Medicare Shared Savings Program

SHARED SAVINGS AND LOSSES, ASSIGNMENT AND QUALITY PERFORMANCE STANDARD METHODOLOGY

Specifications

June 2025 Version #13
Applicable to the Performance Year Starting
on January 1, 2025

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICARE
SHARED SAVINGS
PROGRAM

Revision History (from Version 12 to 13)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
13	May 2025	Revised descriptions to specify the financial methodology applicable for agreement periods beginning on January 1, 2025, and in subsequent years.	Various
13	May 2025	Revised to update references to earlier rulemaking, and other descriptive information.	Section 1.1, Statutory and Regulatory Background
13	May 2025	Revised description of assignment methodology to include a third step in the assignment process.	Section 2, Assignment of Beneficiaries
13	May 2025	Revised list of expenditure exclusions.	Section 3.1.1, Calculating ACO-Assigned Beneficiary Expenditures
13	May 2025	Revised to specify the methodology for establishing the historical benchmark applicable to agreement periods beginning on January 1, 2025, and in subsequent years including calculation and application of the regional adjustment to the historical benchmark, the prior savings adjustment to the historical benchmark, and the health equity benchmark adjustment.	Section 4.1.2, Establishing the Historical Benchmark
13	May 2025	Revised to specify Assignment Window, Expanded Window for Assignment, and Expenditure Period Dates for performance years within the agreement periods beginning on January 1, 2022, January 1, 2023, January 1, 2024, and January 1, 2025.	Appendix B, Table 9
13	May 2025	Revised to specify the definition of primary care services, used in Shared Savings Program beneficiary assignment, applicable to the performance year starting on January 1, 2025, and subsequent performance years, as established with the calendar year (CY) 2025 Physician Fee Schedule (PFS) Final Rule.	Appendix C, Table 10
13	May 2025	Revised to add description of the Quality Performance Report.	Appendix F: Report Descriptions
13	May 2025	Revised to update descriptions, including to specify the calculation methodology applicable for the health equity adjusted quality performance score applicable for performance year (PY) 2025.	Appendix G: Calculation of the Health Equity Adjusted Quality Performance Score

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1 INTRODUCTION

This document is not intended to supersede or replace regulatory requirements in the Code of Federal Regulations (CFR) under 42 CFR part 425. The information provided in this document is intended to supplement and further explain the regulations text. This document is subject to periodic change. Any substantive changes to this document will be noted in the revision history.

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.

Within the Shared Savings Program, the Centers for Medicare and Medicaid Services (CMS) enters into agreements with accountable care organizations (ACOs). ACOs facilitate coordination and cooperation among health care providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce the rate of growth in expenditures under Medicare Parts A and B. For agreement periods beginning on July 1, 2019, and in subsequent years, ACOs may enter participation agreements under one of two tracks—the BASIC track or the ENHANCED track. The BASIC track allows eligible ACOs to begin under a one-sided model and incrementally phase in higher levels of risk and potential reward through the BASIC track's glide path. The ENHANCED track offers the highest level of risk and potential reward under the Shared Savings Program. For each performance year of the agreement period, ACOs share in a percentage of the savings they generate if (1) the expenditures of the ACO's assigned beneficiaries are below their benchmarks (i.e., their unique targets) by an amount that meets or exceeds a minimum savings rate (MSR) threshold, and if (2) they meet the quality performance standard or the alternative quality performance standard and otherwise maintain their eligibility to participate in the Shared Savings Program. Additionally, certain low-revenue ACOs participating in the BASIC track may share in savings even if they do not meet the MSR requirement. ACOs participating in a two-sided model must also pay CMS a percentage of shared losses if expenditures for the ACO's assigned beneficiaries for the performance year exceeds their benchmark by an amount that meets or exceeds a minimum loss rate (MLR) threshold.

The financial methodology used for calculating an ACO's benchmark and determining an ACO's financial performance differs depending on the timing of applicability of the program's regulations and the start date of the ACO's agreement period in the Shared Savings Program. ACOs participating in the Shared Savings Program in performance year (PY) 2025 include the following: ACOs that entered an agreement period beginning on or after July 1, 2019, and before January 1, 2024, to which we (i.e., CMS) apply the methodology for determining the benchmark in accordance with 42 CFR § 425.601; ACOs that entered an agreement period beginning on January 1, 2024, to which we apply the methodology for determining the benchmark in accordance with §§ 425.652–425.660; and ACOs that entered an agreement period beginning on January 1, 2025, to which we apply the methodology for determining the benchmark in accordance with §§ 425.652–425.662.

This document includes the assignment methodology applicable to all ACOs participating in the Shared Savings Program for the performance year starting on January 1, 2025.

1.1 STATUTORY AND REGULATORY BACKGROUND

Section 3022 of the Affordable Care Act[1] amended Title XVIII of the Social Security Act (the Act) (42 U.S.C. 1395 et seq.) by adding the new section 1899 to the Act to establish the Shared Savings Program. The requirements for assignment of Medicare FFS beneficiaries to ACOs participating under the program were amended by the 21st Century Cures Act (December 2016, Pub. L. 114–255). The 21st Century Cures Act amended section 1899 of 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 federally qualified health centers (FQHCs) and rural health clinics (RHCs), effective for performance years beginning on or after January 1, 2019. The Bipartisan Budget Act of 2018 (February 2018, Pub. L. 115–123) amended section 1899 of the Act to provide for greater flexibility in the assignment of Medicare FFS beneficiaries to ACOs by (1) allowing ACOs in tracks under retrospective beneficiary assignment to have a choice of prospective assignment for the agreement period, (2) permitting Medicare FFS beneficiaries to voluntarily identify an ACO professional as their primary care provider for purposes of assigning such beneficiaries to an ACO, (3) requiring that such beneficiaries be notified of their ability to make and change such identification, and (4) mandating that any such voluntary identification will supersede claims-based assignment, among other changes.

For the Shared Savings Program's regulations, refer to 42 CFR part 425. Details on these regulations, and changes to the regulations, are specified in *Federal Register* (FR) publications that can be accessed through the Program Statutes & Regulations webpage of the Shared Savings Program website. CMS published a notice of proposed rulemaking for the Shared Savings Program on April 7, 2011 (76 FR 19528; hereafter the April 2011 Proposed Rule), followed by a period of public comment. 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 the following:

- Calendar Year (CY) 2014 Physician Fee Schedule Final Rule, published December 10, 2013 (78 FR 74230, 74757 through 74764).
- CY 2015 Physician Fee Schedule Final Rule, published November 13, 2014 (79 FR 67548, 67907 through 67931).
- Shared Savings Program Final Rule, published June 9, 2015 (80 FR 32692).
- CY 2016 Physician Fee Schedule Final Rule with comment period, published November 16, 2015 (80 FR 70886, 71263 through 71273).
- 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, 80483 through 80516).

[1] On March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted, followed by enactment of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) on March 30, 2010, which amended certain provisions of Pub. L. 111–148. These public laws are collectively known as the Affordable Care Act.

- CY 2018 Physician Fee Schedule Final Rule, published November 15, 2017 (82 FR 52976, 53209 through 53226).
- Shared Savings Program, Interim Final Rule with Comment Period (IFC), published December 26, 2017 (82 FR 60912).
- CY 2019 Physician Fee Schedule Final Rule, published November 23, 2018 (83 FR 59452, 59707 through 59715, and 59940 through 59990).
- Shared Savings Program Final Rule, published December 31, 2018 (83 FR 67816) (hereafter December 2018 Final Rule), referred to as "Pathways to Success."
- CY 2020 Physician Fee Schedule Final Rule, published November 15, 2019 (84 FR 62568, 62903 through 62914).
- The IFC that appeared in the April 6, 2020, *Federal Register* (85 FR 19230,19267 through 19268) with an effective date of March 31, 2020 (also referred to as the March 31st COVID-19 IFC), and the IFC that appeared in the May 8, 2020 *Federal Register* (85 FR 27550, 27573 through 27587) with an effective date of May 8, 2020 (also referred to as the May 8th COVID-19 IFC), included provisions modifying or clarifying Shared Savings Program policies to address the impact of the coronavirus disease 2019 (COVID-19) pandemic and the resulting public health emergency (PHE)[2] on ACOs.
- CY 2021 Physician Fee Schedule Final Rule, published December 28, 2020 (85 FR 84472, 84716 through 84793, and 84793 through 84797). Through the CY 2021 Physician Fee Schedule Final Rule, CMS finalized certain changes to Shared Savings Program policies, including changes to the Shared Savings Program quality performance standard and quality reporting requirements, and finalized the Shared Savings Program provisions of the March 31 COVID-19 IFC and May 8 COVID-19 IFC with several modifications.
- CY 2022 Physician Fee Schedule Final Rule, published November 19, 2021 (86 FR 64996, 65253 through 65306).
- CY 2023 Physician Fee Schedule Final Rule, published November 18, 2022 (87 FR 69404, 69777 through 69979).
- CY 2024 Physician Fee Schedule Final Rule, published November 16, 2023 (88 FR 78818, 79093 through 79232).
- Final Rule entitled "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023," published September 27, 2024 (89 FR 79152) and effective on October 15, 2024, referred to as the SAHS Billing Activity Final Rule.
- CY 2025 Physician Fee Schedule Final Rule, published December 9, 2024 (89 FR 97710, 98081 through 98213).

1.2 OVERVIEW OF FINANCIAL TRACKS

For agreement periods beginning on July 1, 2019, and in subsequent years, eligible ACOs will enter into an agreement period of not less than 5 years[3] under one of two tracks of the Shared

[2] Refer to 42 CFR § 400.200 for the definition of public health emergency (PHE).
[3] Refer to § 425.200(b)(4)(ii) and (b)(5).

Savings Program: the BASIC track[4] and the ENHANCED track.[5] For more information on the characteristics of these two tracks, refer to Appendix A.

Under the BASIC track, eligible ACOs operate under either a one-sided model or a two-sided model, either sharing savings only or sharing both savings and losses with the Medicare program. Under the BASIC track's glide path, the level of risk and potential reward phases in over the course of the agreement period with ACOs beginning participation under a one-sided model and progressing to incrementally higher levels of risk and potential reward.[6] The glide path includes five levels (Levels A through E): Levels A and B are one-sided models (shared savings only);[7] and Levels C, D, and E are two-sided models (shared savings and shared losses) that provide for incrementally higher performance-based risk.[8] The Shared Savings Program regulations specify the criteria for determining an ACO's eligibility to enter the BASIC track's glide path, and the progression along the glide path.[9]

An ACO that is inexperienced with performance-based risk Medicare ACO initiatives may participate under the BASIC track's glide path for a maximum of two agreement periods.[10] ACOs eligible to enter the BASIC track, but not the glide path, participate in Level E for all performance years of the agreement period.[11]

An ACO in the ENHANCED track operates under a two-sided model, sharing both savings and losses with the Medicare program for the agreement period. An ACO is unable to elect to move to the ENHANCED track within an agreement period under the BASIC track. However, an ACO may apply to renew its agreement early. ACOs may apply to enter a different track at the time of renewal or early renewal, or re-entry into the program after termination or expiration of a participation agreement.

For a summary of participation options refer to the Shared Savings Program Application Reference Manual available on the Shared Savings Program website.[12]

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[4] Refer to §§ 425.600(a)(4) and 425.605.
[5] Refer to §§ 425.600(a)(3) and 425.610.
[6] Refer to § 425.600(a)(4)(i).
[7] Refer to §§ 425.600(a)(4)(i)(A)(*1*) and 425.605(d)(1)(i) (Level A); §§ 425.600(a)(4)(i)(A)(*2*) and 425.605(d)(1)(ii) (Level B).
[8] Refer to §§ 425.600(a)(4)(i)(A)(*3*) and 425.605(d)(1)(iii) (Level C); §§ 425.600(a)(4)(i)(A)(*4*) and 425.605(d)(1)(iv) (Level D); §§ 425.600(a)(4)(i)(A)(*5*) and 425.605(d)(1)(v) (Level E).
[9] Refer to § 425.600. For policies specific to determining ACO participation options for agreement periods beginning on or after July 1, 2019, and before January 1, 2024, refer to § 425.600(d), and § 425.600(a)(4)(i)(B)(*1*). For policies specific to determining ACO participation options for agreement periods beginning on or after January 1, 2024, refer to § 425.600(g), and § 425.600(a)(4)(i)(C). For policies on ACO progression along the BASIC track's glide path, refer to § 425.600(a)(4)(i)(B)(*2*)–(*4*), (a)(4)(i)(C)(*2*)–(*6*), and (h).
[10] Refer to § 425.600(a)(4)(i)(C)(*3*).
[11] Refer to § 425.600(a)(4)(ii), (d), and (g).
[12] See for example, CMS, Medicare Shared Savings Program, *Application Reference Manual* (March 2024, version 6), available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/ssp-application-reference-manual.pdf (refer to Appendix F: Participation Options).

DEFINITIONS (refer to CFR § 425.20)

Accountable care organization (ACO) means a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one or more ACO participants(s) that is (are) defined at § 425.102(a) and may also include any other ACO participants described at § 425.102(b).

Renewing ACO means an ACO that continues its participation in the program for a consecutive agreement period, without a break in participation, because it is either—

(1) an ACO whose participation agreement expired and that immediately enters a new agreement period to continue its participation in the program; or

(2) an ACO that terminated its current participation agreement under § 425.220 and immediately enters a new agreement period to continue its participation in the program.

Re-entering ACO means an ACO that does not meet the definition of a renewing ACO and meets either of the following conditions:

(1) Is the same legal entity as an ACO, as defined according to § 425.20, that previously participated in the program and is applying to participate in the program after a break in participation, because it is either—

  (i) an ACO whose participation agreement expired without having been renewed; or

  (ii) an ACO whose participation agreement was terminated under § 425.218 or § 425.220.

(2) Is a new legal entity that has never participated in the Shared Savings Program and is applying to participate in the program and more than 50 percent of its ACO participants were included on the ACO Participant List under § 425.118, of the same ACO in any of the 5 most recent performance years prior to the agreement start date.

1.3 AGREEMENT PERIOD AND BENCHMARK YEARS

For agreement periods beginning on January 1, 2020, and in subsequent years, the start date is January 1 of that year, and the term of the participation agreement is 5 performance years, each consisting of a 12-month calendar year.[13]

For agreement periods beginning on July 1, 2019, and in subsequent years, in computing an ACO's historical benchmark for its first agreement period under the Shared Savings Program, or in resetting (rebasing) the benchmark for an ACO that renews its agreement for a second or subsequent agreement period, CMS determines the per capita Parts A and B FFS expenditures for beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period, using the ACO participant TINs and CMS certification numbers (CCNs) identified before the start of the agreement period and the beneficiary assignment methodology selected by the ACO for the first performance year of the agreement period.[14] Appendix B, Table 9 presents the relevant dates for both the assignment windows and expenditure periods for BASIC track and ENHANCED track ACOs with agreements beginning on July 1, 2019, and in subsequent years. The benchmark years remain the same for all performance years of the agreement period.

[13] Refer to § 425.200(b)(5).
[14] Refer to §§ 425.601(a) introductory text, 425.601(e)(2), and §§ 425.652(a) introductory text, 425.652(c)(2).

1.4 EXPIRATION OF THE PHE FOR COVID-19

The PHE for COVID-19 was in effect starting in January 2020 and expired on May 11, 2023. For a description of certain Shared Savings Program policies addressing the impact of the COVID-19 pandemic and the resulting PHE on ACOs, refer to the "Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology, Specifications of Policies to Address the Public Health Emergency for COVID-19" (hereafter COVID-19 Specifications).

Refer to the COVID-19 Specifications and Sections 3 and 4 of this document for additional information.

2 ASSIGNMENT OF BENEFICIARIES

Before calculating an ACO's shared savings or losses, beneficiaries must be assigned to an ACO.[15] Beneficiary assignment is determined based on voluntary alignment (refer to Section 2.2) and claims-based assignment (refer to Section 2.3).[16] Voluntary alignment incorporates beneficiary preferences to supplement claims-based beneficiary assignment.

Figure 1 illustrates the voluntary alignment and claims-based assignment processes that are described in detail in this section and in 42 CFR part 425, subpart E.

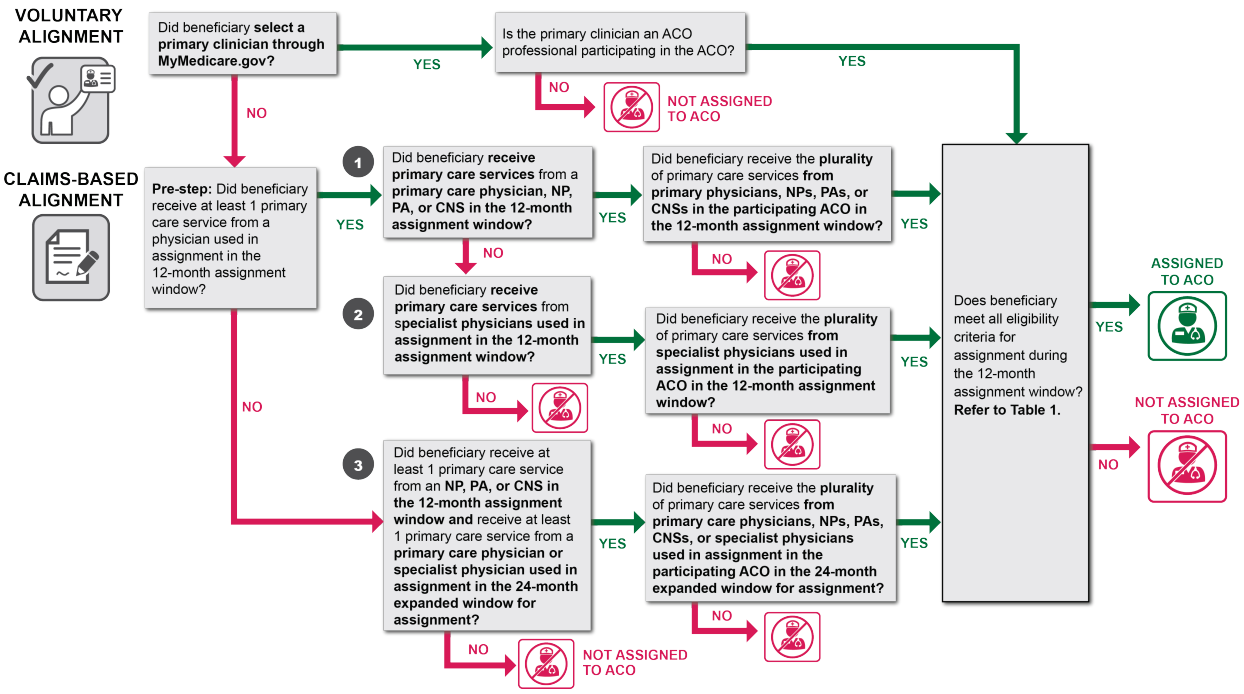

Figure 1. *Voluntary alignment and claims-based assignment process flow*

NOTE: CNS = clinical nurse specialist; NP = nurse practitioner; PA = physician assistant.

[15] Refer to § 425.400(a)(1) and (b).
[16] Refer to §§ 425.402 and 425.404.

2.1 BENEFICIARY ASSIGNMENT CRITERIA

For a performance or benchmark year, a beneficiary may be assigned to an ACO—according to the requirements for claims-based assignment or voluntary alignment—if the beneficiary meets all of the criteria specified in § 425.401(a).[17] These criteria and other factors used in determining a beneficiary's eligibility for assignment are described in Table 1.

