible person years. The updated historical benchmark will be provided in the Financial Reconciliation Report, showing the calculation of shared savings eligibility.

6.2 CALCULATING BENCHMARKS FOR ACOs THAT ENTERED A SECOND AGREEMENT PERIOD IN 2016

The first step in calculating annual shared savings and losses for a performance year in an ACO's second or subsequent agreement periods is to calculate a rebased, or reset, benchmark that is based on three-year historical average benchmark expenditures for assigned beneficiaries in the three years preceding the new agreement period. The steps used to calculate an ACO's rebased historical benchmark, as well as to adjust the rebased historical benchmark or update the rebased historical benchmark, will depend on the year in which the ACO is entering its second agreement period. This section describes the methodologies that apply for the second agreement period only for ACOs that first entered the Shared Savings Program in 2012 or 2013 and renewed for a second agreement period beginning in 2016.

6.2.1 CALCULATING THE REBASED HISTORICAL BENCHMARK: 2016 RENEWALS

The methodology used to calculate the rebased historical benchmark for ACOs that entered a second agreement period in 2016 (i.e., the PY 2016 rebased benchmark) is the same as that described in [Section 6.1.1](#) for an ACO in its first agreement period, with two exceptions.

First, CMS will apply equal weights to the benchmark years' trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations. That is, each benchmark year will be weighted one-third, rather than using weights of 10 percent, 30 percent, and 60 percent for BY1, BY2, and BY3, respectively.

Second, CMS will use data from the ACO's finalized financial reconciliation reports for the performance years that correspond to the current benchmark years (i.e., 2013, 2014, and 2015) to calculate an adjustment for savings generated in the prior agreement period. The calculation will include the following steps (which are also illustrated in Table 8 below).

Step 1. Determine whether the ACO generated net savings.

For each performance year, CMS will determine an average per capita amount reflecting the quotient of the ACO's total updated historical benchmark expenditures minus total performance year expenditures divided by performance year assigned beneficiary person years. However, the ACO's total updated historical benchmark expenditures minus total performance year expenditures may not exceed the performance payment limit for the relevant track. The limit on the adjustment for prior

savings is calculated under a different methodology than the cap that is applied to shared savings payments during financial reconciliation for a performance year. The calculations are intentionally different to accomplish two separate functions with the Shared Savings Program. The goal of the prior savings adjustment is to make an ACO's rebased historical benchmark more reflective of the total cost of care for an ACO's assigned beneficiaries during the prior agreement period and encourage continued participation in subsequent agreement periods, while preventing situations in which the reset benchmark becomes overly inflated based on prior performance to the point where an ACO needs to do little to maintain or change its care practices to generate shared savings. In contrast, the shared savings cap avoids giving ACOs incentives for inappropriate reductions in utilization and expenditures, while rewarding performance for lowering growth in expenditures and meeting quality performance standards.

If the sum of the three performance year per capita amounts is positive, the ACO is determined to have net savings and CMS will proceed with Steps 2 and 3. If the sum of the three performance year per capita amounts is zero or negative, CMS will not make any adjustment to the ACO's rebased benchmark to account for any savings the ACO may have generated under its prior agreement period.

Step 2. Calculate an average per capita amount of savings reflecting the ACO's final sharing rates based on quality performance.

CMS will average the performance year per capita amounts determined in Step 1 to determine the average per capita amount for the agreement period. CMS will also determine the ACO's average final sharing rate based on an average of the ACO's quality performance in each performance year of the agreement period. Therefore, the average per capita amount of savings will account for those situations where an ACO's sharing rate for a performance year is set equal to zero (based on the ACO's failure to meet the quality performance standard in that year). CMS will then calculate an average per capita amount of savings, which is the product of the average performance year per capita amount and the average final sharing rate based on quality performance.

Step 3. Add the average per capita amount of savings determined in Step 2 to the ACO's rebased historical benchmark.

The additional per capita amount will be applied to the ACO's rebased historical benchmark for a number of assigned beneficiaries (expressed as person years) not to exceed the average number of assigned beneficiaries (expressed as person years) under the ACO's first agreement period. Imposing this limit ensures that the adjustment does not exceed the amount of net savings generated by the ACO during the first agreement period due to ACO Participant List changes that may have increased the number of assigned beneficiaries in the second agreement period.

Note that ACOs with an agreement start date of April 1, 2012, or July 1, 2012, had a first performance year spanning a 21-month or 18-month period (respectively), concluding on December 31, 2013. In calculating the average per capita amount of

savings for these ACOs, CMS will use calendar year 2013 data from the PY1 final financial reconciliation for these ACOs to align with the same 12-month period for the corresponding benchmark year under their second agreement.

Table 8. Hypothetical performance data - incorporating savings into rebased benchmark

	PY1	PY2	PY3	AVERAGE
A. Person years	31,024	32,579	32,463	32,022 (average of A for PY1, PY2, PY3)
B. Total benchmark expenditures minus total expenditures	\$19,265,778.00	(\$8,470,676.00)	\$21,824,075.00	—
C. Per capita total benchmark minus total expenditures (C = B/A)	\$621.00	(\$260.00)	\$672.28	\$344.42 (average of C for PY1, PY2, PY3)
D. Final sharing rate	50%	0.0%	40%	30% (average of D for PY1, PY2, PY3)
E. Average per capita amount to add to rebased historical benchmark	—	—	—	\$103.33 (E = average C * average D)

6.2.2 CALCULATING THE ADJUSTED REBASED HISTORICAL BENCHMARK BASED ON PARTICIPANT LIST CHANGES: 2016 RENEWALS

CMS will recalculate the rebased historical benchmark using the same methodology described in [Section 6.2.1](#) and based on the same three benchmark years (prior to the start of its current agreement period) to account for changes in the ACO's certified ACO Participant List. The result is an adjusted rebased historical benchmark. If an ACO does not make participant list changes, it will not have an adjusted benchmark. The finalized rebased (issued during the ACO's first performance year of its second agreement period) or adjusted rebased (in the event the ACO finalizes participant list changes effective for the performance year) historical benchmark will be used to produce the updated rebased historical benchmark for determining shared savings/losses for the relevant performance year. The adjustment for savings generated in the ACO's first

agreement period (described in [Section 6.2.1](#)) will be applied to the ACO's rebased historical benchmark adjusted for changes in its ACO Participant List.