Table 1. *Criteria and other factors used to determine a beneficiary's eligibility to be assigned to an ACO*

CRITERIA AND OTHER FACTORS USED TO DETERMINE ELIGIBILITY FOR ASSIGNMENT		MUST BE MET FOR CLAIMS-BASED ASSIGNMENT	MUST BE MET FOR VOLUNTARY ALIGNMENT
A.	Beneficiary must have at least 1 month of Part A and Part B enrollment and cannot have any months of Part A only or Part B only enrollment.[18]	Yes	Yes
B.	Beneficiary does not have any months of Medicare group (private) health plan enrollment.[19] Those enrolled in a Medicare health plan, including beneficiaries enrolled in Medicare Advantage (MA) plans under Part C, eligible organizations under section 1876 of the Act, and Program of All-Inclusive Care for the Elderly (PACE) programs under section 1894 of the Act are not eligible.[20] Medicare Secondary Payer status does not exclude a beneficiary from assignment to an ACO.	Yes	Yes
C.	Beneficiary is not assigned to any other Medicare shared savings initiative.[21] For example, beneficiaries cannot be assigned to a Shared Savings Program ACO if they are associated with another Medicare shared savings initiative. CMS excludes beneficiaries from each of the ACO's benchmark years if they are aligned to another Medicare shared savings initiative during the corresponding performance year, and if the beneficiary exclusion occurs prior to establishment of the ACO's historical benchmark. Beneficiaries who meet the criteria for being prospectively assigned to an ACO because of their voluntary alignment selections are not assigned to a Shared Savings Program ACO if they are aligned to an entity participating in a disease- or condition-specific CMS Innovation Center model using claims-based assignment that is based on primary care and/or other services..[22]	Yes	Yes

[17] Refer to § 425.400(a)(1) for the general provision on the determination of a beneficiary's eligibility for claims-based assignment. According to § 425.402(e)(2)(ii)(A), the criteria at § 425.401(a) apply for determining whether a voluntarily aligned beneficiary is eligible for assignment to an ACO.
[18] Refer to § 425.401(a)(1).
[19] Refer to § 425.401(a)(2).
[20] Refer to the definition of "Medicare fee-for-service beneficiary" in § 425.20.
[21] Refer to § 425.401(a)(3).
[22] Refer to § 425.402(e)(2)(iii)(D).

CRITERIA AND OTHER FACTORS USED TO DETERMINE ELIGIBILITY FOR ASSIGNMENT		MUST BE MET FOR CLAIMS-BASED ASSIGNMENT	MUST BE MET FOR VOLUNTARY ALIGNMENT
D.	Beneficiary lived in the United States or U.S. territories and possessions, based on the most recent available data in beneficiary records regarding the beneficiary's residence in the last month of the assignment window.[23] If a beneficiary was a U.S. resident in the last available month of the benchmark or performance year or quarterly report assignment window (refer to Appendix B, Table 9), CMS considers the beneficiary to be a U.S. resident for the entire period. U.S. residence includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas. Medicare claims may not be available for beneficiaries who received care outside of the United States or U.S. territories and possessions.	Yes	Yes
E.	Beneficiary had at least one primary care service with a physician who is an ACO professional in the ACO, and is a primary care physician (defined in § 425.20) or has a primary specialty designation specified in § 425.402(c) (listed in Appendix C, Table 11).[24] Refer to Appendix D for details on outpatient facility claims used in beneficiary assignment. In particular, CMS treats a service reported on an FQHC or RHC claim as a primary care service performed by a primary care physician, according to § 425.404(b). Note that beneficiaries who selected a primary clinician at an ACO and are assigned based on voluntary alignment are not required to receive a primary care service at that ACO.	Yes	No
F.	Beneficiary must have received the plurality of their primary care services from the participating ACO. If a beneficiary meets the screening criteria A–E, he or she is eligible for assignment to an ACO according to the two-step assignment algorithm (refer to Section 2.3.3).[25]	Yes	No
G.	Beneficiary designated as a primary clinician through MyMedicare.gov as an ACO professional participating in the ACO.[26] If a beneficiary meets the screening criteria A–D, and is not excluded according to the criteria at § 425.401(b) (refer to Section 2.3.2.2), he or she is prospectively assigned to an ACO.[27] Beneficiaries remain voluntarily aligned to the ACO until they are excluded. Unless a beneficiary changes their selection, the beneficiary's primary clinician selection remains the same in the consecutive performance year.	No	Yes

[23] Refer to § 425.401(a)(4).
[24] Refer to § 425.402(b)(1).
[25] Refer to § 425.402(b)(3) and (b)(4).
[26] Refer to § 425.402(e)(2)(ii)(B).
[27] Refer to § 425.402(e)(1) and (e)(2)(ii).

CRITERIA AND OTHER FACTORS USED TO DETERMINE ELIGIBILITY FOR ASSIGNMENT		MUST BE MET FOR CLAIMS-BASED ASSIGNMENT	MUST BE MET FOR VOLUNTARY ALIGNMENT
H.	If a beneficiary designated a provider or supplier outside of the ACO as a primary clinician through MyMedicare.gov, the beneficiary is not added to an ACO's assignment list even if the beneficiary would otherwise have been assigned to that ACO through claims-based assignment.[28]	Basis for exclusion	N/A

2.2 VOLUNTARY ALIGNMENT

Beneficiaries may voluntarily align themselves to an ACO at any time by logging into MyMedicare.gov and designating a provider or supplier who they believe to be responsible for coordinating their overall care (referred to as a "primary clinician").[29] Notwithstanding the claims-based assignment methodology (refer to Section 2.3), 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 (and regardless of the ACO's selection of beneficiary assignment methodology), annually at the beginning of each benchmark and performance year based on data available at the time that assignment lists are determined for the benchmark and performance year.[30] Sections 425.402(e)(2)(iii)(A)–(D) (as described in Section 2.1, Table 1) specify the conditions that must be satisfied for a beneficiary who voluntarily aligns with an ACO to be added to the ACO's list of assigned beneficiaries while allowing voluntary aligned beneficiaries to be claims-based assigned to an entity participating in a disease- or condition-specific CMS Innovation Center model (like the Kidney Care Choices (KCC) model) using claims-based assignment that is based on primary care and/or other services. Further, at the end of a performance or benchmark year and quarterly during each performance year, CMS applies the exclusion criteria established at § 425.401(b)(1) (described in Section 2.3.2.2) to determine beneficiary eligibility for alignment to an ACO based on the beneficiary's voluntary alignment with an ACO professional.[31] Voluntarily aligned beneficiaries will remain voluntarily aligned to the same ACO in future performance years unless the ACO terminates or makes ACO Participant List changes impacting voluntary alignment, or the beneficiary either changes their voluntary alignment designation through MyMedicare.gov or no longer meets Shared Savings Program assignment eligibility criteria. Voluntarily aligned beneficiaries with a date of death prior to the start of the benchmark or performance year are excluded.

For performance years beginning on January 1, 2020, and subsequent years, voluntary alignment for performance year assignment will be based on beneficiary designations through September 30 of the prior calendar year. For example, for PY 2025, voluntary alignment for determining performance year assignment will be based on beneficiary designations through September 30, 2024.. Refer to Appendix B, Table 9 for the cut-off dates for beneficiary designations used for determining voluntary alignment for select benchmark and performance years for ACOs with agreement periods beginning on July 1, 2019, and in subsequent years.

[28] Refer to § 425.402(e)(2)(ii)(C).
[29] Refer to § 425.402(e).
[30] Refer to § 425.402(e)(1).
[31] Refer to § 425.402(e)(1) and (e)(2)(ii).

2.3 CLAIMS-BASED ASSIGNMENT

In performing claims-based assignment, CMS determines whether allowed charges for a beneficiary's primary care services (as identified for ACO professionals, including at Electing Teaching Amendment [ETA] hospitals and Method II Critical Access Hospitals [CAHs], and services furnished at an FQHC or RHC) in an ACO are greater than allowed charges for the beneficiary's primary care services in any other ACO, or other individual practitioners, or groups of practitioners identified by Medicare-enrolled billing TINs or CCNs[32] that are not participating in the Shared Savings Program.[33] As illustrated in Figure 2, in making this determination, CMS determines where the beneficiary received the plurality of his or her primary care services.

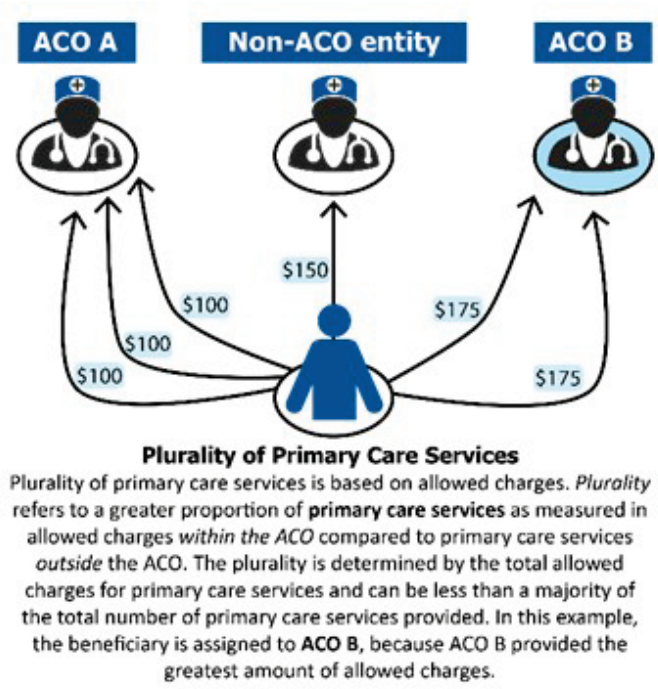

Figure 2. *Claims-based assignment is based on the plurality of allowed charges for primary care services*

For agreement periods beginning on July 1, 2019, and in subsequent years, BASIC track and ENHANCED track ACOs may select either preliminary prospective assignment with retrospective reconciliation or prospective assignment prior to the start of each agreement period.[34] ACOs may elect to change their selection of beneficiary assignment methodology before the start of each performance year during the agreement period. This election is effective at the start of the applicable performance year and for the remaining years of the agreement period, unless superseded by a later election.[35]

CMS provides all ACOs with an assignment list near the start of the performance year according to § 425.702(c)(1)(ii). The amount of claims run-out used will vary. The run-out periods are

[32] FQHCs, RHCs, ETA hospitals, and Method II CAHs will be identified on claims by their CCNs.
[33] Refer to § 425.402(b)(3) and (b)(4); § 425.404(b).
[34] Refer to § 425.400(a)(4)(ii).
[35] Refer to § 425.226(a)(1).

summarized in Appendix F in Table 14 for ACOs under preliminary prospective assignment with retrospective reconciliation and in Table 15 for ACOs under prospective assignment.

2.3.1 ROLE OF ACO PARTICIPANT LIST IN ASSIGNMENT

The ACO Participant List (refer to § 425.118) identifies the collection of ACO participants (defined according to § 425.20) that comprise the ACO and is important to all related Shared Savings Program operations.

DEFINITION
(refer to § 425.20)

ACO participant means an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants that is required under § 425.118.

For example, an ACO's certified ACO Participant List is the basis for the following:

- Identifying Medicare-enrolled TINs participating in the ACO.
- Identifying the individuals or entities that reassigned their billing rights to TINs on the ACO Participant List (i.e., ACO provider/supplier defined according to § 425.20) as identified in the Provider Enrollment, Chain, and Ownership System (PECOS) and specified on the ACO Provider/Supplier List.
- Identifying a CCN with a deactivated enrollment status prior to the start of the performance year or a CCN with no prior Medicare claims experience that enrolls under the TIN of an ACO participant after the ACO certifies its ACO Participant List for the performance year (as specified at § 425.402(f)) via PECOS.

Note: If a CCN enrolled under the TIN of an ACO participant at the start of the performance year enrolls under a different TIN during a performance year, CMS will continue to treat services billed by the CCN as services furnished by the ACO participant it was enrolled under at the start of the performance year for purposes of determining beneficiary assignment to the ACO for the applicable performance year.

In combination, we use TINs identified from the certified ACO Participant List and CCNs for Method II CAHs, ETA hospitals, FQHCs, and RHCs sourced from PECOS, as the basis for beneficiary assignment used in program operations, including the following:

- Determining beneficiaries' eligibility for the Skilled Nursing Facility (SNF) 3-day waiver according to §425.612;
- Calculating the ACO's historical benchmark based on the 3 calendar years prior to the start of its agreement period;
- Determining performance year expenditures used in financial reconciliation;
- Quality reporting
- Promoting Interoperability reporting and
- Producing quarterly and annual feedback reports.

Annually, an ACO may add ACO participants vetted through the CMS screening process or remove participants, which results in a certified ACO Participant List as well as the PECOS-sourced ACO Provider/Supplier List. In combination we use TINs, as well as CCNs, for certain

facilities used in assignment, as the basis for beneficiary assignment used in program operations for the ACO's next performance year.[36]

For more information on the ACO Participant List and ACO Provider/Supplier List, refer to the Medicare Shared Savings Program ACO Participant List and Participant Agreement Guidance available on the Program Guidance & Specifications webpage of the Shared Savings Program website.

For ease of reference, in this document we refer to use of the ACO Participant List more generally for assignment operations, although these references (unless otherwise specified) refer to use of TINs specified on the certified ACO Participant List, and Method II CAHs, ETA hospitals, and FQHCs and RHCs identified based on CCNs sourced from PECOS, as specified on the ACO Provider/Supplier List.

2.3.2 ASSIGNMENT METHODOLOGIES

2.3.2.1 Preliminary Prospective Assignment with Retrospective Reconciliation

For ACOs under preliminary prospective assignment with retrospective reconciliation, CMS assigns beneficiaries in a preliminary manner at the beginning of a performance year based on most recent data available.[37] Near the start of the performance year, ACOs under preliminary prospective assignment with retrospective reconciliation receive an assignment list that includes beneficiaries preliminarily and prospectively assigned via claims-based assignment based on the most recent data available and beneficiaries prospectively assigned as a result of voluntary alignment (refer to Section 2.2).

Assignment will be updated quarterly based on the most recent 12 or 24 months of data.[38] Each quarter, CMS runs claims-based assignment based on data during the specified 12-month assignment window or specified 24-month expanded window for assignment (refer to Section 2.3.3), generating a new preliminary prospective assignment list for these ACOs. The beneficiaries included in the quarterly preliminary prospective assignment list reports may change each quarter. Each assignment list identifies the beneficiaries who received the plurality of primary care services provided during the applicable assignment window or the applicable expanded window for assignment from that ACO, and who meet the assignment criteria identified in Section 2.1, Table 1.

For final assignment, the applicable expanded window for assignment includes the relevant 12-month assignment window and the preceding 12 months. Refer to Appendix B, Table 9.

In determining final assignment for a benchmark or performance year, CMS will exclude any services furnished during the benchmark or performance year that are billed through the TIN of an ACO participant that is an ACO participant in more than one ACO.[39]

[36] Refer to § 425.118(b).
[37] Refer to § 425.400(a)(2)(i).
[38] Refer to § 425.400(a)(2)(ii).
[39] Refer to § 425.400(a)(2)(iii).

The quarterly and final assignment lists include the prospectively assigned voluntarily aligned beneficiaries who continue to meet the eligibility criteria for assignment to an ACO, accounting for the application of the exclusion criteria at § 425.401(b) (as described in Sections 2.2 and 2.3.2.2).[40]

2.3.2.2 Prospective Assignment

For ACOs under prospective assignment, claims-based beneficiary assignment is determined prospectively at the beginning of each benchmark and performance year based on the beneficiary's use of primary care services during the specified 12-month assignment window or specified 24-month expanded window for assignment for which data are available (refer to Section 2.3.3).[41] Near the start of the performance year, ACOs receive an assignment list that includes both beneficiaries prospectively assigned via claims-based assignment and beneficiaries prospectively assigned as a result of voluntary alignment based on most recent available data (refer to Section 2.2).

Prospective assignment uses an offset assignment window and an offset expanded window for assignment (refer to Appendix B, Table 9) to generate the list of prospectively assigned beneficiaries. Although beneficiaries will be assigned prospectively, the claims-based assignment methodology is the same as that used to assign beneficiaries to ACOs under preliminary prospective assignment with retrospective reconciliation, with limited exceptions that are described below.

Once a beneficiary is prospectively assigned to an ACO for a benchmark or performance year, the beneficiary is not eligible for assignment to a different ACO, even if the beneficiary receives the plurality of his or her primary care services in a different ACO during the relevant benchmark or performance year.

A beneficiary assigned to an ACO in one benchmark or performance year may not have been assigned to that ACO in the preceding year(s) because assignment is run separately for each year based on services provided during that year's assignment window.

At the end of a performance or benchmark year and quarterly during each performance year, CMS updates the ACO's prospective assignment list to remove beneficiaries who are no longer eligible for assignment to the ACO. According to § 425.401(b), a prospectively assigned beneficiary who meets any of the following criteria is excluded from the prospective assignment list:

- Does not have at least 1 month of Part A and Part B enrollment; and has any months of Part A–only or Part B–only enrollment.
- Has any months of Medicare group (private) health plan enrollment.
- Did not live in the United States or U.S. territories and possessions, based on the most recent available data in beneficiary records regarding the beneficiary's residence in the last month of the assignment window. Refer to Appendix B, Table 9 for relevant assignment windows.

[40] Refer to § 425.402(e)(2)(ii)(A).
[41] Refer to § 425.400(a)(3).

Also note that in determining prospective assignment for ACOs' benchmark and performance years, CMS identifies beneficiaries who, although assigned using the offset assignment window (October–September), died prior to the start of the benchmark or performance year. CMS excludes these deceased beneficiaries from use in quarterly reports, determining financial reconciliation for the performance year and in determining benchmark year assignment. ACOs are accountable for the cost and quality of care for prospectively assigned beneficiaries with a date of death during the performance year. Benchmark year expenditures include expenditures for beneficiaries prospectively assigned to an ACO for a benchmark year, with a date of death during the benchmark year.

2.3.3 ASSIGNMENT ALGORITHM

According to § 425.400(a), CMS employs the step-wise assignment methodology described in § 425.402 and § 425.404 for purposes of benchmarking, preliminary prospective assignment (including quarterly updates), retrospective reconciliation, and prospective assignment. A Medicare FFS beneficiary is assigned to an ACO if (1) the beneficiary meets the eligibility criteria under § 425.401(a) (refer to Section 2.1, Table 1); and (2) the beneficiary's utilization of primary care services meets the criteria established under the assignment methodology described in § 425.402 and § 425.404 (as described in further detail in this section).

Eligible beneficiaries who voluntarily aligned with an ACO will be prospectively assigned to the ACO as described in Section 2.2. Further, beneficiaries who select a primary clinician not affiliated with an ACO are excluded from assignment to an ACO, even if the beneficiary would otherwise have been assigned to an ACO through claims-based assignment.

As a "pre-step" in the claims-based assignment process, CMS identifies all beneficiaries who had at least one primary care service with a physician who is either (1) both an ACO professional in the ACO and a primary care physician as defined under § 425.20; or (2) who has one of the primary specialty designation specified in § 425.402(c) (listed in Appendix C, Table 11).[42] CMS treats a service reported on an FQHC or RHC claim as a primary care service performed by a primary care physician, according to § 425.404(b). Beginning in PY 2025, beneficiaries who do not meet the criteria outlined in the "pre-step" may be eligible for assignment under claims-based assignment Step 3.

CMS identifies all primary care services furnished to beneficiaries identified in the pre-step.[43] CMS uses allowed charges for primary care services for determining assignment. Allowed charges include the Medicare deductible—the first dollars of Medicare Part B payments by a beneficiary within the year (e.g., $240 in 2025). By using allowed charges rather than a simple service count, CMS also reduces the likelihood of ties. For each ACO, CMS sums 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.[44]

[42] Refer to § 425.402(b)(1).
[43] Refer to § 425.402(b)(2).
[44] All ACOs will have special identifiers (ACO IDs) in the form of Axxxx (with the x's signifying a four-digit number).

Under claims-based assignment, CMS assigns beneficiaries to ACOs through one of three steps as follows.

Step 1: Beneficiary received the plurality of primary care services from primary care physicians, nurse practitioners, physician assistants and clinical nurse specialists in the participating ACO.

CMS assigns a beneficiary to a Shared Savings Program ACO when the beneficiary receives more primary care services (measured by Medicare-allowed charges) furnished by primary care physicians, nurse practitioners, physician assistants and clinical nurse specialists in the participating ACO than from the same type of providers at any other Shared Savings Program ACO, non-ACO CCN, or non-ACO individual or group TIN during the applicable assignment window.[45] Appendix C, Table 11 lists physician specialty codes for primary care physicians included in claims-based assignment Step 1, and Table 12 lists specialty codes for ACO non-physician practitioners (nurse practitioners, clinical nurse specialists, or physician assistants) included in claims-based assignment Step 1. Appendix D, Table 13 specifies outpatient facility claims used in beneficiary assignment.

Step 2: If not assigned in Step 1, a beneficiary received the plurality of primary care services from specialist physicians in the participating ACO.

This step applies only to beneficiaries who have not had a primary care service rendered by any primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist, either inside the ACO or outside the ACO and were therefore not assigned in assignment Step 1. CMS assigns a beneficiary to a Shared Savings Program ACO in this step when the beneficiary receives more primary care services (measured by Medicare-allowed charges) furnished by physicians who are ACO professionals with specialty designations as specified in § 425.402(c) (listed in Appendix C, Table 11) in the participating ACO than from the same type of providers at any other Shared Savings Program ACO, non-ACO CCN, or non-ACO individual or group TIN during the applicable assignment window.[46] Appendix D, Table 13 specifies outpatient facility claims used in beneficiary assignment.

Step 3: If not identified by the "pre-step", a beneficiary received the plurality of primary care services during the expanded window for assignment from ACO professionals.

For the performance year beginning on January 1, 2025, and subsequent performance years, CMS includes a third step in the assignment process which utilizes an expanded window for assignment to identify additional beneficiaries for assignment among Medicare FFS beneficiaries who were not identified under the existing pre-step. The expanded window for assignment is a 24-month period that includes the applicable 12-month assignment window and the preceding 12 months. Claims-based assignment Step 3 identifies all beneficiaries not identified by the pre-step criterion specified in § 425.402(b)(1), who also meet the following criteria:

(1) Received at least one primary care service with a non-physician ACO professional (NP, PA, or CNS) in the ACO during the applicable 12-month assignment window.

[45] Refer to § 425.402(b)(3).
[46] Refer to § 425.402(b)(4).

(2) Received at least one primary care service with a physician who is an ACO professional in the ACO and who is a primary care physician as defined under § 425.20 or who has one of the primary specialty designations included in § 425.402(c) during the applicable 24-month expanded window for assignment.

CMS will assign beneficiaries meeting these criteria to an ACO if the allowed charges for primary care service furnished to the beneficiary by ACO professionals in the ACO who are primary care physicians, non-physician ACO professionals, or physicians with specialty designations included in § 425.402(c) during the applicable expanded window for assignment are greater than the allowed charges for primary care services furnished by primary care physicians, physicians with specialty designations included in § 425.402(c), nurse practitioners, physician assistants, and clinical nurse specialists who are ACO professionals in any other ACO or not affiliated with any ACO and identified by a Medicare-enrolled billing TIN.

Method II CAH, FQHC, RHC, and ETA hospital claims

Appendix D contains details on how outpatient claims for Method II CAHs, FQHCs, RHCs, and ETA hospitals will be identified for use in beneficiary assignment. This approach is used to determine expenditures for beneficiaries within the ACO (through ACO participants) or in a non-ACO organization.

Tie-breaker methodology

CMS has established the following policy in the event of a tie during Step 1, Step 2, or Step 3 of assignment where multiple entities (for example two ACOs, or an ACO and a non-ACO CCN or TIN) have provided the beneficiary with the same amount of allowed charges: The tie-breaker will be the ACO or non-ACO individual or group TIN or other organizational identifier (for FQHCs, RHCs, ETA hospitals, and Method II CAHs) that provided the most recent primary care service through a primary care physician (refer to the list of specialty codes for physicians used in assignment Step 1 in Appendix C, Table 11) or a non-physician practitioner (refer to Appendix C, Table 12). If there is still a tie, then the tie-breaker will be the ACO or non-ACO individual or group TIN or other organizational identifier (for Method II CAHs and ETA hospitals) that provided the most recent primary care service through a specialist physician utilized in assignment (refer to the list of specialty codes for physicians used in assignment Step 2 in Appendix C, Table 11). Though extremely rare, if there is still a tie, the beneficiary is randomly assigned using a random assignment computer calculation.

3 ACO PER CAPITA EXPENDITURES, RISK ADJUSTMENT POLICIES, AND ACO PARTICIPANTS' REVENUE

This section describes how CMS calculates per capita expenditures for an ACO's assigned population and adjusts expenditures for changes in severity and case mix using CMS Hierarchical Condition Category (HCC, also known as CMS-HCC) prospective risk scores. This process begins after CMS completes beneficiary assignment, as described in Section 2 of this document. CMS performs separate calculations for each benchmark year, quarterly aggregate report, and performance year.

CMS adjusts certain Shared Savings Program calculations to address the impact of the COVID-19 pandemic. As specified in § 425.611, CMS excludes from certain Shared Savings Program calculations all Parts A and B FFS payment amounts for a beneficiary's episode of care for treatment of COVID-19, triggered by an inpatient service, and as specified on Parts A and B claims with dates of service during the episode. Refer to the COVID-19 Specifications (see Section 1.4 above).

3.1 ACO PER CAPITA EXPENDITURES

3.1.1 CALCULATING ACO-ASSIGNED BENEFICIARY EXPENDITURES

CMS calculates expenditures for ACO-assigned beneficiaries for each benchmark year and each performance year separately for the following populations based on Medicare enrollment type: end-stage renal disease (ESRD), disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.[47]

As described in further detail in this section, CMS uses the following steps to determine an assigned beneficiary's expenditures and Medicare enrollment type for each month:

- Determine an assigned beneficiary's expenditures for each month.
- Determine the Medicare enrollment status for an assigned beneficiary for each month.
- Allocate a beneficiary's expenditures by month to the identified Medicare enrollment type for the beneficiary for the relevant month.

Step 1: Determine an assigned beneficiary's expenditures for each month.

To calculate expenditures for each assigned beneficiary, CMS does the following:

- Identifies payment amounts included in Parts A and B FFS claims with dates of service in the relevant benchmark or performance year, allowing for a 3-month claims run-out,[48] from all the following: claim payment amounts identified for inpatient, SNF, outpatient, home health agency (HHA), and hospice claims at any provider; and line item payment amounts identified for carrier (including physician/supplier Part B) and durable medical equipment, prosthetics, orthotics & supplies (DMEPOS) claims. For both Parts A and B claims, CMS excludes payments on denied claims or line items from the calculation, for claims or line items with dates of service within the relevant benchmark year or performance year, processed before the end of the 3-month claims run-out period. Table 2 below contains a list of the claim types that CMS uses to determine the expenditure amount and denied line items or denied claims.
- Excludes Indirect Medical Education (IME) payments, Disproportionate Share Hospital (DSH) payments, uncompensated care payments, and the supplemental payment for Indian Health Service (IHS) hospitals, Tribal hospitals, and Puerto Rico hospitals from inpatient

[47] Refer to §§ 425.601(a)(2) and 425.652(a)(2). For consistency with calculation of benchmark expenditures by Medicare enrollment type, we also perform calculations of performance year expenditures by Medicare enrollment type (see explanation in the June 2016 Final Rule, 81 FR 37981).
[48] Refer to the calculation of benchmark expenditures in §§ 425.601(a)(1) and 425.652(a)(1), and performance year expenditures in §§ 425.605(a)(4) and 425.610(a)(5).

claims.[49] Because 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 or DSH payments to Maryland hospitals.

- Excludes all Medicare Parts A and B fee-for-service payment amounts on claims for specified claim types associated with a HCPCS or CPT code identified to be significant, anomalous, and highly suspect billing activity in accordance with §§ 425.670 or 425.672, as applicable.
- Adjusts Parts A and B FFS payment amounts from April 1, 2013, onward to add back in the amount of payment withheld due to sequestration as required by the Budget Control Act of 2011.
- Adds back in reductions to payment amounts associated with population-based payments or other similarly structured payments made under other Medicare shared savings initiatives, including but not limited to the Next Generation ACO Model (model concluded December 31, 2021), Guiding an Improved Dementia Experience (GUIDE) Model, Vermont All-Payer ACO Model, ACO Realizing Equity, Access, and Community Health (REACH) Model, Primary Care First, Making Care Primary (MCP), General All-Payer Health Equity Approaches and Development (AHEAD) Model, and Kidney Care Choices (KCC) Model. Population-based payments are a per-beneficiary per month payment amount intended to replace some or all of the FFS payments with prospective monthly payment.
- Adds in individually beneficiary identifiable payments made under a demonstration, pilot or time-limited program (e.g., care coordination payments) that are final and not subject to further reconciliation.[50]
- Medicare payment adjustments resulting from incentive payment programs, including the Hospital Value-Based Purchasing Program and the Merit-based Incentive Payment System (MIPS), are reflected in payment amounts; therefore, no additional adjustments are needed when developing ACO expenditures.

Payments not included in the claim payment amount or line item payment amount on Part A or Part B FFS claims are not included in ACO expenditures. Therefore, ACO expenditures do not include pass-through payments, such as direct graduate medical education payments, kidney acquisition costs, and bad debt payments. Advanced Alternative Payment Model (Advanced APM) lump sum incentive payments are paid directly to the Advanced APM Entity associated with the Medicare-enrolled billing TIN through which an eligible clinician becomes a Qualifying APM Participant and therefore is not included in ACO expenditures.

Expenditure amounts are calculated for each beneficiary each month, equaling the sum of the adjusted claim payment amounts and line item payment amounts for all claims and claim lines with claim through dates in that month.

[49] Refer to the calculation of benchmark expenditures in §§ 425.601(a)(1)(i) and 425.652(a)(1)(i), and performance year expenditures in §§ 425.605(a)(5)(i) and 425.610(a)(6)(i).
[50] Refer to the calculation of benchmark expenditures in §§ 425.601(a)(1)(ii) and 425.652(a)(1)(ii), and performance year expenditures in §§ 425.605(a)(5)(ii) and 425.610(a)(6)(ii)(B).

Table 2. *Claim types used in total beneficiary expenditure calculations*

CLAIM TYPES	PAYMENT IS EQUAL TO:	CLAIM DENIED IF LEFT JUSTIFIED VALUE IS:	LINE ITEM DENIED IF:	CLAIM THROUGH DATE
SNF (Claim type = 20 or 30)	Claim payment amount	Any non-blank value for "Claim Medicare Non-payment reason code"	N/A	Claim through date
Inpatient (Claim type = 60)	Claim payment amount (excluding IME, DSH, uncompensated care amounts, and the supplemental payment for IHS hospitals, Tribal hospitals, and Puerto Rico hospitals)	Any non-blank value for "Claim Medicare Non-payment reason code"	N/A	Claim through 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 or 5)	N/A	Claim through 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 or 5)	N/A	Claim through date
Carrier (including physician/ supplier Part B[51]) (Claim type = 71 or 72)	Line National Claims History (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
DMEPOS (Claim type = 81 or 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 through date

[51] Carrier claims are FFS claims submitted by professional providers including, but not limited to, physicians, physician assistants, clinical social workers, and nurse practitioners as well as some organizational providers such as independent clinical laboratories, ambulance providers, free-standing ambulatory surgical centers, and free-standing radiology centers (see more information at https://www.resdac.org/cms-data/files/carrier-ffs).

Step 2: Determine the Medicare enrollment status for an assigned beneficiary for each month.

CMS allocates beneficiary months to each Medicare enrollment type, applying the following hierarchy:

1. ESRD: beneficiaries eligible for Medicare as a result of end-stage renal disease;
2. Disabled: beneficiaries eligible for Medicare as a result of disability;
3. Aged/dually eligible: beneficiaries eligible for Medicare by age, and eligible for Medicaid; or
4. Aged/non–dually-eligible: beneficiaries eligible for Medicare by age, but not eligible for Medicaid.

For more information on how CMS identifies a beneficiary's Medicare enrollment type, refer to Appendix E. Beneficiaries are only assigned a monthly enrollment status for months in which they are alive on the first of the month, enrolled in both Parts A and B, and not enrolled in a Medicare Group Health Plan for the month (hereafter referred to as Shared Savings Program–eligible months).

CMS uses the resulting information to determine the beneficiary's total number of Shared Savings Program–eligible months in each Medicare enrollment type for the 12-month benchmark year or performance year. This information is used to calculate the fraction of the year during which the beneficiary was enrolled in each Medicare enrollment type (referred to as person years). To calculate person years, CMS sums the number of Shared Savings Program–eligible months for the beneficiary for each Medicare enrollment type; CMS then divides this number by 12 (the number of months in a calendar year).

Step 3: Determine an assigned beneficiary's expenditures for each enrollment type.

CMS allocates a beneficiary's expenditures for each month (calculated as described in Section 3.1.1, Step 1) to the beneficiary's identified Medicare enrollment type for that month (determined as described in Section 3.1.1, Step 2). For each beneficiary, for each Medicare enrollment type, CMS then sums all monthly expenditures allocated to that enrollment type. A beneficiary who has no months in a particular enrollment type will have zero expenditures for that enrollment type.

3.1.2 ANNUALIZING ASSIGNED BENEFICIARY EXPENDITURES

CMS annualizes the assigned beneficiary's expenditures. CMS divides the beneficiary's total expenditures for each Medicare enrollment type by the beneficiary's person years in each Medicare enrollment type (as described in Section 3.1.1, Step 2).

Annualization (as described in this section) and weighting of beneficiary expenditures (as described in Section 3.1.5) (1) ensure that payments are adjusted for months of beneficiary eligibility, including for new Medicare enrollees and beneficiaries who died during the year, and (2) enable CMS to truncate outlier expenditures.

Example: Annualizing Assigned Beneficiary Expenditures

The following is based on a hypothetical beneficiary.

Medicare enrollment type: aged/dual eligible

Months enrolled in Medicare as aged/dual eligible: 6 months

Total beneficiary expenditures for months as aged/dual eligible: $10,000

Calculate the fraction of the year during which each assigned beneficiary is enrolled in each Medicare enrollment type (referred to as person years).

$$\frac{Months\ enrolled\ in\ aged/dual\ eligible\ status}{12\ months\ (i.e.,1\ year)} = \frac{\mathbf{6}}{\mathbf{12}} = \mathbf{0.5}$$

Calculate annualized expenditures.

$$\frac{Beneficiary\ expenditures}{Fraction\ of\ the\ year\ enrolled\ in\ aged/dual\ eligible\ status} = \frac{\mathbf{\$10,000}}{\mathbf{0.5}} = \mathbf{\$20,000}$$

Thus, the beneficiary's annualized aged/dual eligible expenditures are $20,000.

3.1.3 TRUNCATING ASSIGNED BENEFICIARY EXPENDITURES

After calculating annualized beneficiary expenditures for each Medicare enrollment type (refer to Section 3.1.2), CMS truncates annualized expenditures to an established threshold for those beneficiaries whose annualized expenditures are greater than the threshold.[52]

CMS completes this step to minimize variation from catastrophically large claims. For all beneficiaries in each Medicare enrollment type, the threshold will be the national un-weighted 99th percentile of annualized expenditures for assignable beneficiaries by Medicare enrollment type, calculated by the CMS Office of the Actuary (OACT).[53] The 99th percentile for ESRD beneficiaries is typically much higher than that of aged and disabled beneficiaries.

Similarly, CMS truncates 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

[52] Refer to the calculation of benchmark expenditures in §§ 425.601(a)(4) and 425.652(a)(4), and performance year expenditures in §§ 425.605(a)(3) and 425.610(a)(4)(ii).

[53] CMS adjusts the calculation of fee-for-service expenditures for assignable beneficiaries, as used in determining the 99th percentile of national Medicare fee-for-service expenditures, to exclude all Medicare Parts A and B fee-for-service payment amounts on claims for specified claim types associated with a HCPCS or CPT code identified to be significant, anomalous, and highly suspect billing activity for a calendar year in accordance with §§ 425.670 or 425.672, as applicable.

threshold (i.e., the negative of the national un-weighted 99th percentile of annualized expenditures for assignable beneficiaries) by enrollment type.

OACT calculates the annualized expenditure truncation thresholds based on uncompleted claims. To be consistent with this, the annualized expenditures that are compared to the truncation thresholds are also based on uncompleted claims.

Example: Truncating Annualized Beneficiary Expenditures

If annualized expenditures exceed the truncation threshold, the threshold amount is used—otherwise annualized expenditures are used.

- Year: 2023
- Medicare enrollment type: aged/dual eligible
- Truncation threshold for aged/dual eligible population (2023): $246,100.68

If annualized aged/dual eligible expenditures = $20,000 (i.e., less than the truncation threshold), the annualized expenditures are used.

If annualized aged/dual eligible expenditures = $300,000 (i.e., greater than the truncation threshold), the truncation threshold, $246,100.68 is used.

3.1.4 APPLYING A COMPLETION FACTOR

Once expenditures are annualized and truncated, a completion factor is applied to expenditures. In calculating expenditures for annual reports, CMS uses a 3-month claims run-out with a completion factor.[54] That is, CMS accesses information about the claims after a 3-month claims run-out to allow time for more claims with dates of service during the applicable 12-month period to be added to or changed in the claims processing system; then CMS applies a completion factor. As we explained in earlier rulemaking, the decision to use a 3-month claims run-out and a completion factor was based on our experience with the submission and processing of Parts A and B claims for services and the inherent lag between when a service is performed and when a claim is submitted for payment.[55] Further, claim lags can vary significantly because of a wide range of factors related to the demand for services, submission and processing of claims, and potential corrections or other revisions to claims after initial processing and payment.

CMS applies a completion factor, provided by OACT, because generally claims will be approximately 98–99 percent complete after a 3-month claims run-out. For the quarterly aggregate reports, CMS uses a claims run-out period no longer than 7 days, depending on data availability, and applies a completion factor. Refer to Appendix F, Table 14 and Table 15 for additional information on claims run-out periods and completion factors.

[54] Refer to the calculation of benchmark expenditures in §§ 425.601(a)(1) and , and performance year expenditures in §§ 425.605(a)(4) and 425.610(a)(5).
[55] Refer to the discussion in the February 2016 Proposed Rule, 81 FR 5824, 5842.

Example: Applying Completion Factor to Annualized and Truncated Beneficiary Expenditures

If annualized expenditures exceed the truncation threshold, the threshold amount is used—otherwise annualized expenditures are used.

Year: 2023

Medicare enrollment type: aged/dual eligible

Truncation threshold (2023): $246,100.68

Completion factor with 3-month run-out: 1.013

If annualized aged/dual eligible expenditures = $20,000 (i.e., less than the truncation threshold)

$$Annualized\ Expenditure\ \times Completion\ Factor$$
$$\$\mathbf{20,000} \times \mathbf{1.013} = \$\mathbf{20,260}$$

If annualized aged/dual eligible expenditures = $300,000 (i.e., greater than the truncation threshold)

$$Aged/dual\ eligible\ Truncation\ Threshold\ \times Completion\ Factor$$
$$\$\mathbf{246,100.68} \times \mathbf{1.013} = \$\mathbf{249,299.99}$$

3.1.5 WEIGHTING ASSIGNED BENEFICIARY EXPENDITURES BY MEDICARE ENROLLMENT TYPE

Once CMS has annualized expenditures (Section 3.1.2), truncated expenditures (Section 3.1.3), and applied a completion factor (Section 3.1.4) for each assigned beneficiary, CMS calculates aggregated per capita expenditures for each Medicare enrollment type.[56] CMS multiplies each beneficiary's expenditures in each Medicare enrollment type by each beneficiary's person years in that Medicare enrollment type (as described in Section 3.1.1, Step 2).

CMS calculates expenditures weighted by person years for all assigned beneficiaries in each Medicare enrollment type, and then sums all these expenditure values and divides by the total number of person years in the Medicare enrollment type.

Example: Weighting Expenditures by Amount of Time in Medicare Enrollment Type

Medicare enrollment type and duration: Aged/dual eligible, 6 months

Annualized expenditures: $20,260

Person years: 0.5

$$\$\mathbf{20,260} \times (\mathbf{0.5}) = \$\mathbf{10,130}$$

3.2 RISK ADJUSTMENT POLICIES

When establishing, adjusting, and updating an ACO's historical benchmark, CMS makes certain adjustments to account for the severity and case mix of, and certain demographic factors for,

[56] Refer to § 425.601(a) introductory text, (a)(1), (a)(2), and (a)(4); § 425.652(a) introductory text, (a)(1), (a)(2), and (a)(4); § 425.605(a) introductory text, (a)(3), (a)(4), and (a)(5); § 425.610(a) introductory text, (a)(4), (a)(5), and (a)(6).

the ACO's assigned beneficiary population and the assignable beneficiary population. We use prospective HCC risk scores and (as applicable) demographic risk scores to perform this risk adjustment.