6.2.3 CALCULATING THE UPDATED REBASED BENCHMARK: 2016 RENEWALS

For ACOs that started a second agreement period in 2016, CMS will calculate the updated rebased benchmark expenditures for each performance year in the second agreement period as the sum of risk-adjusted rebased benchmark expenditures (prior to the application of any adjustment for prior agreement period savings) and the flat dollar amount equal to the projected absolute amount of growth in national per capita expenditures for Parts A and B services for assignable beneficiaries under the original FFS program from the benchmark to the performance year, as described in [Section 6.1.3](#) for ACOs in their first agreement period. The adjustment for prior period savings will then be applied to the updated benchmark.

6.3 CALCULATING BENCHMARKS FOR ACOs ENTERING A SECOND OR SUBSEQUENT AGREEMENT PERIOD IN 2017 OR BEYOND

This section describes the methodologies used to calculate the rebased historical benchmark and to adjust and update the rebased historical benchmark for ACOs entering their second or subsequent agreement periods in 2017 or later years.

6.3.1 CALCULATING THE REBASED HISTORICAL BENCHMARK

The methodology that will be used to calculate the rebased historical benchmark for ACOs that enter a second or subsequent agreement period in 2017 or beyond will differ from the methodology used to calculate an ACO's historical benchmark for its first agreement period (and described in [Section 6.1.1](#)) in the following ways.

CMS will replace the national FFS trend factors with regional trend factors to trend forward BY1 and BY2 expenditures to BY3, expressed as growth rates based on regional FFS expenditures. CMS will use the following steps to calculate these regional growth rates:

- For each benchmark year, calculate risk-adjusted county FFS expenditures for the ACO's regional service area. The method used to calculate risk-adjusted regional expenditures is the same as that described in [Sections 2.2.4 and 2.2.5](#).
- For each benchmark year, compute a weighted average of risk-adjusted county-level FFS expenditures using weights that reflect the proportion of an ACO's assigned beneficiaries residing in each county within the ACO's regional service area. Calculations would be performed by Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) based on the ACO's benchmark year assigned population.

- Compute the average growth rates from BY1 to BY3 and from BY2 to BY3 using the weighted average of risk-adjusted county level FFS expenditures for the respective benchmark years for each Medicare enrollment type.

CMS will apply equal weights to the benchmark years' trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations. That is, each benchmark year will be weighted one-third, rather than using weights of 10 percent, 30 percent, and 60 percent for BY1, BY2, and BY3, respectively.

CMS will also adjust the rebased historical benchmark by a percentage of the difference between the average per capita expenditure amount for the ACO's regional service area and the ACO's rebased historical benchmark amount (referred to herein as the "regional FFS adjustment"). The percentage that is applied in calculating the regional FFS adjustment will depend on whether the ACO has higher or lower spending compared to the ACO's regional service area and on the agreement period in which the adjustment is being made (refer to Table 9).

To calculate the regional FFS adjustment, CMS follows these steps for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible):

Step 1: For each enrollment type, CMS will multiply the average per capita amount of expenditures for the ACO's regional service area for BY3 as calculated in [Section 2.2.4](#) (weighted average of county risk-adjusted expenditures with weights based on the proportion of ACO assigned beneficiaries residing in each county for BY3) by the ACO's BY3 CMS-HCC risk score, to adjust for differences in severity and case mix between the ACO's assigned beneficiary population and the assignable beneficiary population for the ACO's regional service area. Under this approach, if an ACO's population is healthier than the assignable beneficiaries in the ACO's regional service area, with lower average risk scores for the relevant period, the risk adjustment would reduce the amount of the regional FFS adjustment. Similarly, if the ACO's assigned beneficiary population is comparably sicker than the assignable beneficiaries in the ACO's regional service area, with higher average risk scores for the relevant period, the risk adjustment would increase the amount of the regional FFS adjustment.

Step 2: From the risk-adjusted average per capita expenditure amount for the ACO's regional service area calculated in Step 1, CMS will subtract the average per capita amount of the ACO's rebased historical benchmark.

Step 3: CMS will multiply the difference for each Medicare enrollment type calculated in Step 2 by the determined percentage (as noted below) to obtain the regional FFS adjustment for that enrollment type.

Step 4: CMS will then add the regional FFS adjustment amount for the Medicare enrollment type calculated in Step 3, which may be positive or negative, to the truncated, trended, and risk-adjusted average per capita value of the ACO's rebased historical benchmark for the same Medicare enrollment type.

Step 5: The last step will be to take a weighted average of the adjusted values of the ACO’s rebased historical benchmark across the four Medicare enrollment types using the ACO’s BY3 assigned beneficiary proportions for each Medicare enrollment type as weights.

To determine the percentage that will be applied when calculating the regional FFS adjustment, CMS will first determine whether, on average, the ACO has higher or lower spending than the ACO’s regional service area. After CMS has determined the difference between the risk-adjusted average per capita amount for the ACO’s regional service area and the average per capita amount of the ACO’s rebased historical benchmark for each enrollment type (Step 1 above), CMS will multiply the difference for each Medicare enrollment type by the ACO’s BY3 assigned beneficiary proportions for each Medicare enrollment type. Then CMS will take the sum of these weighted differences across the four Medicare enrollment types.

If the sum computed above is a net positive value (i.e., ACO’s historical spending is lower than its regional service area), CMS will use a weight of 35 percent if the performance year is within the agreement period in which the ACO is subject to the revised rebasing methodology for the first time and a weight of 70 percent if the performance year is in an agreement period in which the ACO is subject to the methodology for a second time (refer to Table 9 for an example). If the sum is a net negative value (i.e., ACO’s historical spending is higher than its regional service area), CMS will use lower weights if the performance year is within the first two agreement periods in which the ACO is subject to the revised rebasing methodology (25 percent and 50 percent, respectively). A weight of 70 percent is applied in the third and subsequent agreement periods the ACO is subject to rebasing under this methodology.

Table 9. Percentage weight used in calculating the regional FFS adjustment for a 2014 starter entering a second agreement period in 2017

AGREEMENT PERIOD IN SHARED SAVINGS PROGRAM	AGREEMENT PERIOD ACO IS SUBJECT TO REGIONAL FFS ADJUSTMENT [^]	ACO’S SPENDING RELATIVE TO ITS REGION	WEIGHT USED TO CALCULATE ADJUSTMENT FOR PERFORMANCE YEARS
Second	First	ACO spending lower	35%
Second	First	ACO spending higher	25%
Third	Second	ACO spending lower	70%
Third	Second	ACO spending higher	50%
Fourth	Third	ACO spending lower	70%
Fourth	Third	ACO spending higher	70%

[^]ACOs with initial start dates in 2012 and 2013 renewed for a second agreement period in 2016. These ACOs will not have regional FFS adjustments applied until their third agreement period beginning in 2019.

6.3.2 CALCULATING THE ADJUSTED REBASED HISTORICAL BENCHMARK BASED ON PARTICIPANT LIST CHANGES

For an ACO that changes its ACO Participant List for the second or third performance year of an agreement period in which it is subject to the rebasing methodology that incorporates factors based on regional FFS expenditures, CMS will recalculate the rebased historical benchmark using the same methodology described in [Section 6.3.1](#) to account for changes in the ACO's certified ACO Participant List. The resulting adjusted rebased historical benchmark is based on the same three benchmark years (prior to the start of its current agreement period). The risk-adjusted regional expenditures used to calculate regional trend factors used to establish the rebased historical benchmark and the regional FFS adjustment to the rebased benchmark will be recalculated such that the weights applied to county-level expenditures will reflect benchmark year assignment based on the ACO's new participant list. Specifically, in redetermining the regional FFS adjustment to account for changes to the ACO's certified ACO Participant List, CMS will:

- Redetermine the ACO's regional service area during BY3 based on the residence of the ACO's assigned beneficiaries for BY3 determined using the new ACO Participant List.
- Redetermine the regional FFS adjustment to the ACO's rebased historical benchmark based on regional average expenditures for the ACO's updated regional service area. In re-determining the regional FFS adjustment, CMS would also adjust for differences between the health status of the ACO's assigned beneficiaries determined using the new ACO Participant List and the population of assignable beneficiaries in the ACO's regional service area for BY3. CMS will also use the BY3 assigned population determined using the new ACO Participant List to determine the ACO's proportion of beneficiaries by Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) in calculating the regional FFS adjustment.
- Redetermine whether the ACO is considered to have lower or higher spending compared to the ACO's regional service area for purposes of determining the percentage to be used in calculating the regional FFS adjustment.

6.3.3 CALCULATING THE UPDATED REBASED BENCHMARK

For ACOs starting a second or subsequent agreement periods in 2017 or beyond, CMS will calculate updated rebased benchmark expenditures for each performance year. Before applying the update, CMS will first risk-adjust the regionally adjusted rebased historical benchmark expenditures for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) using the method described in [Section 4.5](#) that accounts separately for newly and continuously assigned beneficiaries. CMS will then multiply the risk-adjusted rebased historical benchmark expenditures for each enrollment type by a regional update factor. The regional update factor for a given

Medicare enrollment type is expressed as a growth rate and is calculated as the ratio of performance year risk-adjusted regional expenditures to BY3 risk-adjusted regional expenditures. CMS will use the following steps to calculate the benchmark update:

- For each calendar year corresponding to a performance year, determine the ACO's regional service area defined based on the ACO's assigned beneficiary population used to perform financial reconciliation for the relevant performance year and calculate risk-adjusted county FFS expenditures for the ACO's regional service area. The method used to calculate risk-adjusted regional expenditures is the same as that described in [Sections 2.2.4 and 2.2.5](#).
- Compute growth rates as the ratio of weighted average risk-adjusted county level FFS expenditures for applicable two years, comparing expenditures determined in the previous step for the relevant performance year with expenditures determined for the ACO's regional service area for BY3.
- To obtain the overall updated rebased benchmark for the performance year, CMS will then take a weighted average across the four Medicare enrollment types, using the performance year Medicare enrollment type proportions as weights.