More generally, to calculate the weighted average ACO-level risk score for each Medicare enrollment type, CMS multiples each beneficiary's risk score for that enrollment type by the beneficiary's person years enrolled in that enrollment type. CMS then sums these person-year–weighted risk score values across all beneficiaries assigned to the ACO and divides by total person years for that enrollment type among beneficiaries assigned to the ACO.

In this section, we describe calculation of prospective HCC risk scores (Section 3.2.1) and demographic risk scores (Section 3.2.2). We describe risk adjustment for purposes of establishing the ACO's historical benchmark (Section 3.2.3), and the annual adjustment to the ACO's historical benchmark for changes in severity and case mix of the ACO's assigned beneficiary population (Section 3.2.4). We also describe how we cap regional risk score growth increases to the regional component of the benchmark update factor (Section 3.2.5). As relevant, we specify the applicability of the policies based on agreement period start date.

3.2.1 CALCULATION OF PROSPECTIVE HCC RISK SCORES

CMS maintains the HCC risk adjustment models for the Medicare Advantage (MA) program. CMS maintains HCC risk adjustment models for populations of beneficiaries based on age, disability status, gender, institutional status, eligibility for Medicaid, and health status (see section 1853(a)(1)(C)(i) of the Act), including a separate MA risk adjustment model for the ESRD population, and a Part D risk adjustment model (known as the RxHCC model). Over time, CMS has implemented revised versions of the HCC risk adjustment models (also referred to generally as the "CMS-HCC model"). Historically, transitions to a revised version of the CMS-HCC model have been gradually phased-in over time by blending the old risk adjustment model and the revised risk adjustment model.[57]

Using the specified model, or blend of models (if applicable), CMS calculates prospective HCC risk scores for all Medicare beneficiaries, including FFS beneficiaries.

The Shared Savings Program's regulations specify the approach to calculating prospective HCC risk scores used in Shared Savings Program benchmark calculations (refer to § 425.659). CMS applies the relevant HCC risk adjustment methodology in calculating a Medicare FFS beneficiary's prospective HCC risk score for use in Shared Savings Program calculations, based on agreement period start date:

For agreement periods beginning before January 1, 2024: For each benchmark year and performance year, CMS applies the HCC risk adjustment model(s) applicable for the calendar year corresponding to the respective benchmark year or performance year.[58]

For agreement periods beginning on January 1, 2024, and in subsequent years: For each benchmark year and performance year, CMS applies the CMS-HCC risk adjustment model(s) applicable for the calendar year corresponding to the performance year. [59]

[57] Refer to 88 FR 79201.
[58] Refer to § 425.659(b)(1)(i) and (ii).
[59] Refer to § 425.659(b)(1)(i) and (iii).

Further, in calculating the prospective HCC risk scores for a benchmark or performance year, CMS removes the MA coding intensity adjustment (if applicable) and renormalizes the risk scores by Medicare enrollment type based on the national assignable FFS population for the relevant benchmark or performance year.[60] For each beneficiary, CMS uses 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.[61] Risk-adjustment-eligible diagnoses codes from final action FFS claims (inpatient, outpatient, and physician) are included in the prospective HCC risk scores for FFS beneficiaries. Risk adjustment-eligible diagnoses from these settings are considered in risk score calculation, including primary and secondary diagnoses codes. Additional information on the calculation of CMS-HCC risk adjustment model risk scores can be found on the CMS.gov website.

A beneficiary's final risk score for each month is the risk score determined based on the beneficiary's risk adjustment model status for that month. There are risk adjustment models for MA subpopulations, for example community model versus institutional model versus new enrollee model for aged/non-dual eligible non-dual eligible beneficiaries, 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. Risk scores used by the Shared Savings Program for beneficiaries in a Medicare enrollment type (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).[62]

A beneficiary's average risk score for a particular Medicare enrollment type for a given year is 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 risk scores from year to year, given changes made to the underlying risk score models.[63]

3.2.2 DEMOGRAPHIC RISK SCORES

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 scores consider only certain specified patient demographic factors, such as age, sex, Medicaid status, and the basis for Medicare entitlement (that is, age, disability, or ESRD), without incorporating diagnostic information. As such, demographic risk scores are not subject to changes in coding intensity or coding accuracy in the same way that prospective HCC risk scores are. While the Shared Savings Program uses the same demographic factors as those used in MA, Shared Savings Program demographic factor coefficients are calibrated based on the entire Medicare FFS population instead of new Medicare enrollees (as MA uses).[64] Similarly to how CMS renormalizes prospective HCC risk scores, CMS renormalizes demographic risk scores based on a national assignable FFS population.

[60] Refer to § 425.659(b)(2)(i) and (ii).
[61] Refer to § 425.659(b)(2)(iii).
[62] Refer to 88 FR 79201.
[63] Refer to 88 FR 79201.
[64] Refer to 88 FR 79201.

3.2.3 RISK ADJUSTMENT FOR ESTABLISHING THE HISTORICAL BENCHMARK

When establishing the historical benchmark, CMS uses the CMS-HCC prospective risk adjustment model to calculate beneficiary risk scores to adjust for changes in severity and case mix of the population assigned to the ACO.[65] These adjustments account for changes in severity and case mix between the first benchmark year (BY1) and BY3 and between BY2 and BY3.[66]

CMS risk-adjusts the county-level expenditures[67] used in calculating the regional component of the national-regional blended growth rate used to trend BY1 and BY2 to BY3 (refer to Section 4.1.2, Step 2 for additional discussion of the national-regional blended growth rates).[68]

3.2.4 ANNUAL ADJUSTMENT TO THE HISTORICAL BENCHMARK FOR CHANGES IN SEVERITY AND CASE MIX OF ACO-ASSIGNED BENEFICIARY POPULATION

For agreement periods beginning on July 1, 2019, and in subsequent years, CMS further adjusts the ACO's historical benchmark at the time of reconciliation for a performance year to account for changes in severity and case mix of the ACO's assigned beneficiary population between BY3 and the performance year.[69] In making this risk adjustment, CMS makes separate adjustments for populations of beneficiaries for each Medicare enrollment type used in the Shared Savings Program (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).[70]

CMS uses HCC prospective risk scores to adjust the historical benchmark for changes in severity and case mix for the assigned beneficiary population, subject to a cap on positive adjustments for the agreement period. This cap is the maximum increase in risk scores allowed for each agreement period which ensures that the risk ratios (ratios of the ACO's performance year risk score to the BY3 risk score), when applied to historical benchmark expenditures to capture changes in health status between BY3 and the performance year, will never exceed the cap for any performance year over the course of the agreement period.

The resulting prospective HCC risk ratio is multiplied by the ACO's historical benchmark expenditures for the relevant Medicare enrollment type at the time of reconciliation for a performance year, which accounts for changes in severity and case mix for the ACO's assigned beneficiary population between BY3 and the performance year.

3.2.4.1 For Agreement Periods Beginning on or after July 1, 2019, and before January 1, 2024

CMS applies a cap such that any positive adjustments in prospective HCC risk scores between BY3 and any performance year in the agreement period cannot be larger than 3 percent,

[65] Refer to §§ 425.601(a)(3) and 425.652(a)(3).
[66] Refer to §§ 425.601(a)(6) and 425.652(a)(6).
[67] Refer to § 425.601(c)(4) and (d), and § 425.654(a)(4) and (b).
[68] Refer to §§ 425.601(a)(5) and 425.652(a)(5).
[69] Refer to the calculation of benchmark expenditures in §§ 425.601(a)(10) and 425.652(a)(10), and performance year expenditures in § 425.605(a)(1) and (a)(2), and § 425.610(a)(2) and (a)(3).
[70] Refer to §§ 425.605(a)(2) and 425.610(a)(3).

referred to as the "3 percent cap."[71] The cap is applied separately for populations of beneficiaries for each Medicare enrollment type.[72]

Table 3 provides an illustrative example of how the positive 3 percent cap is applied to the risk ratio used to adjust historical benchmark expenditures to reflect changes in health status between BY3 and the performance year, for any performance year in the agreement period.[73] In the example, the increase in the aged/dual eligible risk score is subject to the positive 3 percent cap. Changes in the ESRD, disabled, and aged/non-dual eligible risk scores are not affected by the cap; the ACO would receive full upward and downward adjustment, as applicable, for these Medicare enrollment types.

Table 3. *Hypothetical data on application of positive 3 percent cap on performance year to BY3 risk ratios for agreement periods beginning on or after July 1, 2019, and before January 1, 2024*

FACTOR	ESRD	DISABLED	AGED/ DUAL ELIGIBLE	AGED/ NON-DUAL ELIGIBLE
BY3 Renormalized CMS-HCC Risk Score [A]	1.031	1.123	0.987	1.025
PY Renormalized CMS-HCC Risk Score [B]	1.054	1.074	1.046	1.001
CMS-HCC Risk Ratio (Before Cap) [C] = [B] / [A]	1.022	0.956	1.060	0.977
Final CMS-HCC Risk Ratio (After Cap, if Applicable) [D] = if [C] is greater than 1.030, then equal to 1.030, otherwise [C]	1.022	0.956	1.030	0.977

3.2.4.2 For Agreement Periods Beginning on January 1, 2024, and in Subsequent Years

CMS applies a cap such that any positive adjustments in prospective HCC risk scores between BY3 and the performance year cannot be larger than the ACO's aggregate growth in demographic risk scores between BY3 and the performance year (positive or negative, across the four Medicare enrollment types) plus 3 percentage points, referred to as the "demographic plus 3 percent cap." The demographic plus 3 percent cap is applied only if the ACO's aggregate growth in prospective risk scores between BY3 and the performance year across all Medicare enrollment types exceeds the cap. If the ACO is determined to be subject to the cap, it is applied for any Medicare enrollment type for which the prospective HCC risk ratio is greater than the demographic plus 3 percent cap.[74]

The steps that follow describe how we calculate and implement the demographic plus 3 percent cap.[75]

[71] Refer to §§ 425.605(a)(1)(i) and 425.610(a)(2)(i).
[72] Refer to §§ 425.605(a)(2) and 425.610(a)(3).
[73] Refer to 83 FR 68009.
[74] Refer to § 425.605(a)(1)(ii) and (a)(2), and § 425.610(a)(2)(ii) and (a)(3).
[75] Refer to §§ 425.605(a)(1)(ii) and 425.610(a)(2)(ii); 87 FR 69932–69946.

Step 1: Determine demographic risk score growth for each Medicare enrollment type.

Demographic risk score growth is measured as the ratio of the ACO's performance year renormalized demographic risk score for an enrollment type to the ACO's BY3 renormalized demographic risk score for that enrollment type.[76]

Step 2: Calculate the aggregate growth in demographic risk scores.

Calculate the weighted average demographic risk ratio across the four enrollment types to obtain a single aggregate weighted average demographic risk ratio.

Step 3: Calculate the demographic plus 3 percent cap.

Calculate the sum of the aggregate weighted average demographic risk ratio from Step 2 and 0.030. This aggregate amount constitutes the demographic plus 3 percent cap.

Step 4: Determine prospective HCC risk score growth for each Medicare enrollment type.

Prospective HCC risk score growth is measured as the ratio of the ACO's performance year renormalized prospective HCC risk score for that enrollment type to the ACO's BY3 renormalized prospective HCC risk score for that enrollment type.[77]

Step 5: Calculate the aggregate growth in prospective HCC risk scores.

Calculate the weighted average prospective HCC risk ratio across the four enrollment types to obtain a single aggregate weighted average prospective HCC risk ratio.

Step 6: Determine if the ACO will be subject to the cap.

- If the ACO's aggregate weighted average prospective HCC risk ratio determined in Step 5 is less than the amount of the demographic plus 3 percent cap determined in Step 3, then no cap is applied to the prospective HCC risk ratio for any enrollment type, even if the prospective HCC risk ratio for a given enrollment type is higher than the cap.
- If the ACO's aggregate weighted average prospective HCC risk ratio determined in Step 5 is greater than or equal to the amount of the demographic plus 3 percent cap determined in Step 3, proceed to Step 7.

Step 7: Apply the demographic plus 3 percent cap, if applicable.

- If the ACO is subject to the cap (according to Step 6), then compare the prospective HCC risk ratio for each enrollment type calculated in Step 4 to the amount of the demographic plus 3 percent cap determined in Step 3.
- If the prospective HCC risk ratio for a given enrollment type is greater than the demographic plus 3 percent cap, then the prospective HCC risk ratio for that enrollment type is set equal to the cap.

[76] Before calculating these demographic risk ratios, the demographic risk scores for each enrollment type for each year will be renormalized by dividing by the national mean demographic risk score for that enrollment type for that year (as described in Section 3.2.2).
[77] Before calculating these prospective HCC risk ratios, the prospective HCC risk scores for each enrollment type for each year will be renormalized by dividing by the national mean prospective HCC risk score for that enrollment type for that year (refer to Section 3.2.1).

- If the prospective HCC risk ratio for a given enrollment type is less than or equal to the demographic plus 3 percent cap, then no cap would apply to the prospective HCC risk ratio for that enrollment type.

Calculating weighted average growth in demographic or prospective HCC risk scores
(Calculation in Steps 2 and 5)

The aggregate growth rates in demographic risk scores and prospective HCC risk scores are calculated by taking a weighted average of the growth in demographic risk scores or prospective HCC risk scores, as applicable, across the four Medicare enrollment types for BY3 and the performance year.[78]

Growth in risk scores is expressed as a ratio of the ACO's performance year risk score to the ACO's BY3 risk score, for each enrollment type.

The weight applied to the growth in risk scores for each Medicare enrollment type is calculated by

- taking the product of historical benchmark expenditures for the enrollment type and the performance year assigned beneficiary person years for that enrollment type; and
- dividing by the product of historical benchmark expenditures and performance year assigned beneficiary person years summed across all enrollment types.

The aggregate weighted average demographic or prospective HCC risk ratio is computed by multiplying the risk ratio for each enrollment type by its respective weight and then summing across the four enrollment types.

Table 4 provides an illustrative example of how the demographic plus 3 percent cap is applied to the risk ratio used to adjust historical benchmark expenditures to reflect changes in health status between BY3 and the performance year, for any performance year in the agreement period. In the example, the demographic plus 3 percent cap applies since the aggregate prospective HCC risk score growth is larger than the aggregate cap. The increases in the aged/dual eligible and aged/non-dual eligible risk scores are subject to the demographic plus 3 percent cap. Changes in the ESRD and disabled risk scores are not affected by the cap; the ACO would receive the full upward and downward adjustment, as applicable, for these Medicare enrollment types.

Table 4. *Hypothetical data on application of demographic plus 3 percent cap on performance year to BY3 risk ratios, for agreement periods beginning on January 1, 2024, and in subsequent years*[79]

FACTOR	ESRD	DISABLED	AGED/DUAL ELIGIBLE	AGED/NON-DUAL ELIGIBLE	WEIGHTED AVERAGE
Risk Score Weights [A]	0.050	0.075	0.080	0.795	
Demographic Risk Ratio [B]; weighted average equals the sum of the product of [A] × [B] across enrollment types	1.035	1.020	0.990	1.030	1.026
Aggregate Cap [C] = weighted average [B] + 0.030					1.056

[78] Refer to §§ 425.605(a)(1)(ii)(C) and 425.610(a)(2)(ii)(C); see also 87 FR 69935 and 69946.
[79] Refer to 87 FR 69936.

FACTOR	ESRD	DISABLED	AGED/DUAL ELIGIBLE	AGED/NON-DUAL ELIGIBLE	WEIGHTED AVERAGE
CMS-HCC Risk Ratio (Before Cap) [D]; weighted average equals the sum of the product of [A] × [D] across enrollment types	0.980	1.050	1.089	1.076	1.070
Is ACO Subject to Cap [E] (ACO subject to Aggregate Cap [C], if weighted average [D] ≥ [C], otherwise no cap applied)					Yes
CMS-HCC Risk Ratio (After Cap, if Applicable) [F] (cap applied to [D] for each enrollment type, as applicable)	0.980	1.050	1.056	1.056	

3.2.5 REGIONAL RISK SCORE GROWTH CAP ADJUSTMENT FACTOR

For agreement periods beginning on January 1, 2024, and in subsequent years, CMS applies a cap on prospective HCC risk score growth in an ACO's regional service area between BY3 and the performance year by applying an adjustment factor to the regional component of the three-way blended benchmark update factor (refer to Section 4.1.4, Step 2).[80] The cap is equal to the aggregate growth in regional demographic risk scores between BY3 and the performance year plus 3 percentage points, adjusted for an ACO's aggregate market share.[81] Capping regional risk score growth has the effect of increasing the regional component of the update factor for ACOs in regions with aggregate regional growth of prospective HCC risk scores that is above the cap, with ACOs with higher aggregate market shares seeing smaller increases, all else being equal. The steps that follow describe how we calculate the regional risk score growth cap adjustment factor.[82]

Step 1: Calculate county-level risk scores.

For both BY3 and the performance year, CMS determines the renormalized, prospective HCC and demographic risk score for each assignable beneficiary in each county in the ACO's regional service area.[83] For both prospective HCC and demographic risk scores, CMS then computes the weighted average risk score for each county for each Medicare enrollment type, by multiplying each assignable beneficiary's risk score for that enrollment type by the beneficiary's person years enrolled in that enrollment type, summing these weighted risk scores across all assignable beneficiaries for that enrollment type in the county, and then dividing by total person years for that enrollment type among assignable beneficiaries in the county. This calculation is similar to the approach used to calculate the county-level weighted average

[80] Refer to § 425.652(b).
[81] Refer to § 425.655.
[82] Refer to §§ 425.652(b)(2)(ii) and 425.655, and 88 FR 79178–79179.
[83] Refer to § 425.655(b).

prospective HCC risk scores as an intermediate step in calculating risk-adjusted regional expenditures (refer to Section 4.1.1, Step 1).

Step 2: Calculate regional risk scores.

CMS then calculates regional-level BY3 and performance year prospective HCC and demographic risk scores as a weighted average of county-level risk scores for the Medicare enrollment type (calculated in Step 1), with weights reflecting the proportion of the ACO's assigned beneficiaries in the county.[84] This proportion is determined by the number of the ACO's assigned beneficiaries (by enrollment type) residing in each county in relation to the ACO's total number of assigned beneficiaries for that Medicare enrollment type for the relevant benchmark or performance year. In performing this calculation, CMS uses assigned beneficiary person years. These would be the same weights as used to calculate regional expenditures under Section 4.1.1, Step 3.

Step 3: Determine aggregate growth in regional risk scores.

To calculate aggregate growth in regional risk scores, CMS first calculates growth in prospective HCC and demographic risk scores between BY3 and the performance year for each Medicare enrollment type, expressed as the ratio of the performance year regional risk score for a Medicare enrollment type (calculated in Step 2) to the BY3 regional risk score for that enrollment type (calculated in Step 2). CMS next takes a weighted average of the regional prospective HCC or demographic risk ratios, as applicable, across the four Medicare enrollment types, where the weight applied to the growth in risk scores for each Medicare enrollment type is the ACO's performance year assigned beneficiary person years for the Medicare enrollment type multiplied by the ACO's regionally adjusted historical benchmark expenditures for the Medicare enrollment type.[85]

Step 4: Determine the cap on regional risk score growth.

CMS first calculates a non–market-share-adjusted cap on the ACO's regional risk score growth as the sum of the aggregate growth in regional demographic risk scores (calculated in Step 3) and 3 percentage points.

$$Non\text{–}Market\text{-}Share\text{-}Adjusted\ Cap\ on\ Regional\ Risk\ Score\ Growth = Aggregate\ Regional\ Demographic\ Risk\ Score\ Growth + 0.03$$

CMS then adjusts the cap to reflect the ACO's aggregate market share.[86] CMS calculates an ACO's aggregate market share as a weighted average of the ACO's market share across the four Medicare enrollment types. An ACO's market share for each Medicare enrollment type is equal to the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO for the applicable performance year. This is equal to the weight that is applied to the national component of the blended update factor in the two-way blend (refer to § 425.652(b)(2)(iv), and see Section 4.1.4, Step 2). In calculating this weighted average, the weight applied to the share for each Medicare enrollment type is equal to the ACO's performance year assigned beneficiary person years for that enrollment type.

[84] Refer to § 425.655(c).
[85] Refer to § 425.655(d).
[86] Refer to § 425.655(e).

The market share adjustment applied to the cap is the product of an ACO's aggregate market share and the difference (subject to a floor of zero) between the aggregate regional prospective HCC risk score growth (calculated in Step 3) and the non–market-share-adjusted cap (calculated in this step).

$$\begin{aligned} &Market\ Share\ Adjustment \\ &\quad = ACO's\ Aggregate\ Market\ Share \\ &\quad \times (Aggregate\ Regional\ Prospective\ HCC\ Risk\ Score\ Growth \\ &\quad - Non\text{–}Market\text{-}Share\text{-}Adjusted\ Cap\ (subject\ to\ a\ floor\ of\ zero)) \end{aligned}$$

The market-share-adjusted cap on regional risk score growth is calculated as the sum of the non–market-share-adjusted cap and the market share adjustment.

$$\begin{aligned} &Market\text{-}Share\text{-}Adjusted\ Cap\ on\ Regional\ Risk\ Score\ Growth \\ &\quad = Non\text{–}Market\text{–}Share\text{–}Adjusted\ Cap + Market\ Share\ Adjustment \end{aligned}$$

This adjustment of the cap on regional risk score growth using the ACO's aggregate market share creates a sliding scale. Under this approach, as an ACO's aggregate market share increases, so does the cap on the ACO's regional risk score growth, ultimately limiting the potential increase to the regional update factor for ACOs with high market share.[87]

Step 5: Determine the regional risk score growth cap adjustment factor.

The cap calculated in Step 4 is applied through a risk score growth cap adjustment factor which is calculated for each Medicare enrollment type and multiplied by the ACO's regional update factor for that enrollment type as determined in accordance with § 425.652(b)(2)(ii).[88]

The first step in calculating the adjustment factor is to compare an ACO's aggregate regional prospective HCC risk score growth (calculated in Step 3) to the market-share-adjusted cap on regional risk score growth (calculated in Step 4):

- If an ACO's aggregate regional prospective HCC risk score growth does not exceed the market-share-adjusted cap on regional risk score growth, the ACO's regional risk score growth is not subject to the cap. For these ACOs the regional risk score growth cap adjustment factor is set equal to 1 for each Medicare enrollment type (which is effectively no adjustment).
- If an ACO's aggregate regional prospective HCC risk score growth exceeds the market-share-adjusted cap on regional risk score growth, the ACO's regional risk score growth is subject to the cap. For these ACOs we will next determine whether the market-share-adjusted cap on regional risk score growth applies for each Medicare enrollment type. To do this, CMS compares regional prospective HCC risk score growth for each Medicare enrollment type with the market-share-adjusted cap:
    - If the regional risk score growth for a Medicare enrollment type does not exceed the cap, the enrollment type is not subject to the cap and the regional risk score growth cap adjustment factor for that Medicare enrollment type is set equal to 1.

[87] See 88 FR 79179.
[88] Refer to §§ 425.652(b)(2)(ii)(C) and 425.655(f).

- If the regional risk score growth for a Medicare enrollment type exceeds the cap, the Medicare enrollment type is subject to the cap. The adjustment factor for the Medicare enrollment type is set equal to the regional prospective HCC risk score growth for the Medicare enrollment type divided by the market-share-adjusted cap on regional risk score growth. Therefore, the adjustment factor for the Medicare enrollment type will represent a measure of how far above the cap the regional prospective HCC risk score growth is.

Once the risk score growth cap adjustment factor is determined for each enrollment type, it is multiplied by the ACO's regional update factor for that enrollment type.[89] Where the adjustment factor is set equal to 1 for an enrollment type, this is effectively no adjustment to the regional update factor for that enrollment type. Where the adjustment factor is set equal to a value greater than 1, as a result of applying the cap, the impact of the adjustment factor is to increase the ACO's regional update factor for that enrollment type.

Table 5 provides an illustrative example of how the regional risk score growth cap adjustment factor is calculated and applied to the regional component of the update factor.[90] In the example, the ACO's aggregate regional prospective HCC risk score growth (refer to row [H]) exceeds the market-share-adjusted cap on regional risk score growth (refer to row [N]), and therefore the ACO's regional risk score growth is subject to the cap (refer to row [O]). In the example, growth in regional prospective HCC risk scores for the ESRD, disabled, and aged/non-dual eligible regional enrollment types exceed the market-share-adjusted cap (refer to row [P]). For these Medicare enrollment types, the adjustment factor is set equal to the regional prospective HCC risk score growth for the enrollment type divided by the market-share-adjusted cap (refer to row [Q]). Growth in regional prospective HCC risk scores for the aged/dual eligible enrollment type does not exceed the market-share-adjusted cap, so the adjustment factor for this enrollment type is set equal to 1 (refer to row [Q]).

Table 5. *Hypothetical data on calculation of the regional risk score growth cap adjustment factor, applied to the regional update factor, for agreement periods beginning on January 1, 2024, and in subsequent years*

REGIONAL-LEVEL MEASURE	ESRD	DISABLED	AGED/ DUAL ELIGIBLE	AGED/NON-DUAL ELIGIBLE	WEIGHTED AVERAGE
Results of Step 2 (Regional risk scores; calculation not shown)					
[A] BY3 Prospective HCC Risk Scores	1.027	1.016	1.037	1.006	
[B] PY Prospective HCC Risk Scores	1.075	1.049	1.043	1.053	
[C] BY3 Demographic Risk Scores	1.016	0.996	1.047	1.007	
[D] PY Demographic Risk Scores	0.962	1.012	1.054	0.983	
Step 3 (Determine aggregate growth in regional risk scores)					
[E] Prospective HCC Risk Ratio, [B] / [A]	1.047	1.032	1.006	1.047	
[F] Demographic Risk Ratio, [D] / [C]	0.947	1.016	1.006	0.977	

[89] Refer to § 425.652(b)(2)(ii)(C).
[90] Refer to 88 FR 79180.

REGIONAL-LEVEL MEASURE	ESRD	DISABLED	AGED/ DUAL ELIGIBLE	AGED/NON-DUAL ELIGIBLE	WEIGHTED AVERAGE
[G] Risk Score Weights (ACO performance year assigned person years multiplied by ACO's regionally adjusted historical benchmark expenditures, as a proportion)	0.010	0.090	0.150	0.750	
[H] Aggregate regional prospective HCC risk score growth, weighted average of [E] Prospective HCC Risk Ratio using weights [G]					1.039
[I] Aggregate regional demographic risk score growth, weighted average of [F] Demographic Risk Ratio using weights [G]					0.984
Step 4 (Determine the cap on regional risk score growth)					
[J] Non–Market-Share-Adjusted Cap, [I] + 0.030					1.014
[K] Market Share Weights (ACO performance year assigned person years, as a proportion)	0.007	0.085	0.120	0.788	
[L] ACO Market Share (Share of assignable beneficiaries in ACO's regional service area assigned to the ACO for the PY)	0.150	0.200	0.180	0.300	
[M] ACO's Aggregate Market Share, weighted average of [L] using weights [K]					0.276
[N] Market-Share-Adjusted Cap, [J] + ([M] × ([H] − [J])), Note that [H]−[J] is subject to a floor of 0					1.021
Step 5 (Determine the regional risk score growth cap adjustment factor)					
[O] Is the ACO Subject to Cap? [H] > [N]?					Yes
[P] Is the Enrollment Type Subject to Cap, If [O] = Yes, is [E] > [N]? If [O] = No, then No	Yes	Yes	No	Yes	
[Q] Regional Risk Score Growth Cap Adjustment Factor,[91] If [P] =Yes, then [E]/[N], else 1	1.025	1.011	1.000	1.025	

NOTE: This numeric example shows only three decimal places and so attempting to replicate the calculations may result in slight differences due to rounding. In actual calculations, all decimal places are used.

[91] For agreement periods beginning on January 1, 2024, and in subsequent years, the Regional Risk Score Growth Cap Adjustment Factor, indicated in Table 5 row [Q], will be applied in the calculation of the regional component of the update factor. Refer to § 425.652(b)(2)(ii)(C) and Section 4.1.4, Step 2.

3.3 ACO PARTICIPANTS' REVENUE

ACO participants' total Medicare Parts A and B FFS revenue is calculated as the sum of Medicare payment amounts on all non-denied claims or line items associated with TINs on the ACO's certified ACO Participant List, or the CCNs enrolled under an ACO participant TIN as identified in PECOS, for all claim types used in program expenditure calculations that have dates of service during the performance year, using 3 months of claims run-out. ACO participant Medicare FFS revenue is not limited to claims associated with the ACO's assigned beneficiaries and is instead based on the claims for all Medicare FFS beneficiaries furnished services by the ACO participant.

In calculating ACO participant Medicare FFS revenue, we add back in reductions to payment amounts associated with population-based payments made under other Medicare shared savings initiatives and include individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program. We exclude all Medicare Parts A and B fee-for-service payment amounts on claims for specified payment types associated with a HCPCS or CPT code identified to be significant, anomalous, and highly suspect billing activity for a calendar year in accordance with §§ 425.670 or 425.672, as applicable. We also apply the same completion factor that is used for annual expenditure calculations (refer to Section 3.1.4 and Appendix F, Table 14 and Table 15). Unlike when calculating assigned beneficiary expenditures, we do not truncate a beneficiary's total annual FFS expenditures, and we do not adjust payments to remove IME, DSH, uncompensated care payments, or the supplemental payment for IHS hospitals, Tribal hospitals, and Puerto Rico hospitals or to add back in reductions made for sequestration. As with expenditures, ACO participant Medicare FFS revenue reflects any payment adjustments reflected in the payment amounts (for example, under MIPS or the Hospital Value-Based Purchasing Program). Refer to December 2018 Final Rule (83 FR 67856) and CY 2023 PFS Final Rule (87 FR 69954–69956).

4 SHARED SAVINGS AND LOSSES CALCULATIONS

This section describes how CMS does the following: establishes an ACO's historical benchmark (including to apply the regional adjustment or the prior savings adjustment, as applicable); annually adjusts the historical benchmark for changes in severity and case mix of the ACO's assigned beneficiary population between BY3 and the performance year; adjusts the historical benchmark for certain changes during the agreement period; annually updates the historical benchmark; rebases the historical benchmark at the start of each new agreement period; and calculates an ACO's shared savings and shared losses for each performance year. As relevant, we specify the applicability of the policies based on agreement period start date.

Close to the start of an ACO's agreement period beginning on January 1, CMS establishes the ACO's historical benchmark and provides the ACO with its benchmark amount by issuing a preliminary historical benchmark report. After completion of the 3-month claims run-out period of the most recent benchmark year and after other data and inputs required for this benchmark year become available (such as truncation thresholds, risk scores, and financial reconciliation data used in calculating the prior savings adjustment, as applicable), CMS provides final Historical Benchmark Reports to ACOs in the first performance year of an agreement period.

CMS adjusts the historical benchmark for certain changes during the ACO's agreement period, resulting in an adjusted benchmark for the ACO's first or subsequent performance year (as applicable) as described in Section 4.1.3.[92]

The historical benchmark—which is either the final historical benchmark issued during the ACO's first performance year or the adjusted historical benchmark that may be issued during the second and subsequent performance years within the ACO's agreement period—will be used to calculate the updated historical benchmark for determining shared savings and losses for the relevant performance year. The updated historical benchmark includes the annual risk adjustment to the historical benchmark according to § 425.601(a)(10) and § 425.652(a)(10) and the annual update to the historical benchmark. The update factor is calculated using either a two-way blend of national and regional growth rates according to § 425.601(b) for agreement periods beginning on or after July 1, 2019, and before January 1, 2024, or a three-way blend calculated as a weighted average of a two-way blend of national and regional growth rates and the Accountable Care Prospective Trend (ACPT; except in cases where a two-way blend is applied under a guardrail policy) according to § 425.652(b) and § 425.660 for agreement periods beginning on January 1, 2024, and in subsequent years. Refer to Appendix F for a description of the reports CMS provides to Shared Savings Program ACOs.

SUMMARY OF BENCHMARK TERMINOLOGY

An ACO's historical benchmark can change throughout its participation in the Shared Savings Program.

Preliminary and Final Historical Benchmarks: An ACO's historical benchmark is established near the start of the ACO's agreement period.

Updated Historical Benchmark: At the time of financial reconciliation for each performance year, CMS does the following:

- Adjusts the historical benchmark to account for changes in severity and case mix for the ACO's assigned beneficiary population between BY3 and the performance year. (Refer to Sections 3.2.4 and 4.1.4.)
- Updates the historical benchmark
  - using a two-way blend of national and regional growth rates, for agreement periods beginning on or after July 1, 2019, and before January 1, 2024 (refer to Section 4.1.4); or
  - using a three-way blend (calculated as a weighted average of a two-way blend of national and regional growth rates and the ACPT) for agreement periods beginning on January 1, 2024, and in subsequent years, applies a cap on prospective HCC risk score growth in an ACO's regional service area between BY3 and the performance year in calculating the regional component of the three-way blended benchmark update (refer to Sections 4.1.4 and 3.2.5).

  The resulting benchmark is referred to as the updated historical benchmark.

Adjusted Historical Benchmark: An ACO's historical benchmark is adjusted annually to account for certain changes during the ACO's agreement period, as described in Section 4.1.3. If there are no changes, the benchmark will not be adjusted.

Rebased Historical Benchmark: An ACO's benchmark is reset at the start of a new agreement period. Refer to Section 4.1.5.

[92] Refer to §§ 425.601(a)(9) and 425.652(a)(9) (describing certain adjustments to the ACO's historical benchmark during the term of the agreement period). See also § 425.212 (specifying an ACO is subject to all regulatory changes that become effective during the agreement period, with several exceptions).

4.1 CALCULATING HISTORICAL BENCHMARKS

As specified in § 425.650, the methodology by which CMS establishes, adjusts, updates and resets an ACO's historical benchmark is described within 42 CFR part 425, subpart G. The benchmarking methodology for agreement periods beginning on or after July 1, 2019, and before January 1, 2024, is specified in § 425.601 and § 425.659. The benchmarking methodology for agreement periods beginning on January 1, 2024, is specified in §§ 425.652 through 425.660. The benchmarking methodology for agreement periods beginning on or after January 1, 2025, is specified in §§ 425.652 through 425.662. The historical benchmark calculation involves historical expenditures for the ACO's assigned beneficiaries as well as expenditures CMS calculates for assignable FFS beneficiaries in the ACO's regional service area.

4.1.1 DETERMINING REGIONAL FFS EXPENDITURES

To determine an ACO's regional FFS expenditures used in benchmark calculations CMS does the following steps (as applicable, refer to § 425.601(c) and (d) for agreement periods beginning on or after July 1, 2019, and before January 1, 2024; or § 425.654 for agreement periods beginning on January 1, 2024, and in subsequent years).

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

According to § 425.20, "assignable beneficiary" means a Medicare FFS beneficiary who receives at least one primary care service with a date of service during a specified 12-month or 24-month assignment window from a Medicare-enrolled physician who is a primary care physician[93] or who has one of the specialty designations included in § 425.402(c).[94] According to § 425.404(b), for performance years starting on January 1, 2019, and subsequent performance years, under the assignment methodology in § 425.402, CMS treats a service reported on an FQHC or RHC claim as a primary care service performed by a primary care physician.

For agreement periods beginning on or after July 1, 2019, and before January 1, 2024: The assignable beneficiary population will be identified consistently, regardless of an ACO's choice of beneficiary assignment methodology, using the assignment window for the 12-month calendar year corresponding to the relevant benchmark or performance year.[95]

For agreement periods beginning on January 1, 2024, for PY 2024: The assignable beneficiary population is identified for the relevant benchmark or performance year using the assignment window that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).[96]

For agreement periods beginning on January 1, 2025, for PY 2025: The assignable beneficiary population is identified for the relevant benchmark or performance year using the expanded

[93] As defined in § 425.20, for PY 2019 and subsequent years, the definition of primary care physician means a physician who has a primary care specialty designation of internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine.
[94] Refer to Appendix C, Table 11 for a list of physician specialty codes used in assignment.
[95] Refer to § 425.601(c)(1)(i).
[96] Refer to § 425.654(a)(1)(i).

window for assignment that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).[97]

Some beneficiaries who meet the definition of "assignable beneficiary" will ultimately be excluded from assignment to an ACO because they fail to meet the assignment criteria specified under § 425.401(a). [98]

CMS calculates county FFS expenditures in the same way that is used to calculate ACO expenditures in order to assure parity with the calculation of ACO benchmark and performance year expenditures, including removing all Medicare Parts A and B fee-for-service payment amounts on claims for specified payment types associated with a HCPCS or CPT code identified to be significant, anomalous, and highly suspect billing activity for a calendar year in accordance with §§ 425.670 or 425.672, as applicable.[99] Refer to Section 3.1 for descriptions of the methodology used for calculating beneficiary expenditures, annualizing expenditures, truncating expenditures, and weighting expenditures by Medicare enrollment type.

CMS makes separate expenditure calculations for populations of assignable beneficiaries for each Medicare enrollment type used in the Shared Savings Program: ESRD, disabled, aged/dual eligible, aged/non-dual eligible.[100] CMS calculates assignable beneficiary expenditures using the same approach to calculating beneficiary expenditures as described in Section 3.1.1, Step 1.[101]

For each assignable beneficiary in a county, CMS computes annualized, truncated[102] FFS expenditures for each enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). CMS then calculates average per capita county-level FFS expenditures for each Medicare enrollment type by weighting truncated annualized expenditures for each assignable beneficiary in the county by the person years the beneficiary is enrolled in that enrollment type (refer to Section 3.1.1, Step 2), summing these weighted expenditures across all assignable beneficiaries in the county, removing expenditures related to SAHS billing codes, and then dividing by total person years for that enrollment type among assignable beneficiaries in the county.[103]

CMS adjusts average per capita county-level FFS expenditures for severity and case mix of assignable beneficiaries in the county using HCC prospective risk scores and makes this calculation for populations of beneficiaries for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible).[104] CMS determines the renormalized, HCC prospective risk score for each assignable beneficiary and computes weighted average HCC prospective risk scores for each county for each Medicare enrollment type, by multiplying each assignable beneficiary's risk score for that enrollment type by the beneficiary's person years enrolled in that enrollment type, summing these weighted risk scores across all assignable beneficiaries in the county, and then dividing by total person years for that enrollment type

[97] Refer to § 425.654(a)(1)(i).
[98] Refer to 81 FR 37961.
[99] Refer to 81 FR 37985.
[100] Refer to §§ 425.601(c)(1)(ii) and 425.654(a)(1)(ii).
[101] Refer to §§ 425.601(c)(2) and 425.654(a)(2).
[102] Refer to §§ 425.601(c)(3) and 425.654(a)(3).
[103] Refer to §§ 425.601(c)(1) and 425.654(a)(1).
[104] Refer to §§ 425.601(c)(4) and 425.654(a)(4).

among assignable beneficiaries in the county. Refer to Section 3.2.1 for a description of the approach for determining beneficiary HCC prospective risk scores.

When calculating assignable beneficiary annualized, truncated expenditures, prospective HCC risk scores, and Medicare enrollment type eligibility fractions, CMS only considers months in which the beneficiary is enrolled in both Part A and Part B and is not enrolled in a Medicare health plan.[105] For example, if a beneficiary with disabled status is enrolled in both Part A and Part B and not enrolled in a Medicare health plan for the first 6 months of the year but is enrolled in a Medicare health plan for the second 6 months of the year, his or her disability eligibility fraction would be equal to 0.5 (6/12) and his or her annualized, truncated expenditures and HCC risk score would be computed based only on the first 6 months of the year.

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 divides average per capita county-level FFS expenditures by the county average renormalized HCC risk score to obtain risk-adjusted county expenditures.

Note that county-level expenditure and risk score data are publicly released by CMS annually on the Data.CMS.gov website.

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

The ACO's regional service area is defined in the Shared Savings Program's regulations as all counties in which one or more beneficiaries assigned to the ACO reside (§ 425.20). CMS determines the ACO's regional service area using beneficiary assignment for the relevant benchmark or performance year.

Note that 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 on the Data.CMS.gov website.

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

CMS weights the risk-adjusted county-level FFS expenditures determined in Step 1 of this section according to 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). To determine the ACO's proportion of assigned beneficiaries in the county, CMS divides the number of the ACO's assigned beneficiaries in the applicable population (according to Medicare enrollment type) residing in the county by the ACO's total number of assigned beneficiaries in the applicable population (according to Medicare enrollment type) for the relevant benchmark or performance year.[106] In performing this calculation, CMS uses assigned beneficiary person years. CMS then aggregates these values across counties within the ACO's regional service area, for each population of beneficiaries by Medicare enrollment type.[107] This will result

[105] Refer to Table 1 in Section 2.1.
[106] Refer to §§ 425.601(d)(1) and 425.654(b)(1).
[107] Refer to §§ 425.601(d)(2) and 425.654(b)(2).