6.4 ANNUAL FINANCIAL RECONCILIATION CALCULATIONS- ONE-SIDED MODEL

This section details how CMS will perform the annual financial reconciliation calculations under the one-sided model. First, CMS will calculate the per capita updated historical benchmark as described above. CMS will then run the claims-based assignment algorithm at the end of each performance year and exclude prospective voluntarily aligned beneficiaries who died before the performance year or became ineligible during the year. CMS will then calculate per capita assigned beneficiary performance year expenditures. For both the benchmark and the applicable performance year, CMS will multiply each ACO's per capita expenditures by the assigned beneficiary person years in the performance year.

Next, CMS will calculate total savings or losses for the performance year. First, CMS determines if the total updated historical benchmark minus the total assigned beneficiary performance year expenditures is greater than zero (potential savings). If so, CMS then determines whether the savings generated by the ACO are greater than or equal to the MSR, which is based on the number of assigned beneficiaries. As noted in [Section 5](#), the MSR is the minimum threshold necessary to share savings. Note that for the one-sided model, the ACO's MSR is based on a sliding scale relative to the size of its assigned beneficiary population, ranging from 2.0 to 3.9 percent of the ACO's updated historical benchmark for ACOs with a least 5,000 assigned beneficiaries. If total savings are greater than or equal to the MSR, then savings occurred. Otherwise, there are neither shared savings nor shared losses since ACOs participating under the one-sided model are not responsible for any losses.

CMS will then calculate the shared savings percentage. The maximum quality performance sharing rate percentage is 50 percent under the one-sided model (with the remaining percent going to the Medicare program). CMS will base the quality-sharing rate on the ACO's quality performance. The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate of 50 percent (if the ACO has met the quality performance standard for the performance year). In an ACO's first performance year, an ACO can earn the maximum 50 percent of shareable savings for quality performance based on complete and accurate reporting of quality measures (known as pay-for-reporting). Following the first performance year, an ACO must continue to report completely and accurately on all measures; In addition, its performance will be assessed relative to performance benchmarks for a specified set of measures in each performance year (known as pay-for-performance). If the ACO does not meet the quality performance standard for the performance year, it will not be eligible for any shared savings (i.e., the final sharing rate will be zero percent).

The final savings rate will apply to an ACO's savings on a first dollar basis; it will apply to an ACO's total savings below its benchmark, not only savings that exceed the MSR. Under the one-sided model, shared savings are subject to a cap equal to 10 percent of total updated historical benchmark expenditures in each performance year. If an ACO is eligible to receive shared savings, CMS will reduce the shared savings amount paid to the ACO by 2 percent due to sequestration. This 2 percent reduction will be applied after all other calculations for shared savings are complete and prior to applying the cap. For those ACOs that are participating in the Advance Payment Model or the ACO Investment Model, sequestration is applied to the gross payment amount and then the advance payment withhold is subtracted.

6.5 ANNUAL FINANCIAL RECONCILIATION CALCULATIONS- TWO-SIDED MODELS

This section describes how CMS will perform the annual financial reconciliation calculations under the two-sided model. First, CMS will calculate the per capita updated historical benchmark as described above. For Track 2 ACOs, CMS will then run its assignment algorithm at the end of each performance year to determine the final list of retrospectively assigned beneficiaries and exclude prospectively voluntarily aligned beneficiaries who died before the performance year or became ineligible during the year. We will then calculate per capita assigned beneficiary performance year expenditures.

For Track 1+ Model and Track 3 ACOs, CMS will determine the final list of prospectively assigned and voluntarily aligned beneficiaries, having removed excluded beneficiaries who match the assignment criteria B, C, D and E described in [Section 3](#) above and beneficiaries who died prior to the start of the performance year. To determine total expenditures, CMS will multiply each ACO's per capita updated historical benchmark and performance year expenditures by the assigned beneficiary person years in the performance year.

Next, CMS will calculate total savings or losses for the performance year. First, CMS determines if the total updated historical benchmark minus the total assigned beneficiary performance year expenditures is greater than zero (potential savings) or less than zero (potential losses). CMS then determines whether the savings or losses generated by the ACO are equal to or greater than the MSR or the MLR, expressed as a percentage of the ACO's updated historical benchmark. The choices of symmetrical MSR and the MLR under the two-sided models are described in [Section 5](#). For example, with an MSR of 2 percent, the total updated historical benchmark expenditures multiplied by 2 percent is the MSR dollar amount. Likewise, if the MLR percentage is set at negative 2 percent, the MLR dollar amount is equal to the total updated historical benchmark expenditures multiplied by negative 2 percent.

If total savings are equal to or greater than the MSR, then the ACO may be eligible to receive a share of these savings, depending on quality performance. If total losses are equal to or greater than the MLR, then the ACO will be accountable for repaying a share of those losses. Otherwise, there are neither shared savings nor shared losses.

CMS will then calculate the shared savings percentage. Under the two-sided models, the maximum sharing rate percentage is 50 percent for the Track 1+ Model, 60 percent for Track 2, and 75 percent for Track 3 (with the remaining percent going to the Medicare program). CMS will base the final sharing rate on the ACO quality performance. In an ACO's first performance year, a Track 1+ Model ACO can earn the maximum 50 percent, a Track 2 ACO can earn the maximum 60 percent, and a Track 3 ACO can earn the maximum of 75 percent of shareable savings for quality performance based on complete and accurate reporting of quality measures (known as pay-for-reporting). Following the first performance year, an ACO must continue to report completely and accurately on all measures; in addition, its performance will be assessed relative to performance benchmarks for a specified set of measures in each performance year (known as pay-for-performance). The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate of 50 percent for the Track 1+ Model; 60 percent for Track 2; or 75 percent for Track 3 if the ACO has met the quality performance standard for the performance year. If the ACO does not meet the quality performance standard for the performance year, it will not be eligible for any shared savings. Furthermore, Track 1+, Track 2, and Track 3 ACOs that do not meet the quality performance standard for the performance year will be accountable for shared losses based on the highest shared loss rate.

For Track 1+ Model ACOs, the final loss rate is fixed at 30 percent. For Track 2 and Track 3 ACOs, the final loss rate is equal to one minus the final sharing rate. The final loss rate will not be less than 40 percent for ACOs in either Track 2 or Track 3 and will not exceed 60 percent for Track 2 or 75 percent for Track 3. The final savings and loss rates will apply to an ACO's savings or losses on a first dollar basis.

Under the two-sided models, shared savings are subject to caps equal to 10 percent (for the Track 1+ Model), 15 percent (for Track 2), or 20 percent (for Track 3) of total updated historical benchmark expenditures in each year.

For ACOs in the Track 1+ Model, the loss sharing limit is determined using the bifurcated approach discussed in Section 6.5.1. First agreement period Track 2 ACOs are subject to a limit on shared losses equal to 5 percent of total updated historical benchmark expenditures in PY1, 7.5 percent of total updated historical benchmark expenditures in PY2, and 10 percent of total updated historical benchmark expenditures in PY3 and during any subsequent agreement period. Track 3 shared losses are subject to a limit equal to 15 percent of total updated historical benchmark expenditures for each performance year.

If an ACO is eligible to receive shared savings, CMS will reduce the shared savings amount paid to the ACO by 2 percent due to sequestration. This 2 percent reduction will be applied after all other calculations for shared savings are complete and prior to applying the cap. For ACOs that are participating in the Advance Payment Model or the ACO Investment Model, sequestration is applied to the gross payment amount and then the advance payment withhold is subtracted.

If an ACO has shared losses, the ACO must pay CMS in full within 90 days of receipt of notification. CMS shall draw upon the repayment mechanism established by the ACO as a condition of eligibility to participate in the two-sided model at the request of the ACO during the 90-day repayment period and if the ACO fails to make payment in full within this time. If an ACO's self-executing repayment mechanism is not adequate to pay for all of the losses in the current year, the unpaid amount and any accrued interest are due in full.

6.5.1 LOSS SHARING LIMIT FOR TRACK 1+ MODEL ACOs

Track 1+ Model ACOs are subject to either a revenue- or benchmark-based loss sharing limit based on whether any of the following criteria are met: the ACO includes an ACO participant that is an inpatient prospective payment system (IPPS) hospital, cancer center, or a rural hospital with more than 100 beds, or is owned or operated by, in whole or in part, such a hospital or by an organization that owns or operates such a hospital.

If none of these criteria are met, the ACO's loss sharing limit is 8 percent of the ACO participant Medicare Part A and Part B FFS annual revenue for performance years 2018, 2019, and 2020. ACO participant Medicare FFS revenue is based on total Part A and B FFS revenue for all providers and suppliers that bill through the TIN of an ACO participant. It is calculated as the sum of Medicare paid amounts on all non-denied claims associated with ACO participant TINs for all claim types used in program expenditure calculations that have dates of service during the performance year using three months of claims run-out. ACO participant Medicare FFS revenue will not be limited to claims associated with the ACO's assigned beneficiaries and will not be

truncated or adjusted to remove payments for IME, DSH, or uncompensated care payments or to add back in reductions made for sequestration. ACO participant Medicare FFS revenue will include any payment adjustments reflected in the claim payment amounts (e.g., value-based payment modifier or MIPS) and will also include individually identifiable final payments made under a demonstration, pilot, or time-limited program, and will be determined using the same completion factor used for annual expenditure calculations. If the loss-sharing limit, as a percentage of ACO participants' Part A and Part B FFS revenue exceeds the amount that is 4 percent of the ACO's updated historical benchmark, then the loss sharing limit would be capped and set at 4 percent of the updated historical benchmark.

The loss sharing limit under this bifurcated structure is determined by CMS near the start of the ACO's agreement period under the Track 1+ Model (based on the ACO's initial application to the model or application for renewal under the model), and re-determined annually based on an annual certification process. Changes to the ACO's loss sharing limit (applicability of either the revenue- or benchmark-based methodology) may be made by CMS based on the annual certification process that occurs prior to the start of a performance year under the Track 1+ Model. An ACO's loss sharing limit could be adjusted up or down on this basis.

6.6 REPAYMENT MECHANISM

ACOs choosing a two-sided model (Track 1+ Model, Track 2, or Track 3) must show they have a repayment mechanism in place to assure CMS that they can repay losses for which they may be liable.

An ACO participating in Track 2 or Track 3 must show that they can repay at least 1 percent of its total annual estimated per capita Medicare FFS Parts A and B expenditures for its assigned beneficiaries based on expenditures used to establish the historical benchmark. CMS will determine whether this repayment mechanism is adequate when looking at an ACO's application to participate in the program. Beginning with the 2016 performance year, ACOs participating under Track 2 or Track 3 must show that this repayment mechanism is adequate once at the beginning of a three-year agreement period.