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.

4.1.2 ESTABLISHING THE HISTORICAL BENCHMARK

As described in this section, CMS uses a step-wise process to establish the ACO's historical benchmark, including to apply the regional adjustment for agreement periods beginning on or after July 1, 2019, and before January 1, 2024.[108] CMS uses the regional adjustment, the prior savings adjustment or no adjustment (as applicable) for agreement periods beginning on January 1, 2024[109]. For agreement periods beginning on January 1, 2025 and subsequent years, CMS uses the regional adjustment, the prior savings adjustment, the health equity benchmark adjustment (HEBA), or no adjustment (as applicable).[110]

Step 1: Calculate annualized, truncated per capita expenditures.

For each ACO, CMS calculates the annualized, truncated per capita expenditures for each of the 3 benchmark years (BY1–BY3) for the ESRD, disabled, aged/dual eligible and aged/non-dual eligible populations.

Step 2: Calculate trend factor using a blend of national and regional growth rates.

CMS trends forward expenditures for each benchmark year (BY1 and BY2) to BY3 dollars using a blend of national and regional growth rates (referred to hereafter as the "national-regional blend," and may also be referred to as a "two-way blend").[111] To trend forward the benchmark, CMS makes separate calculations for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).[112] The national-regional blend is a weighted average of national FFS and regional growth rates.[113]

The national growth rates are computed using OACT national Medicare expenditure data for each of the years making up the historical benchmark for assignable beneficiaries identified for the 12-month calendar year corresponding to each benchmark year.[114] CMS identifies national assignable FFS expenditures by ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations and calculates a separate growth rate for each Medicare enrollment type. The growth rates are the ratio of national assignable FFS per capita expenditures for BY3 to national assignable FFS per capita expenditures from each prior benchmark year (BY1 and BY2). Expenditures for each year include a 3-month claims run-out period. A claims completion factor of 1.013 is applied to expenditures.

The regional component of the national-regional blend is an average growth rate in Parts A and B FFS expenditures for assignable beneficiaries for each Medicare enrollment type, including the ACO's assigned beneficiaries, based on the ACO's regional service area. CMS determines the counties included in the ACO's regional service area based on the ACO's assigned beneficiary population for the relevant benchmark year. CMS calculates the ACO's regional

[108] Refer to § 425.601(a) and (f).
[109] Refer to §§ 425.652(a), 425.656, 425.658, and 425.659.
[110] Refer to §§ 425.652(a), 425.656, 425.658, 425.659, and 425.662.
[111] Refer to §§ 425.601(a)(5) and 425.652(a)(5).
[112] Refer to §§ 425.601(a)(5)(i) and 425.652(a)(5)(i).
[113] Refer to §§ 425.601(a)(5)(iv) and 425.652(a)(5)(iv).
[114] Refer to §§ 425.601(a)(5)(ii) and 425.652(a)(5)(ii).

expenditures for each year (refer to Section 4.1.1) and then calculates the growth rates.[115] The regional trend factors reflect changes in expenditures within given counties over time, as well as shifts in the geographic distribution of an ACO's assigned beneficiary population.

The weight assigned to the national component of the national-regional blend for a given Medicare enrollment type represents the share of assignable beneficiaries in the ACO's regional service area for BY3 that are assigned to the ACO in BY3 for that Medicare enrollment type, calculated by taking a weighted average of county-level shares as specified in § 425.601(a)(5)(v) and § 425.652(a)(5)(v) (as applicable).[116] To calculate this share, CMS first calculates the county-level share of assignable beneficiaries who are assigned to the ACO for each county in the ACO's regional service area for that Medicare enrollment type.[117] CMS then weights the county-level shares according to the ACO's proportion of assigned beneficiaries in the county, determined by the number of the ACO's assigned beneficiaries residing in the county in relation to the ACO's total number of assigned beneficiaries for that Medicare enrollment type. CMS then sums these weighted county-level shares for all counties in the ACO's regional service area for each Medicare enrollment type.

The weight assigned to the regional component of the national-regional blend is equal to one minus the weight applied to the national component for each Medicare enrollment type.[118] That is, as an ACO's penetration in its region increases, a higher weight is placed on the national component of the national-regional blend and a lower weight on the regional component.

The national and regional growth rates are blended together by taking a weighted average of the two.[119] Specifically, for each Medicare enrollment type, the national-regional blended growth rate is equal to the sum of the following: (1) the growth rate for national assignable FFS expenditures for BY3 to the benchmark year (BY1 or BY2) multiplied by the weight assigned to the national component, and (2) the average growth rate for regional FFS expenditures based on the ACO's regional service area multiplied by the weight assigned to the regional component.

[115] Refer to §§ 425.601(a)(5)(iii) and 425.652(a)(5)(iii).
[116] Refer to §§ 425.601(a)(5)(iv)(A) and 425.652(a)(5)(iv)(A).
[117] For ACOs in agreements periods beginning on January 1, 2025, for PY 2025—the assignable population of beneficiaries is identified for BY3 using the expanded window for assignment that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).
[118] Refer to §§ 425.601(a)(5)(iv)(B) and 425.652(a)(5)(iv)(B).
[119] Refer to §§ 425.601(a)(5)(iv) and 425.652(a)(5)(iv).

Example: Calculating the National-Regional Blend Trend Factor by Medicare Enrollment Type

Assume an ACO has 11,000 assigned aged/dual eligible beneficiaries in BY3 and the ACO's regional service area consists of two counties: County A and County B.

Calculate expenditure growth rates for each BY.

National assignable FFS per capita expenditures for aged/dual eligible beneficiaries, with growth rate (ratio of BY3 to BYx):

BY1 (2021): $19,479; growth rate = 1.171
BY2 (2022): $20,765; growth rate = 1.099
BY3 (2023): $22,818; growth rate = 1.000

Regional FFS expenditures for aged/dual eligible beneficiaries in the ACO's regional service area, with growth rate (ratio of BY3 to BYx):

BY1 (2021): $12,000; growth rate = 1.083
BY2 (2022): $12,500; growth rate = 1.040
BY3 (2023): $13,000; growth rate = 1.000

Calculate weights assigned to the national and regional components for BY3.

County A:

- 10,000 assignable aged/dual eligible beneficiaries in BY3
- 9,000 assigned aged/dual eligible beneficiaries to the ACO in BY3

County B:

- 12,000 assignable aged/dual eligible beneficiaries in BY3
- 2,000 assigned aged/dual eligible beneficiaries to the ACO in BY3

Weight of national component for aged/dual eligible enrollment type:

$$\left[\left(\frac{Assigned\ Beneficiaries\ in\ County\ A}{Assignable\ Beneficiaries\ in\ County\ A}\right) \times \left(\frac{Assigned\ Beneficiaries\ in\ County\ A}{Total\ Assigned\ Beneficiaries}\right)\right] +$$
$$\left[\left(\frac{Assigned\ Beneficiaries\ in\ County\ B}{Assignable\ Beneficiaries\ in\ County\ B}\right) \times \left(\frac{Assigned\ Beneficiaries\ in\ County\ B}{Total\ Assigned\ Beneficiaries}\right)\right]$$
$$\left[\left(\frac{9{,}000}{10{,}000}\right) \times \left(\frac{9{,}000}{11{,}000}\right)\right] + \left[\left(\frac{2{,}000}{12{,}000}\right) \times \left(\frac{2{,}000}{11{,}000}\right)\right] = 0.767, or\ 76.7\%$$

Weight of the regional component for aged/dual eligible Medicare enrollment type:

$$1 - weight\ of\ national\ component$$
$$1 - 0.767 = 0.233, or\ 23.3\%$$

Calculate national-regional blended trend factor for aged/dual eligible Medicare enrollment type for BY1.

$$[(BY1\ growth\ rate\ national\ assignable\ FFS\ expenditures) \times (BY3\ national\ component\ weight)] +$$
$$[(BY1\ growth\ rate\ regional\ FFS\ expenditures) \times (BY3\ regional\ component\ weight)]$$

BY1 national-regional blended trend factor for aged/dual eligible Medicare enrollment type:

$$[(1.171) \times (0.767)] + [(1.083) \times (0.233)] = 1.150$$

Step 3: Risk adjust and trend benchmark year expenditures.

CMS risk-adjusts the benchmark year expenditures using the renormalized prospective HCC risk scores for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible assigned populations for each ACO (refer to Sections 3.2.1 and 3.2.3). CMS determines the risk ratios of the ACO's BY3 risk score divided by the ACO's risk score for each benchmark year (BY1 and BY2) for each Medicare enrollment type. For example, the risk ratio applied to an ACO's BY1 aged/dual eligible expenditures is equal to the ACO's BY3 aged/dual eligible risk score divided by the ACO's BY1 aged/dual eligible risk score.

CMS calculates the product of annualized, truncated per capita expenditures (Step 1 above), blended national-regional trend factor (Step 2 above), and risk ratio (Step 3 above), for each benchmark year, and for each Medicare enrollment type.

Step 4: Apply benchmark year weights.

CMS applies the benchmark year weights to the trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations. In an ACO's first agreement period, CMS weights BY1 at 10 percent, BY2 at 30 percent, and BY3 at 60 percent.[120] Benchmark years are weighted equally for ACOs receiving a rebased historical benchmark; refer to Section 4.1.5. CMS sums these weighted amounts by Medicare enrollment type, across the benchmark years to obtain a single dollar value for each Medicare enrollment type. The trended, risk-adjusted and weighted expenditure amounts for each Medicare enrollment type are used in calculating the regional adjustment as described in Step 5 below.

Step 5: Calculate the regional adjustment.

CMS calculates an adjustment to historical benchmark expenditures, by Medicare enrollment type, that is equal to a percentage of the difference between the average per capita expenditure amount for the ACO's regional service area for BY3 and the ACO's historical benchmark amount (referred to hereafter as the "regional adjustment").[121] The percentage that is applied in calculating the regional adjustment depends on whether the ACO has lower or higher spending compared to the ACO's regional service area and the agreement period subject to the regional adjustment (refer to Table 6).[122]

a. To calculate the regional adjustment for ACOs in agreement periods beginning on or after July 1, 2019, and before January 1, 2024, CMS does the following for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible):[123]

   (1) CMS calculates an average per capita amount of expenditures for the ACO's regional service area for BY3. CMS determines the counties included in the ACO's regional service area based on the ACO's BY3 assigned beneficiary population. CMS determines the ACO's regional expenditures for BY3 as calculated in Section 4.1.1.

   (2) CMS adjusts for differences in severity and case mix between the ACO's assigned beneficiary population and the assignable beneficiary population for the ACO's regional

[120] Refer to §§ 425.601(a)(7) and 425.652(a)(7).
[121] Refer to § 425.601(a)(8); §§ 425.652(a)(8) and 425.656.
[122] Refer to § 425.601(e)(2)(ii) and (f); § 425.656(e) and (f).
[123] Refer to § 425.601(a)(8).

service area identified for the 12-month calendar year that corresponds to BY3.[124] For each enrollment type, CMS multiplies the average per capita amount of expenditures for the ACO's regional service area for BY3 by the ACO's BY3 HCC risk score.

(3) From the risk-adjusted average per capita expenditure amount for the ACO's regional service area calculated in the previous step, CMS subtracts the average per capita amount of the ACO's historical benchmark (as described in Step 4, above).[125]

(4) CMS multiplies the difference for each Medicare enrollment type by the applicable regional adjustment weight to obtain the regional adjustment for each Medicare enrollment type.[126]

(5) CMS caps the resulting per capita dollar amount for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) at a dollar amount equal to 5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3. This cap on per capita dollar amount applies for assignable beneficiaries in that Medicare enrollment type identified for the 12-month calendar year corresponding to BY3 using data from OACT.[127]

(i) For positive adjustments, the per capita dollar amount for a Medicare enrollment type is capped at 5 percent of the national per capita expenditure amount for the enrollment type for BY3.[128]

(ii) For negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at negative 5 percent of the national per capita expenditure amount for the enrollment type for BY3.[129]

(6) CMS adds the capped regional adjustment amount for the Medicare enrollment type, which may be positive or negative, to the truncated, trended, and risk-adjusted average per capita value of the ACO's historical benchmark for the same Medicare enrollment type (as determined in Step 4 above).

b. To calculate the regional adjustment for ACOs in an agreement period beginning on January 1, 2024, and in subsequent years, CMS does the following for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible):[130]

(1) CMS calculates an average per capita amount of expenditures for the ACO's regional service area for BY3. CMS determines the counties included in the ACO's regional service area based on the ACO's BY3 assigned beneficiary population. CMS determines the ACO's regional expenditures for BY3 as calculated in Section 4.1.1.

[124] For additional explanation of the impact of accounting for differences in health status between the ACO's population and the ACO's regional service area in calculating the regional adjustment, refer to the discussion in the June 2016 Final Rule, 81 FR 37966.
[125] Refer to § 425.601(a)(8)(ii)(A).
[126] Refer to § 425.601(a)(8)(ii)(B).
[127] Refer to § 425.601(a)(8)(ii)(C).
[128] Refer to § 425.601(a)(8)(ii)(C)(*1*).
[129] Refer to § 425.601(a)(8)(ii)(C)(*2*).
[130] Refer to § 425.656.

(2) CMS adjusts for differences in severity and case mix between the ACO's assigned beneficiary population and the assignable population of beneficiaries for the ACO's regional service area. For PY 2024, the assignable population of beneficiaries is identified for BY3 using the assignment window that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).[131] For each enrollment type, CMS multiplies the average per capita amount of expenditures for the ACO's regional service area for BY3 by the ACO's BY3 prospective HCC risk score.

(3) From the risk-adjusted average per capita expenditure amount for the ACO's regional service area calculated in the previous step, CMS subtracts the average per capita amount of the ACO's historical benchmark (as described in Step 4 above).[132]

(4) CMS multiplies the difference for each Medicare enrollment type by the applicable regional adjustment weight to obtain the regional adjustment for each Medicare enrollment type.[133]

(5) CMS caps the resulting per capita dollar amount for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) at a dollar amount equal to a percentage of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3 for assignable beneficiaries in that Medicare enrollment type identified for the 12-month calendar year corresponding to BY3 using data from OACT.[134]

   a. For positive adjustments, the per capita dollar amount for a Medicare enrollment type is capped at 5 percent of the national per capita expenditure amount for the enrollment type for BY3.

   b. For negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at −1.5 percent of the national per capita expenditure amount for the enrollment type for BY3.

(6) CMS then applies an offset factor (if applicable) that gradually decreases the negative regional adjustment amount as an ACO's proportion of dual eligible Medicare and Medicaid beneficiaries increases or its weighted average prospective HCC risk score increases.[135] The offset factor is based on [A] the ACO's overall proportion of BY3 assigned beneficiaries who are dual eligible for Medicare and Medicaid (including dual eligible ESRD, disabled, and aged beneficiaries) and [B] the ACO's weighted average prospective HCC risk score for BY3 taken across the four Medicare enrollment types. When calculating the weighted average prospective HCC risk score, the weight applied to the prospective HCC risk score for BY3 for each Medicare enrollment type is equal to the product of the BY3 per capita expenditures for that enrollment type and the BY3 person years for that enrollment type divided by total BY3 expenditures. Before taking this weighted average, the risk score for each enrollment type will be renormalized by

[131] Refer to § 425.656(b)(3).
[132] Refer to § 425.656(c)(1).
[133] Refer to § 425.656(c)(2).
[134] Refer to § 425.656(c)(3).
[135] Refer to § 425.656(c)(4); see also 87 FR 69915–69923.

dividing by the national mean risk score for the assignable FFS population for that enrollment type identified for the calendar year corresponding to BY3.

(7) The offset factor is calculated as [A] + ([B] − 1) and is subject to a minimum value of zero and maximum value of one.

(8) We apply the offset factor by subtracting its value from 1 and multiplying this difference by the negative regional adjustment for each Medicare enrollment type, calculated as:

a. Final regional adjustment = Negative regional adjustment × (1 − offset factor)

(9) CMS expresses the regional adjustment as a single value by taking a person-year weighted average of the Medicare enrollment type-specific regional adjustment values determined in Step 5.b.(4)–(6) above. CMS uses the regional adjustment expressed as a single value for purposes of determining the adjustment, if any, that will be applied to the benchmark under Step 7.[136]

(10) For ACOs with a negative regional adjustment, expressed as a single per capita value, after the application of the cap (described in Step 5.ii.e) and the offset factor, CMS will not apply a regional adjustment.[137] This ACO may still be eligible to receive a prior savings adjustment discussed in Step 6 below.

To determine whether the ACO has lower or higher spending compared to the ACO's regional service area, CMS does the following:[138]

- As described previously, CMS determines the difference between the risk-adjusted average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's historical benchmark for each population of beneficiaries by Medicare enrollment type. CMS multiplies the difference for each Medicare enrollment type by the applicable proportion of the ACO's assigned beneficiary population for each Medicare enrollment type for BY3 of the historical benchmark.
- CMS sums the amounts of these weighted differences across the four Medicare enrollment types.
- If the resulting sum is a net positive value, the ACO is considered to have lower spending compared to the ACO's regional service area. If the resulting sum is a net negative value, the ACO is considered to have higher spending compared to the ACO's regional service area.

Table 6 shows the phase-in of weights used in calculating the regional adjustment. For example, if an ACO is considered to have lower spending compared to the ACO's regional service area, and it is the ACO's first agreement period subject to the regional adjustment, CMS uses a weight of 35 percent when applying the regional adjustment. If an ACO is considered to have higher spending compared to the ACO's regional service area, and it is the ACO's first agreement period subject to the regional adjustment, then CMS uses a weight of 15 percent when applying the regional adjustment.

[136] Refer to § 425.656(d).
[137] Refer to § 425.652(a)(8).
[138] Refer to §§ 425.601(f)(5) and 425.656(e)(5).

Table 6. Percentage weight applied in calculating the regional adjustment

AGREEMENT PERIOD WHEN ACO IS SUBJECT TO REGIONAL ADJUSTMENT	WEIGHT USED TO CALCULATE REGIONAL ADJUSTMENT FOR ACOS THAT ARE LOWER SPENDING COMPARED TO THEIR REGION	WEIGHT USED TO CALCULATE REGIONAL ADJUSTMENT FOR ACOS THAT ARE HIGHER SPENDING COMPARED TO THEIR REGION
First	35%	15%
Second	50%	25%
Third	50%	35%
Fourth and subsequent	50%	50%

NOTE: Refer to § 425.601(e)(2)(ii) and (f), and § 425.656(e) and (f). Refer to the December 2018 Final Rule (83 FR 67908–67909) Table 6 for examples of phase-in of regional adjustment weights based on agreement start date and applicant type.

Step 6: Calculate the prior savings adjustment.

For agreement periods beginning on January 1, 2024, and in subsequent years, CMS calculates an adjustment to the historical benchmark to account for savings generated in the 3 years prior to the start of an ACO's current agreement period for renewing or re-entering ACOs that were reconciled for one or more performance years in the Shared Savings Program during this period.[139] To calculate the prior savings adjustment, CMS does the following:[140]

a. Calculate total per capita savings or losses in each performance year that constitutes a benchmark year for the current agreement period.[141] For each performance year we determine an average per capita amount reflecting the quotient of the ACO's total updated benchmark expenditures minus total performance year expenditures divided by performance year assigned beneficiary person years. CMS applies the following requirements in determining the amount of per capita savings or losses for each performance year:[142]

   (1) The per capita savings or losses will be set to zero for a performance year if the ACO was not reconciled for the performance year.

   (2) If an ACO generated savings for a performance year but was not eligible to receive a shared savings payment for that year due to noncompliance with Shared Savings Program requirements, the per capita savings for that year will be set to zero.