For Track 1+ Model ACOs, a bifurcated approach will be used to determine the amount of the repayment mechanism, for consistency with the bifurcated approach to determining the loss-sharing limit. Consistent with Track 2 and 3, a Track 1+ Model ACO subject to the benchmark-based loss sharing limit must establish a repayment mechanism equal to at least 1 percent of its total annual estimated Medicare Parts A and B FFS expenditures for its assigned beneficiaries, as determined based on per capita expenditures used to establish the ACO's benchmark. Track 1+ Model ACOs under the revenue-based loss sharing limit must establish a repayment mechanism equal to at least 2 percent of ACO participant Medicare Part A and Part B FFS revenue (total annual Parts A and B FFS revenue). The repayment mechanism amount for these

ACOs will be capped at 1 percent of the ACO's total annual estimated Medicare Parts A and B FFS expenditures for its assigned beneficiaries, as determined based on per capita expenditures used to establish the ACO's benchmark. Unlike for Track 2 and Track 3 ACOs, the repayment mechanism amount for Track 1+ Model ACOs may be re-determined each performance year in an agreement period if the ACO's composition changes. The Track 1+ Model ACO's repayment mechanism amount could be adjusted up or down on this basis.

All ACOs under a two-sided model must select one or more of the following three types of repayment arrangements: (1) funds placed in escrow, (2) a line of credit as evidenced by a letter of credit, or (3) a surety bond. ACOs must also demonstrate that they would be able to repay shared losses incurred at any time within the agreement period, and for a reasonable period after the end of each agreement period (the "tail period"). If any portion of the repayment mechanism is used to repay shared losses owed to CMS, an ACO is required to replenish the amount of its repayment mechanism within 90 days. For additional details, refer to the Repayment Mechanism Arrangements Guidance.¹⁸

6.7 ADVANCE PAYMENT ACO MODEL AND ACO INVESTMENT MODEL

Some ACOs participating in the Shared Savings Program also participate in the Advance Payment ACO Model or ACO Investment Model. Through the Advance Payment ACO Model and ACO Investment Model, selected small, rural, or physician-only ACOs receive upfront and monthly payments. CMS will automatically withhold any shared savings payments earned during the agreement period until the full amount of advance payments to the ACO as of the date of the financial reconciliation is offset and thereby repaid by the ACO. For a performance payment to be offset to repay advance payments, an ACO must earn a performance payment (generate shared savings that meet or exceed its MSR) and otherwise qualify for a performance payment (e.g., through adequate quality reporting or performance). In any given performance year, the repayment for advance payments cannot exceed the value of the earned shared savings.

7 REPORTS PROVIDED TO ACOs

CMS will provide ACOs with information on their assigned populations (including beneficiaries assigned via voluntary alignment) and financial performance at the start of the agreement period and routinely during the performance year. CMS will provide:

- Assignment List Report with beneficiary identifiable information on the ACO's assigned population and identifying select ACO participants (TINs) and ACO providers/suppliers (NPIs, CCNs) who treat assigned beneficiaries.

¹⁸ Refer to the [Medicare Shared Savings Program & Medicare ACO Track 1+ Model Repayment Mechanism Arrangements Guidance](#).

- Track 1 and Track 2: ACO receives an initial preliminary prospective assignment list close to the start of each performance year, retrospective assignment lists for each benchmark year, quarterly reports on the ACO's preliminary prospectively assigned population throughout each performance year, and a year-end report on retrospectively assigned beneficiaries used for financial reconciliation.
- Track 1+ Model and Track 3: ACO receives a prospective assignment list for the performance year close to the start of the year, prospective assignment lists for each benchmark year, quarterly lists for the performance year indicating which beneficiaries have been removed from the ACO's assignment list as a result of meeting select assignment exclusion criteria, and a year-end report on assigned beneficiaries used for financial reconciliation (similarly indicating beneficiaries determined to be excluded from assignment based on select criteria).
- Assignment Summary Report providing aggregate information on the ACO's assigned beneficiaries and the primary care services they received.
 - Track 1 and Track 2: ACO receives a report based on its initial preliminary prospective assignment list close to the start of each performance year, a report based on preliminarily prospectively assigned population for each benchmark year, report based on preliminarily prospectively assigned population for each quarter, and a year-end report on beneficiaries retrospectively assigned for financial reconciliation.
 - Track 1+ Model and Track 3: ACO receives a report based on its prospective assignment list close to the start of each performance year, reports based on prospectively assigned beneficiaries for each benchmark year, quarterly reports based on the ACO's currently assigned beneficiaries for the performance year updated to identify exclusions made in the year-to-date period, and a year-end report on prospectively assigned beneficiaries for the performance year updated to identify beneficiaries no longer eligible for assignment at the end of the performance year.
- Aggregate Expenditure and Utilization Report provided each quarter during the agreement period, and provided for each benchmark year and annually for each performance period.
- Historical benchmark report specifying the calculation of the ACO's three-year average per capita benchmark value. A historical benchmark report is provided within three months of the ACO's agreement start date. These historical benchmark reports may be adjusted each performance year to account for changes in the ACO's certified ACO Participant List effective for the performance year and/or to account for program-wide regulatory changes. ACOs that are new starters or renewals also will receive a final historical benchmark report in the summer of the first performance year of their new agreement period, based on finalized data for BY

3. An updated historical benchmark that reflects performance year growth factors is provided to all ACOs with financial reconciliation report packages.
- Reconciliation package containing financial and quality performance reports and informational reports on the ACO’s performance year assigned population.
 - Financial reconciliation reports specifying the calculation of the ACO’s historical benchmark, updated historical benchmark, and determination of shared savings/losses.
 - Quality performance reports specifying the ACO’s quality performance results for the performance year, including an overall report on quality performance and a detailed Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for ACOs report.