   (3) For a new ACO that is identified as a re-entering ACO, per capita savings or losses will be determined based on the per capita savings or losses of the ACO in which the majority of the ACO participants in the re-entering ACO were participating.

b. Calculate an average per capita amount of savings by taking a simple average of the values for each of the 3 performance years as determined in Step 6.a, including values of zero, if

[139] Refer to § 425.658(a).
[140] Refer to § 425.658; see also 88 FR 79192, and 88 FR 79195–79196.
[141] Refer to § 425.658(b)(1).
[142] Refer to § 425.658(b)(1)(i)–(iii).

applicable.[143] We will use the average per capita amount of savings to determine the ACO's eligibility for the prior savings adjustment as follows:[144]

(1) If the average per capita value is less than or equal to zero, the ACO is not eligible to receive a prior savings adjustment.

(2) If the average per capita value is positive, the ACO is eligible for a prior savings adjustment. We will apply a proration factor (described in Step 6.c below) to account for any upward growth in the ACO's assigned population in the benchmark years of the ACO's current agreement period as compared to the size of the assigned population when the ACO was reconciled for the corresponding performance years in its prior agreement period.

c. Apply a proration factor to the per capita savings calculated in Step 6.b, for an ACO eligible for a prior savings adjustment, to account for changes in assigned beneficiary population size. The proration factor is equal to the ratio of the average person years for the 3 performance years that immediately preceded the start of the ACO's current agreement period (regardless of whether these 3 performance years fall in one or more prior agreement periods), and the average person years in benchmark years for the ACO's current agreement period, capped at 1.

   If the ACO was not reconciled for 1 or more of the 3 years preceding the start of the ACO's current agreement period, the person years from that year (or years) will be excluded from the averages in the numerator and the denominator of this ratio.

   For a new ACO that is identified as a re-entering ACO, the person years of the ACO in which the majority of the ACO participants of the re-entering ACO were participating will be used in the numerator of the calculation.

   This ratio will be redetermined for each performance year during the agreement period in the event of any changes to the number of average person years in the benchmark years as a result of changes to the ACO's certified ACO Participant List, a change to the ACO's beneficiary assignment methodology selection, or changes to the beneficiary assignment methodology.[145] (Refer to Section 4.1.3.)

   To apply the proration factor, CMS multiplies the average per capita savings (Step 6.b) by the proration factor.

d. Calculate the per capita prior savings adjustment. If an ACO is eligible for the prior savings adjustment, the prior savings adjustment will equal the lesser of the following:[146]

   (1) 50 percent of the pro-rated average per capita amount from Step 6.c.

   (2) 5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3 for assignable beneficiaries identified for the 12-month calendar year corresponding to BY3 using data from OACT and expressed as a

[143] Refer to § 425.658(b)(2).
[144] Refer to § 425.658(b)(3).
[145] Refer to § 425.652(a)(9)(iv).
[146] Refer to § 425.658(c).

single value by taking a person-year weighted average of the Medicare enrollment type-specific values.

e. Recalculation of the prior savings adjustment during an agreement period.[147] The ACO's prior savings adjustment is recalculated for changes to the ACO's savings or losses for a performance year used in the prior savings adjustment calculation in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315.

For a new ACO identified as a re-entering ACO, the prior savings adjustment is recalculated for changes to savings or losses for a performance year used in the prior savings adjustment calculation, if the savings or losses of the ACO in which the majority of the new ACO's participants were participating change in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315.

Step 7: Calculate the health equity benchmark adjustment.

For agreement periods beginning on January 1, 2025, and in subsequent years, CMS calculates an adjustment to the historical benchmark to account for ACOs serving higher proportions of beneficiaries enrolled in the Medicare Part D low income subsidy or dually eligible for Medicare and Medicaid.. To calculate the health equity benchmark adjustment, CMS does all of the following:[148]

a. Calculates the weighted average of the ACO's third benchmark year (BY3) national per capita expenditure amounts across the following populations of beneficiaries, where the weights are the ACO's BY3 proportion of assigned beneficiaries for that enrollment type:

(1) ESRD.

(2) Disabled.

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

(4) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

b. Calculates the health equity benchmark adjustment scaler which is equal to the difference of the following:[149]

(1) 5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3 for assignable beneficiaries identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary, expressed as a single value by taking a person year weighted average of the Medicare enrollment type-specific values: ESRD, disabled, aged/dually eligible for Medicare and Medicaid, and aged/non-dually eligible for Medicare and Medicaid, and

(2) the higher of the regional adjustment expressed as a single value (refer to Step 5.a.(7)), the prior savings adjustment (refer to Step 6), or no adjustment in the case

[147] Refer to § 425.658(e) and Section 4.1.3.
[148] Refer to § 425.662; see also 89 FR 98155–98167.
[149] Refer to § 425.662(b)(2).

where the regional adjustment is negative, and the ACO is not eligible for the prior savings adjustment.

c. Determines the ACO's eligibility for the HEBA based on the proportion of the ACO's assigned beneficiaries for the performance year who are enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid. An ACO is only eligible for the HEBA if this proportion is greater than or equal to 15 percent. An ACO with a proportion less than 15 percent is ineligible to receive a HEBA.

d. For ACOs that are eligible, the health equity benchmark adjustment amount is equal to the product of the HEBA scaler and the proportion of the ACO's assigned beneficiaries for the performance year who are enrolled in the Medicare Part D LIS or dually eligible for Medicare and Medicaid.[150]

Step 8: Apply the regional adjustment, prior savings adjustment, or health equity benchmark adjustment to the benchmark, as applicable.

For agreement periods beginning on January 1, 2024, CMS determines which adjustment, if any, is applied to the benchmark: the regional adjustment (refer to Step 5.b), the prior savings adjustment (refer to Step 6), or no adjustment. CMS does all of the following to determine the adjustment, if any, to apply to the historical benchmark:[151]

- If an ACO is not eligible to receive a prior savings adjustment under Step 6.b.(1), and the regional adjustment (expressed as a single value as described in Step 5.a.(7)) is positive, the ACO will receive an adjustment to its benchmark equal to the positive regional adjustment amount. The adjustment will be calculated as described in Step 5.b.(1)–(6), and applied separately by Medicare enrollment type.[152]
- If an ACO is not eligible to receive a prior savings adjustment under Step 6.b.(1), and the regional adjustment (expressed as a single value as described in Step 5.a.(7)) is negative or zero, the ACO will not receive an adjustment to its benchmark.[153]
- If an ACO is eligible to receive a prior savings adjustment under Step 6.b.(2) and the regional adjustment (expressed as a single value as described in Step 5.a.(7)) is positive, the ACO will receive an adjustment to its benchmark equal to the higher of the following:[154]

  (A) The positive regional adjustment amount. The adjustment will be calculated as described in Step 5.b.(1)–(6), and applied separately by Medicare enrollment type.

  (B) The prior savings adjustment. The adjustment will be calculated as described in Step 6 and applied as a flat dollar amount to each Medicare enrollment type.
- If an ACO is eligible to receive a prior savings adjustment under Step 6.b.(2) and the regional adjustment, expressed as a single value as described in Step 5.b.(7), is negative or zero, the ACO will receive an adjustment to its benchmark equal to the prior savings

[150] Refer to § 425.662(b)(4).
[151] Refer to § 425.652(a)(8)(i).
[152] Refer to § 425.652(a)(8)(i)(B).
[153] Refer to § 425.652(a)(8)(i)(C).
[154] Refer to § 425.652(a)(8)(i)(D).

adjustment. The adjustment will be calculated as described in Step 6 and applied as a flat dollar amount to each Medicare enrollment type.[155]

For agreement periods beginning on January 1, 2025, and in subsequent years, CMS compares the regional adjustment, expressed as a single value as described in (refer to Step 5.b), if any, the prior savings adjustment (refer to Step 6), if any, the health equity benchmark adjustment (refer to Step 7), if any, or no adjustment. CMS does all of the following to determine the adjustment, if any, to apply to the historical benchmark:[156]

- The ACO will receive the highest of the positive adjustments for which it is eligible. The adjustment will be calculated as described in Step 5.b.(7), Step 6.b.(2), or Step 7, respectively, and applied separately to the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.[157]
- If an ACO is not eligible to receive a prior savings adjustment under § 425.658(b)(3)(i) or the health equity benchmark adjustment under § 425.662(b)(3), and the regional adjustment, expressed as a single value as described in § 425.656(d), is negative or zero, the ACO will not receive an adjustment to its benchmark.[158]

CMS adds the regional adjustment amount, prior savings adjustment amount, or health equity benchmark adjustment amount (as applicable) for the Medicare enrollment type, to the truncated, trended, and risk-adjusted average per capita value of the ACO's historical benchmark for the same Medicare enrollment type (as determined in Step 4 above).

Step 9: Apply BY3 proportions by Medicare enrollment type and sum expenditures across enrollment types.

CMS multiplies the resulting historical benchmark expenditures for each Medicare enrollment type, calculated under Step 5.a.(6) and Step 8 (as applicable and including any applicable adjustment), by the proportion of assigned beneficiary person years for BY3 for each Medicare enrollment type. This calculation restates BY1 and BY2 trended and risk-adjusted expenditures into BY3 proportions by Medicare enrollment type.[159] CMS sums the resulting expenditures across the Medicare enrollment types to determine a single per capita amount of the ACO's historical benchmark.

4.1.3 ADJUSTING THE HISTORICAL BENCHMARK FOR CERTAIN CHANGES DURING THE AGREEMENT PERIOD

CMS adjusts an ACO's historical benchmark annually—using the relevant methodology described in Section 4.1.2 (as applicable) and based on the same 3 benchmark years—to account for certain changes during the agreement period. The changes resulting in adjustment to the ACO's historical benchmark during the agreement period vary depending on the

[155] Refer to § 425.652(a)(8)(i)(E).
[156] Refer to § 425.652(a)(8)(ii).
[157] Refer to § 425.652(a)(8)(ii)(B)(1).
[158] Refer to § 425.652(a)(8)(ii)(B)(2).
[159] Refer to §§ 425.601(a)(6) and 425.652(a)(6).

benchmarking methodology applicable based on agreement period start date and are described in Table 7.

Table 7. *Changes resulting in adjustment to the ACO's historical benchmark during the agreement period*

CHANGES RESULTING IN ADJUSTMENT TO THE ACO'S HISTORICAL BENCHMARK DURING THE AGREEMENT PERIOD (REFER TO § 425.601(A)(9) AND § 425.652(A)(9).)	ADJUSTMENT APPLIED FOR ACOS IN AGREEMENT PERIODS BEGINNING ON OR AFTER JULY 1, 2019, AND BEFORE JANUARY 1, 2024?	ADJUSTMENT APPLIED FOR ACOS IN AGREEMENT PERIODS BEGINNING ON JANUARY 1, 2024, AND IN SUBSEQUENT YEARS?
For the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b) (refer to Section 2.3.1).	Yes, adjustment applied for the second and each subsequent performance year.	Yes, adjustment applied for the second and each subsequent performance year.
For a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1).	Yes, adjustment applied for the second and each subsequent performance year.	Yes, adjustment applied for the second and each subsequent performance year.
For a change to the beneficiary assignment methodology specified in 42 CFR part 425, subpart E.	Yes, adjustment applied for the second and each subsequent performance year.	Yes, adjustment applied for the second and each subsequent performance year.
For a change in the HCC risk adjustment methodology used to calculate prospective HCC risk scores under § 425.659.	N/A	Yes, adjustment applied for the second and each subsequent performance year.
For changes in values used in benchmark calculations in accordance with § 425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under § 425.315.[160]	N/A	Yes, adjustment applied for the first performance year, and the second and each subsequent performance year.
For changes in values used in benchmark calculations as a result of the performance year being affected by significant, anomalous, and highly suspect billing under § 425.672	Yes, adjustment applied for the second and each subsequent performance year.	Yes, adjustment applied for the first performance year, and the second and each subsequent performance year.

[160] With respect to the prior savings adjustment calculation, refer to § 425.658(e) and Section 4.1.2, Step 6. See also discussion of calculation of the prior savings adjustment in the CY 2024 PFS Final Rule, 88 FR 79195–79200.

To adjust the benchmark, CMS does the following (as applicable):

- CMS takes into account the expenditures of beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period.[161]
- CMS redetermines risk-adjusted, regional expenditures used in factors based on regional FFS expenditures, as a result of redetermining the ACO's regional service area and proportion of assigned beneficiaries in each county in the ACO's regional service area by Medicare enrollment type.
    - CMS redetermines the regional component of the trend factors based on a national-regional blend, and recomputes the weight that would be applied to the national and regional components of the blended trend factors, described in Section 4.1.2, Step 2.[162]
    - CMS redetermines the regional adjustment amount described in Section 4.1.1 and Section 4.1.2, Step 5.
        - CMS redetermines the regional adjustment amount according to the ACO's assigned beneficiaries for BY3.[163] For ACOs in an agreement period beginning on January 1, 2024, for PY 2024, the regional adjustment is calculated based on the assignable population of beneficiaries identified for BY3 using the assignment window that is consistent with the beneficiary assignment methodology selected by the ACO for the performance year according to § 425.400(a)(4)(ii).
        - For ACOs in an agreement period beginning on January 1, 2024, and in subsequent years, CMS redetermines the offset factor used in determining the negative regional adjustment amount under § 425.656(c)(4) and (5). [164]
        - CMS redetermines whether the ACO is considered to have lower spending or higher spending compared to the ACO's regional service area for purposes of determining the percentage used in calculating the regional adjustment.[165]

For ACOs in an agreement period beginning on January 1, 2025, for PY 2025, CMS does the following:

- CMS redetermines the proration factor used in calculating the prior savings adjustment under § 425.658(b)(3)(ii), if applicable, to account for changes in the ACO's assigned beneficiary population in the benchmark years of the ACO's current agreement period due to the addition and removal of ACO participants or ACO providers/suppliers in accordance with § 425.118(b), a change to the ACO's beneficiary assignment methodology selection under § 425.226(a)(1), or changes to the beneficiary assignment methodology under 42 CFR part 425, subpart E.[166]
- In accordance with § 425.652(a)(8), CMS redetermines the adjustment to the historical benchmark based on the redetermined regional adjustment (as specified under § 425.656),

[161] Refer to §§ 425.601(a)(9)(i) and 425.652(a)(9)(i).
[162] Refer to §§ 425.601(a)(5) and 425.652(a)(5).
[163] Refer to §§ 425.601(a)(9)(ii) and 425.652(a)(9)(ii).
[164] Refer to § 425.652(a)(9)(iii).
[165] Refer to §§ 425.601(f)(5)(iv) and 425.656(e)(5)(iv).
[166] Refer to § 425.652(a)(9)(iv)

the prior savings adjustment (as specified under § 425.658), or the health equity benchmark adjustment (as specified under § 425.662).[167]

- CMS recalculates the prior savings adjustment to account for changes in values used in benchmark calculations due to compliance action taken to address avoidance of at-risk beneficiaries, or as a result of the issuance of a revised initial determination of financial performance for a previous performance year following a reopening of ACO shared savings and shared losses calculations.[168]
- CMS redetermines factors based on prospective HCC risk scores calculated for benchmark years by calculating the prospective HCC risk scores using the HCC risk adjustment methodology that applies for the calendar year corresponding to the applicable performance year in accordance with § 425.659(b)(1).[169]

An ACO's historical benchmark may also be adjusted to account for any regulatory changes affecting the benchmarking methodologies that become effective during the agreement period.[170]

4.1.4 RISK ADJUSTING AND UPDATING THE HISTORICAL BENCHMARK

CMS calculates an updated historical benchmark for each performance year during annual financial reconciliation. An ACO's historical benchmark—either the final historical benchmark issued during the ACO's first performance year or the adjusted historical benchmark issued during the ACO's agreement period (as described in Section 4.1.3)—is adjusted and updated at the time of financial reconciliation to reflect certain changes between BY3 and the performance year. Specifically, CMS adjusts the historical benchmark to account for changes in severity and case mix for the ACO's assigned beneficiary population, between BY3 and the performance year[171] and updates the historical benchmark using either a two-way blend of national and regional growth rates or, if applicable, a three-way blend of national and regional growth rates and the ACPT.[172] The updated historical benchmark is used to determine whether an ACO has shared savings or losses for the relevant performance year.

[167] Refer to §§ 425.652(a)(9).
[168] Refer to §§ 425.652(a)(9) and 425.658(e); 88 FR 79195–79200.
[169] Refer to § 425.652(a)(9)(vii).
[170] Refer to § 425.212. Under § 425.212, an ACO is subject to all regulatory changes that become effective during the agreement period, with the exception of the following program areas, unless otherwise required by statute: (1) eligibility requirements concerning the structure and governance of ACOs; and (2) calculation of sharing rate. See discussion in earlier rulemaking, including 80 FR 32730–32732, and 85 FR 84747–84755. Further, the Shared Savings Program's longstanding approach is to implement changes to the assignment methodology on a performance year basis (see 88 FR 79161), and to maintain a consistent benchmarking methodology for the duration of an ACO's agreement period (see 88 FR 79207).
[171] Refer to §§ 425.601(a)(10) and 425.652(a)(10).
[172] Refer to § 425.601(b); §§ 425.652(b) and 425.660.

Step 1: Risk adjust historical benchmark expenditures.

CMS risk-adjusts the adjusted historical benchmark expenditures for each Medicare enrollment type (refer to Section 4.1.2, Step 8) to account for changes in severity and case mix between BY3 and the performance year, for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible), using the applicable method described in Section 3.2.4.

Step 2: Apply benchmark update factor.

CMS multiplies the risk-adjusted historical benchmark expenditures for each Medicare enrollment type (Section 4.1.4, Step 1) by an update factor.

For agreement periods beginning on or after July 1, 2019, and before January 1, 2024, the update factor blends national and regional expenditure growth rates between BY3 and the performance year for each Medicare enrollment type.[173] Refer to the description of the calculation of trend factors based on a national-regional blend described in Section 4.1.2, Step 2. Specifically, for each Medicare enrollment type, the national-regional blended growth rate is equal to the sum of the following: (1) the growth rate for national assignable FFS expenditures for BY3 to the performance year multiplied by the weight assigned to the national component, and (2) the average growth rate for regional FFS expenditures based on the ACO's regional service area multiplied by the weight assigned to the regional component.[174]

The weights used to blend the national and regional components of the two-way blended update factor would be calculated in the same manner as described in Section 4.1.2, Step 2, except the weight applied to the national growth rate is calculated as the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO for the applicable performance year (rather than for BY3). The weight applied to the regional growth rate is equal to 1 minus the weight applied to the national growth rate.[175]

For agreement periods beginning on January 1, 2024, and in subsequent years, the update factor is a three-way blend of national and regional growth rates and the ACPT between BY3 and the performance year.[176] The regional component of the update factor is multiplied by the regional risk score growth cap adjustment factor for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) as calculated in Section 3.2.5. The methodology for calculating the ACPT and three-way blended update factor are described in detail in the Specifications of the ACPT and Three-Way Blended Benchmark Update Factor (hereafter "ACPT Specifications"). As described in the ACPT Specifications, a "guardrail" policy ensures that the use of the three-way blended update factor will not result in lower benchmarks than the two-way national-regional blended update factor in a way that poses higher financial risk for ACOs under two-sided models, or that could jeopardize an ACO's continued participation in the Shared Savings Program under the financial performance monitoring policy described in § 425.316(d), or both.[177]

[173] Refer to § 425.601(b)(1).
[174] Refer to § 425.601(b).
[175] Refer to § 425.601(b)(4).
[176] Refer to §§ 425.652(b) and 425.660.
[177] Refer to 87 FR 69885 and § 425.652(b)(5).

Step 3: Apply PY expenditure proportions by Medicare enrollment type and sum benchmark expenditures across enrollment types.

CMS multiplies the resulting risk-adjusted and updated historical benchmark expenditures for each Medicare enrollment type (Section 4.1.4, Step 2) by the proportion of assigned beneficiary person years for the relevant PY for each Medicare enrollment type. CMS sums the resulting expenditures across the Medicare enrollment types to determine a single per capita amount of the ACO's updated historical benchmark.