Table 10 below provides a comparison of characteristics and data sources for the above-mentioned ACO reports. Table 11 provides the same information for Track 1+ Model and Track 3 ACOs. In order to provide timely data to the ACOs during each quarter, a smaller claims run-out must be used. Consequently, the expenditure completion factors must be larger for quarterly data to account for this shorter claims run-out. These tables illustrate the differences between reports produced on a quarterly basis and reports produced on an annual basis. For reports produced annually, a three-month claims run-out is used, whereas a run-out of up to seven days is used for reports produced quarterly. Table 12 provides a data and report schedule for 2018.

CMS is also continuing to enhance the dynamic report functionality (referred to as Cognos/Dynamic Reporting) in the Shared Savings Program ACO Portal (SSP ACO Portal). This functionality includes the capacity for ACOs to generate reports electronically by selecting variables provided in static reports from multiple timeframes and to download these reports. ACOs may also access additional data for certain static report measures.

Table 10. Selected characteristics of Shared Savings Program ACO reports for Tracks 1 and Track 2 ACOs

CHARACTERISTIC	ASSIGNMENT SUMMARY REPORT (QUARTERLY)	ASSIGNMENT SUMMARY REPORT (ANNUAL)	EXPENDITURE /UTILIZATION REPORT (QUARTERLY)	EXPENDITURE /UTILIZATION REPORT (ANNUAL)	HISTORICAL BENCHMARK REPORT
Claims Run-out	≤ 7 days	3 months	≤ 7 days	3 months	3 months
Assignment Dates of Service	Most recent 12 months	Calendar Year	Most recent 12 months	Calendar Year	Calendar Year
Expenditure Completion Factors	N/A	N/A	1.072	1.013	1.013

CHARACTERISTIC	ASSIGNMENT SUMMARY REPORT (QUARTERLY)	ASSIGNMENT SUMMARY REPORT (ANNUAL)	EXPENDITURE /UTILIZATION REPORT (QUARTERLY)	EXPENDITURE /UTILIZATION REPORT (ANNUAL)	HISTORICAL BENCHMARK REPORT
Medicare Enrollment Type Determined	Monthly	Monthly	Monthly	Monthly	Monthly

N/A = not applicable. Expenditures and utilization are not included in all reports, and a completion factor is not used for utilization rates.

Table 11. Selected characteristics of Shared Savings Program ACO reports for Track 1+ Model and Track 3 ACOs

CHARACTERISTIC	ASSIGNMENT SUMMARY REPORT (QUARTERLY)	ASSIGNMENT SUMMARY REPORT (ANNUAL)	EXPENDITURE /UTILIZATION REPORT (QUARTERLY)	EXPENDITURE /UTILIZATION REPORT (ANNUAL)	HISTORICAL BENCHMARK REPORT
Claims Run-out	≤ 7 days	3 months	≤ 7 days	3 months	3 months
Assignment Dates of Service	Prospective Assignment Period	Prospective Assignment Period	Prospective Assignment Period	Prospective Assignment Period	Prospective Assignment Period
Assignment Exclusion Dates of Service	Calendar Year to Date	Calendar Year	Calendar Year to Date	Calendar Year	Calendar Year
Expenditure Completion Factors	N/A	N/A	Ranges from 1.283 to 1.072, depending on quarter	1.013	1.013
Medicare Enrollment Type Determined	Monthly	Monthly	Monthly	Monthly	Monthly

Prospective Assignment Period uses data from October 1 two years prior to the start of the performance or benchmark year through September 30 of the year prior to the performance or benchmark year. Beneficiaries are excluded from the prospective assignment lists on a quarterly basis and annually prior to financial reconciliation based on select assignment exclusion criteria. N/A = not applicable. Expenditures and utilization are not included in all reports, and a completion factor is not used for utilization rates.

Table 12. 2018 Shared Savings Program report schedule

MONTH*	CMS REPORT	REPORT RECIPIENTS† AND NOTES
December	Assignment List Report & Assignment Summary Report	Made available to existing ACOs, initial ACOs, and renewals
Monthly	Claim and Claim Line Feed (CCLF) Files	Made available to existing ACOs, initial ACOs, and renewals Beneficiary- and provider-identifiable Medicare Part A, B and D claims data

MONTH*	CMS REPORT	REPORT RECIPIENTS [†] AND NOTES
February	Prior Performance Year Quarter 4 Report Package: Assignment List Report; Assignment Summary Report; Aggregate Expenditure/Utilization Report	Made available to existing ACOs and renewals only
March	Adjusted Historical Benchmark Report	Made available to existing ACOs in a second or subsequent year of an agreement period only
March	Preliminary Historical Benchmark Report	Made available to initial ACOs and renewals in the first performance year of their agreement period only
May	Quarter 1 Report Package: Assignment List Report; Assignment Summary Report; Aggregate Expenditure/Utilization Report	Made available to existing ACOs, initial ACOs, and renewals
June	Final Historical Benchmark Report	Made available to initial ACOs and renewals in the first performance year of their agreement period only
July	Embargoed Prior Performance Year Reconciliation Package: Financial Reconciliation Report & ACO Quality Performance Reports	Made available to existing ACOs and renewals only Report packages contain informational reports on the ACO's performance year assigned population, including Assignment List Report, Assignment Summary Report, and Aggregate Expenditure/Utilization Report; and detailed reports on performance on quality measures
August	Quarter 2 Report Package: Assignment List Report; Assignment Summary Report; Aggregate Expenditure/Utilization Report	Made available to existing ACOs, initial ACOs, and renewals
August	Unembargoed Prior Performance Year Reconciliation Package: Financial Reconciliation Report & ACO Quality Performance Reports	Made available to existing ACOs and renewals only
November	Quarter 3 Report Package: Assignment List Report; Assignment Summary Report; Aggregate Expenditure/Utilization Report	Made available to existing ACOs, initial ACOs, and renewals

* This is the planned report delivery schedule; dates are subject to change. Active ACOs should refer to Program Announcements and the Report Schedule available on the SSP ACO Portal for up-to-date information.

[†] Existing ACOs (within current agreement period) include 2015 starters that began in Track 1 and were approved to defer by one year entering a two-sided risk track for their second agreement period, 2016 and 2017 starters within their first agreement period. Renewing ACOs include ACOs that renewed for their second agreement period in 2016, 2017, or 2018. Initial ACOs refers to ACOs beginning their first agreement period in 2018.

LIST OF ABBREVIATIONS

Acronym	Definition
ACO	Accountable Care Organization
APM	Alternative Payment Model
BY	Benchmark Year
CAH	Critical Access Hospital
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	CMS Hierarchical Condition Category
CPT	Current Procedural Terminology
CY	Calendar Year
DME	Durable Medical Equipment
DO	Doctor of Osteopathic Medicine
DSH	Disproportionate Share Hospital
EIN	Employer Identification Number
ESRD	End-Stage Renal Disease
ETA	Electing Teaching Amendment
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
IDR	Integrated Data Repository
IME	Indirect Medical Education
MA	Medicare Advantage
MD	Medical Doctor
MIPS	Merit-based Incentive Payment System
MLR	Minimum Loss Rate
MSP	Medicare Secondary Payer
MSR	Minimum Savings Rate
NCH	National Claims History
NPI	National Provider Identifier
OACT	CMS Office of the Actuary
OPPS	Outpatient Prospective Payment System
PACE	Program of All Inclusive Care for the Elderly
PECOS	Provider Enrollment, Chain, and Ownership System
PY	Performance Year
QMBs	Qualified Medicare beneficiaries
RHC	Rural Health Clinic
SLMBs	Specified Low-Income Medicare beneficiaries
SNF	Skilled Nursing Facility
SSN	Social Security Number
TIN	Taxpayer Identification Number

APPENDIX A: CHARACTERISTICS OF BENCHMARKING APPROACHES BY AGREEMENT PERIOD

Table 13. Characteristics of Benchmarking Approaches by Agreement Period

SOURCE OF METHODOLOGY	AGREEMENT PERIOD	HISTORICAL BENCHMARK TREND FACTORS (TREND BY1, BY2, TO BY3)	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR REGIONAL FFS EXPENDITURES (PERCENTAGE APPLIED IN CALCULATING ADJUSTMENT)	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR SAVINGS IN PRIOR AGREEMENT PERIOD?	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR ACO PARTICIPANT LIST CHANGES	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR HEALTH STATUS AND DEMOGRAPHIC FACTORS OF PERFORMANCE YEAR ASSIGNED BENEFICIARIES	UPDATE TO THE HISTORICAL BENCHMARK FOR GROWTH IN FFS SPENDING
November 2011 Final Rule	First	National FFS	No	No	Calculated using benchmark year assignment based on the ACO's certified ACO Participant List for the performance year.	Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score	National FFS
As modified by June 2015 Final Rule	Second (beginning 2016)	National FFS	No	Yes	Same as methodology for first agreement period.	Same as methodology for first agreement period	National FFS
As modified by the June 2016 Final Rule: Rebasing	First	National Assignable FFS	No	No	Same as original methodology for first agreement period.	Same as original methodology for first agreement period.	National Assignable FFS

SOURCE OF METHODOLOGY	AGREEMENT PERIOD	HISTORICAL BENCHMARK TREND FACTORS (TREND BY1, BY2, TO BY3)	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR REGIONAL FFS EXPENDITURES (PERCENTAGE APPLIED IN CALCULATING ADJUSTMENT)	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR SAVINGS IN PRIOR AGREEMENT PERIOD?	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR ACO PARTICIPANT LIST CHANGES	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR HEALTH STATUS AND DEMOGRAPHIC FACTORS OF PERFORMANCE YEAR ASSIGNED BENEFICIARIES	UPDATE TO THE HISTORICAL BENCHMARK FOR GROWTH IN FFS SPENDING
Methodology for second or subsequent agreement periods beginning 2017 and subsequent years	Second (third for 2012/2013 starters)	Regional	Yes (35 percent, or 25 percent if ACO is determined to have higher spending compared to its region.)	No	Same as methodology for first agreement period; regional FFS adjustment redetermined based on ACO's certified ACO Participant List for the performance year.	No change	Regional
	Third (fourth for 2012/2013 starters)	Regional	Yes (70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking, or 50 percent if ACO is determined to have higher spending compared to its region.)	No	Same as methodology for second agreement period beginning 2017 and subsequent years.	No change	Regional

SOURCE OF METHODOLOGY	AGREEMENT PERIOD	HISTORICAL BENCHMARK TREND FACTORS (TREND BY1, BY2, TO BY3)	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR REGIONAL FFS EXPENDITURES (PERCENTAGE APPLIED IN CALCULATING ADJUSTMENT)	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR SAVINGS IN PRIOR AGREEMENT PERIOD?	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR ACO PARTICIPANT LIST CHANGES	ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR HEALTH STATUS AND DEMOGRAPHIC FACTORS OF PERFORMANCE YEAR ASSIGNED BENEFICIARIES	UPDATE TO THE HISTORICAL BENCHMARK FOR GROWTH IN FFS SPENDING
	Fourth and subsequent (fifth and subsequent for 2012/2013 starters)	Regional	Yes (70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking.)	No	Same as methodology for second agreement period beginning 2017 and subsequent years.	No change	Regional