4.1.5 RESETTING THE HISTORICAL BENCHMARK

An ACO's benchmark is reset (or rebased) at the start of each subsequent agreement period, based on beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the start of the new agreement period.[178] For second or subsequent agreements periods beginning on July 1, 2019, and in subsequent years, CMS establishes, adjusts, and updates the rebased historical benchmark in accordance with the methodology used to establish the ACO's first agreement period historical benchmark, as specified in § 425.601(a)–(d) (applicable to agreement periods beginning on or after July 1, 2019, and before January 1, 2024) and § 425.652(a)–(c) (applicable to agreement periods beginning on January 1, 2024, and in subsequent years) (refer to Sections 4.1.1–4.1.4) with the following modifications: (1) the weighting of the BYs,[179] and (2) the weight applied to calculate the regional adjustment to the benchmark.[180]

In calculating an ACO's rebased historical benchmark, CMS applies equal weights to the benchmark years' trended, risk-adjusted expenditures for the ESRD, disabled, aged/dual eligible, and aged/non-dual eligible populations (refer to Section 4.1.2, Step 4). That is, each benchmark year is weighted one-third, rather than weighting BY1 at 10 percent, BY2 at 30 percent, and BY3 at 60 percent.[181]

Refer to § 425.601(e)(2)(ii) and (f); § 425.656(e) and (f); and Table 6 for further information on the regional adjustment weights that will be applied. We note that for renewing or re-entering ACOs that previously received a rebased historical benchmark under the benchmarking methodology set forth in § 425.603, we will consider the agreement period the ACO is entering upon renewal or re-entry—in combination with the weight previously applied to calculate the regional adjustment to the ACO's benchmark in the ACO's most recent prior agreement period—to determine the weight that will apply in the new agreement period. For a new ACO identified as a re-entering ACO because greater than 50 percent of its ACO participants have recent prior participation in the same ACO, we will consider the weight most recently applied to calculate the regional adjustment to the benchmark for the ACO in which the majority of the new ACO's participants were participating previously. Refer to December 2018 Final Rule, 83 FR 68024, and CY 2023 PFS Final Rule, 87 FR 69957.

[178] Refer to §§ 425.601(e) and 425.652(c).
[179] Refer to §§ 425.601(e)(2)(i) and 425.652(c)(2).
[180] Refer to § 425.601(e)(2)(ii) and (f); § 425.656(e) and (f).
[181] Refer to §§ 425.601(e)(2)(i) and 425.652(c)(2).

4.2 MINIMUM SAVINGS RATE AND MINIMUM LOSS RATE

The MSR and MLR are thresholds, calculated as a percentage of the ACO's updated historical benchmark. The ACO must meet or exceed this threshold to share in savings or to be liable for shared losses.[182] For agreement periods beginning on January 1, 2024, and in subsequent years, certain low-revenue ACOs participating in the BASIC track may be eligible to share in savings at a reduced sharing rate even if they do not meet or exceed the MSR if certain criteria are met as established under § 425.605(h) and described in Section 4.3, Step 5.[183]

The MSR is designed to provide a level of confidence that Medicare is measuring true cost savings (efficiency) on the part of the ACO rather than paying for normal expenditure fluctuations. "Normal" variation in annual per capita medical care expenditures (claims costs) for an ACO's patient population 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, an MLR is applied to provide sufficient confidence that the losses experienced during a given performance year are not simply the result of normal variation.

4.2.1 MSR: ONE-SIDED MODELS

For ACOs under a one-sided model of the BASIC track's glide path (Level A or Level B), CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO for the performance year to establish the MSR for the ACO.[184] We refer to the resulting MSR as a variable MSR based on the ACO's number of assigned beneficiaries.

Table 8 below shows the MSR as a function of the number of beneficiaries annually assigned to the ACO. Under this approach, ACOs with more assigned beneficiaries have a lower MSR and ACOs with fewer assigned beneficiaries have a higher MSR. For example, the minimum MSR is set at 2 percent for ACOs with 59,999 or more beneficiaries and 3.9 percent for ACOs with 5,000 beneficiaries. MSRs that are in between the stated endpoints are calculated by the equation specified in the example below, which is a weighted average of the stated endpoints in Table 8 below.

[182] Refer to § 425.100(b); § 425.605(a)(6), (b)(3), and (b)(4); § 425.610(a)(7), (b)(2), and (b)(3).
[183] Refer to § 425.605(b)(3), (c)(2), (d)(1) and (h). See also CY 2023 PFS Final Rule, 87 FR 69946–69952.
[184] Refer to § 425.605(b)(1).

Example: Determining MSR for ACOs in a One-Sided Model

- Total assigned beneficiaries: 5,333 beneficiaries
- MSR Low End (5,000): 3.9%
- MSR High End (5,999): 3.6%

$$\frac{MSR_{Low} \times (Upper\ bound - Assigned\ beneficiaries)}{(Upper\ bound - Lower\ bound)} + \frac{MSR_{High} \times (Assigned\ beneficiaries - Lower\ bound)}{(Upper\ bound - Lower\ bound)}$$

$$\frac{3.9\% \times (5{,}999 - 5{,}333)}{(5{,}999 - 5{,}000)} + \frac{3.6\% \times (5{,}333 - 5{,}000)}{(5{,}999 - 5{,}000)} = 3.8\%$$

Table 8. *MSR by number of assigned beneficiaries as specified in § 425.605(b)(1)*

NUMBER OF ASSIGNED BENEFICIARIES	MSR (LOW END OF ASSIGNED BENEFICIARIES)	MSR (HIGH END OF ASSIGNED BENEFICIARIES)
1–499	≥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%

NOTE: To be in compliance with Shared Savings Program requirements, an ACO must have at least 5,000 assigned beneficiaries. Refer to § 425.110. If an ACO's performance year assigned beneficiary population falls below 5,000, CMS will apply a relatively higher MSR, corresponding to the size of the population, as described in this table, and the ACO may be subject to actions described in § 425.216 (actions prior to termination) and § 425.218 (termination of the participation agreement by CMS).

4.2.2 MSR/MLR: TWO-SIDED MODELS

ACOs in a two-sided model (Levels C, D, or E of the BASIC track, or the ENHANCED track) must choose from one of the following options for the MSR/MLR:[185]

1. Zero percent MSR/MLR;

[185] Refer to §§ 425.605(b)(2)(i) and 425.610(b)(1).

2. Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2 percent; or
3. Symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO. The MSR is the same as the MSR that would apply for an ACO under a one-sided model of the BASIC track's glide path (refer to Section 4.2.1). The MLR is equal to the negative MSR.

These MSR/MLR options give ACOs flexibility in setting the threshold they must meet before being eligible to share in savings (except as provided under § 425.605(h)) or being held 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 an 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, it will have a corresponding higher threshold to meet before sharing in savings. ACOs with larger populations will have a relatively lower threshold to meet before being eligible to share in savings or losses.

ACOs participating under Level A or Level B of the BASIC track's glide path must choose the MSR/MLR to be applied before the start of their first performance year in a two-sided model. This selection will occur before the ACO enters Levels C, D, or E of the BASIC track's glide path, depending on whether the ACO is automatically transitioned to a two-sided model (Level C or E) or elects to more quickly transition to a two-sided model within the glide path (Level C, D, or E), and will be in effect for the duration of the agreement period that the ACO is under two-sided risk.[186]

ACOs participating in the ENHANCED track, or an agreement period in Level E of the BASIC track, make their MSR/MLR selection at the time of application for, or renewal of, program participation. The selection will apply for the duration of the ACO's agreement period under a two-sided model.[187]

4.2.3 MODIFYING THE MSR/MLR TO ADDRESS SMALL POPULATION SIZES

An ACO must have at least 5,000 assigned beneficiaries in each of the 3 benchmark years prior to the start of its agreement period and during each performance year of its agreement period, as specified under § 425.110. If at any time during the performance year, an ACO's assigned population falls below 5,000, the ACO may be subject to actions described in § 425.216 (actions prior to termination) and § 425.218 (termination of the participation agreement by CMS). There are circumstances in which CMS will determine financial performance for an ACO with fewer than 5,000 assigned beneficiaries. CMS will use a variable MSR/MLR based on the number of beneficiaries assigned to the ACO (refer to Table 8) in determining financial performance if the assigned beneficiary population for an ACO participating under a two-sided model falls below

[186] Refer to § 425.605(b)(2) introductory text and (b)(2)(ii).
[187] Refer to § 425.605(b)(2) and (b)(2)(ii)(A); § 425.610(b)(1).

5,000 for the performance year and the ACO selected a fixed MSR/MLR. The MSR and MLR revert to the fixed level previously selected by the ACO for any subsequent performance year in the agreement period in which the ACO's assigned beneficiary population is 5,000 or more.[188] (Refer to Section 4.3, Step 5.)

4.3 PERFORMANCE YEAR FINANCIAL RECONCILIATION CALCULATIONS

CMS compares the updated historical benchmark (refer to Section 4.1.4) to an ACO's assigned beneficiaries' per capita expenditures during the performance year to determine whether the ACO may share in savings or losses, if owed. The shared savings methodologies used under the one- and two-sided models are largely the same. The steps below describe how CMS performs annual financial reconciliation calculations for BASIC track and ENHANCED track ACOs: shared savings calculations for ACOs under one-sided models and two-sided models, and shared losses calculations for ACOs under two-sided models.

Step 1: Calculate updated historical benchmark.

CMS calculates the per capita updated historical benchmark as described in Section 4.1.4.

Step 2: Determines performance year assigned population and calculates assigned beneficiary average per capita expenditures and person years for the performance year (refer to Section 3).

As described in Section 2, CMS determines the final list of performance-year-assigned beneficiaries.

CMS then calculates average per capita Medicare Parts A and B FFS expenditures by Medicare enrollment type and person years by Medicare enrollment type for the ACO's assigned beneficiary population for the performance year (refer to Section 3.1).[189] CMS then multiplies per capita expenditures for each Medicare enrollment type by the proportion of assigned beneficiary person years for the performance year for each Medicare enrollment type and then sums these expenditures across the Medicare enrollment types to determine a single per capita expenditure value. To determine total person years for this calculation, we sum person years across the Medicare enrollment types.

Step 3: Determine total updated benchmark and total performance year expenditures.

CMS multiplies an ACO's per capita updated historical benchmark expenditures (refer to Section 4.1.4, Step 3) and per capita performance year expenditures by the assigned beneficiary population's person years in the performance year (refer to Section 4.3, Step 2 within this list).

Step 4: Determine difference between total updated benchmark expenditures and total performance year expenditures.

If the total updated historical benchmark expenditures minus the total assigned beneficiary performance year expenditures is greater than zero, the ACO is considered to have generated savings and the ACO may qualify to share in savings. If the total updated historical benchmark

[188] Refer to § 425.110(b)(3)(iii).
[189] Refer to § 425.605(a) introductory text; § 425.610(a) introductory text.

minus the total assigned beneficiary performance year expenditures is less than zero, the ACO is considered to have generated losses, and a two-sided model ACO may be liable to share in losses.[190]

Step 5: Determine if savings or losses generated meet or exceed the MSR or MLR.

CMS determines whether the savings or losses generated by the ACO meet or exceed the MSR or the MLR (for two-sided model ACOs), expressed as a percentage of the ACO's updated historical benchmark.[191] For ACOs under a one-sided model, the MSR is based on the ACO's number of assigned beneficiaries as described in Section 4.2.1. The choices of a symmetrical MSR/MLR for ACOs under two-sided models are described in Section 4.2.2, and the policy for modifying the MSR/MLR for small population sizes for two-sided model ACOs is described in Section 4.2.3.

If savings meet or exceed the MSR (calculated as a dollar amount by multiplying total updated benchmark expenditures by the MSR percentage), then the ACO may be eligible to receive a shared savings payment.[192] For agreement periods beginning before January 1, 2024, an ACO that does not meet or exceed the MSR is ineligible to share in savings.

For agreement periods beginning on January 1, 2024, and in subsequent years, BASIC track ACOs whose savings did not meet or exceed the MSR may be eligible to qualify for a shared savings payment, in which the ACO shares in savings at a reduced sharing rate, if all of the following criteria are met:[193]

- The ACO has average per capita Medicare Parts A and B FFS expenditures for the performance year below the updated benchmark. That is, the ACO generated savings for the performance year as determined in Section 4.3, Step 4 (prior step in this list).
- The ACO is a low-revenue ACO as defined in § 425.20 as determined at the time of financial reconciliation for the performance year.
- The ACO has at least 5,000 assigned beneficiaries for the relevant performance year as determined at the time of financial reconciliation for the performance year.
- The ACO is participating in an agreement period beginning on January 1, 2024, or in subsequent years.

For ACOs participating in a two-sided model, if losses (in absolute value terms) meet or exceed the MLR (calculated as a dollar amount by multiplying total updated benchmark expenditures by the MLR percentage), then the ACO will be liable for repaying a share of those losses.[194] Otherwise, the ACO does not share in losses.

Under the guardrail policy that applies for agreement periods beginning on January 1, 2024, and in subsequent years, if an ACO generates losses for a performance year that meet or exceed its MLR (for two-sided model ACOs) or negative MSR (for one-sided model ACOs) under the three-way blended update factor, CMS will recalculate the ACO's updated benchmark using the

[190] Refer to § 425.605(a) introductory text; § 425.610(a) introductory text.
[191] Refer to § 425.605(a)(6), (b)(3), and (b)(4); § 425.610(a)(7), (b)(2), and (b)(3).
[192] Refer to § 425.100(b); § 425.605(a)(6) and (c); § 425.610(a)(7) and (c).
[193] Refer to § 425.605(h).
[194] Refer to §§ 425.605(b)(4) and 425.610(b)(3).

two-way national-regional blended update factor. If the ACO generates a smaller number of losses using the two-way blend, CMS will use this smaller number to determine the ACO's responsibility for shared losses, if applicable, and in determining the ACO's financial performance for monitoring purposes under § 425.316(d).[195] If an ACO generates savings using the two-way blend to update its benchmark but does not generate savings under the three-way blend, the ACO will neither be responsible for shared losses (if in a two-sided model) nor be eligible for shared savings for the applicable performance year, even if the savings generated exceed the ACO's MSR.[196]

Step 6: Calculate final shared savings rate and shared loss rate.

Calculation of final shared savings rate.

Meeting the quality performance standard or the alternative quality performance standard. The quality performance standard is the overall standard the ACO must meet in order to be eligible to receive shared savings for a performance year.[197] CMS uses the ACO's quality performance to determine the ACO's eligibility to receive shared savings, and the rate at which ACOs share in these savings. We base the final shared savings rate on the ACO's quality performance.[198] CMS designates an alternative quality performance standard at § 425.512(a)(5)(ii)(B) available to ACOs that do not meet the quality performance standard. ACOs that qualify for the alternative qualify performance standard will share in savings (if otherwise eligible) at a rate that is scaled by their health equity adjusted quality performance score. ENHANCED track ACOs that meet the alternative qualify performance standard will owe scaled shared losses (if any). For more information on the alternative quality performance standard, please refer to "Alternative Quality Performance Standard" section of this step.

Quality Performance Standard

The Shared Savings Program quality performance standard for performance years beginning on or after January 1, 2025, is specified in § 425.512(a)(2) and § 425.512(a)(5)(i).[199] For PY 2025, ACOs are required to report the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set ACOs can meet the quality performance standard via one of three pathways:

- ***For all ACOs:*** Achieve a health equity adjusted quality performance score (refer to Appendix G) that is equivalent to or higher than the 40th percentile across all MIPS Quality

[195] Refer to 87 FR 69885 and § 425.652(b)(5).
[196] Refer to 87 FR 69885 and § 425.652(b)(5)(ii).
[197] Refer to § 425.512(a)(1).
[198] See, for example, CY 2021 PFS Final Rule (85 FR 84737). The policies that govern the Shared Savings Program quality performance standard, and calculation of the final sharing rate based on ACO quality performance have been modified over time, including through annual calendar year PFS rulemaking (refer to Section 1.1).
[199] See also Medicare Shared Savings Program Quality Performance Standard: Performance Year 2025 40th Percentile MIPS Quality Performance Category Score, available at https://www.cms.gov/files/document/performance-year-2025-40th-percentile-mips-quality-performance-category-score.pdf

performance category scores, excluding entities/providers eligible for facility-based scoring.[200]

- ***For ACOs that report the 4 electronic clinical quality measures (eCQMs)/MIPS clinical quality measures (CQMs) and meet the MIPS data completeness requirement for all 4 measures (eCQM/MIPS CQM reporting incentive):*** Achieve a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark[201] on at least one of the three outcome measures in the APP Plus quality measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the five remaining measures in the APP Plus quality measure set.
- ***For ACOs in their first performance year of their first agreement period:*** Meet the MIPS data completeness requirement on the four eCQMs/MIPS CQMs/Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) in the APP Plus quality measure set and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for MIPS Survey.

For ACOs meeting the applicable quality performance standard established under § 425.512(a)(2) or § 425.512(a)(5)(i), the final sharing rate is equal to the maximum sharing rate specific to the ACO's track or level of participation as follows: 40 percent for ACOs participating in Level A or Level B of the BASIC track, 50 percent for ACOs participating in Levels C, D, or E of the BASIC track, and 75 percent for ACOs participating in the ENHANCED track.

Alternative Quality Performance Standard

As established under § 425.512(a)(5)(ii), if an ACO fails to meet the quality performance standard to qualify for the maximum sharing rate but the ACO reports the APP Plus quality measure set and achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the three outcome measures in the APP Plus quality measure set (referred to as the alternative quality performance standard), then the ACO will share in savings (if otherwise eligible) at a lower rate that reflects the ACO's health equity adjusted quality performance score (refer to Appendix G). Specifically, the ACO's final sharing rate would be a scaled rate that is calculated by multiplying the maximum sharing rate for the ACO's track (or payment model within a track) by the ACO's health equity adjusted quality performance score (expressed as a percentage) (refer to Appendix G).

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[200] In PY 2025, CMS will continue to use historical submission-level MIPS Quality performance category scores to calculate the 40th percentile MIPS Quality performance category score value used for the quality performance standard. For further information on this value and the methodology used to calculate it, please refer to the Medicare Shared Savings Program Quality Performance Standard: Performance Year 2025 40th Percentile MIPS Quality Performance Category Score document referenced above in Footnote 204.

[201] Measure benchmarks are posted annually in the Quality Payment Program (QPP) Resource Library. PY 2025 eCQMs/MIPS CQMs/Medicare CQM measure benchmarks are available at https://qpp.cms.gov/api/frontend/benchmarks-csv/quality/2025. PY 2025 performance period benchmarks will be posted following the submission period in CY 2026 for administrative claims measures. The CAHPS for MIPS 40th percentile decile score will be available in the Performance Year 2025 Shared Savings Program Quality Performance Reports included as part of the Performance Year 2025 Financial Reconciliation Report package.

Not Meeting the Quality Performance Standard or the Alternative Quality Performance Standard

To be eligible for shared savings and to avoid owing maximum shared losses under the ENHANCED Track, ACOs must report quality data on the APP Plus quality measure set and receive a MIPS Quality performance category score based on that quality reporting. If an ACO does not satisfy all required reporting requirements, it will automatically fail the quality performance standard and alternative quality performance standard.

An ACO will not meet the quality performance standard or the alternative quality performance standard for PY 2025 if the ACO (1) does not report any of the 4 eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set, and (2) does not administer a CAHPS for MIPS Survey, unless the ACO does not meet the minimum beneficiary sampling requirements as specified in 42 CFR § 414.1380(b)(1)(vii)(B). ACOs that do not meet the quality performance standard under § 425.512(a)(2) or § 425.512(a)(5)(i) for the performance year, or the alternative quality performance standard under § 425.512(a)(5)(ii)(B) will not be eligible for shared savings, and ACOs participating in the ENHANCED track will owe maximum shared losses.[202]

Calculation of final sharing rate under exception for certain BASIC track ACOs to qualify for a shared savings payment if the ACO does not meet the MSR requirement. For agreement periods beginning on January 1, 2024, and subsequent years, low-revenue ACOs participating in the BASIC track eligible to share in savings even if they do not meet the MSR, (Section 4.3, Step 5 within this list) will have a final sharing rate equal to one half of the rate determined when the MSR is met or exceeded. That is, for eligible ACOs meeting the applicable quality performance standard established under § 425.512(a)(2) or § 425.512(a)(5)(i), the final sharing rate is equal to one half of the maximum sharing rate for the ACO's level of participation in the BASIC track: 20 percent instead of 40 percent under Levels A and Level B, and 25 percent instead of 50 percent under Levels C, D, and E. For eligible ACOs that do not meet the quality performance standard required to share in savings at the maximum sharing rate but do meet the alternative quality performance standard at § 425.512(a)(5)(ii), the final sharing rate is equal to one half of the maximum sharing rate for the ACO's applicable level of the BASIC track multiplied by the ACO's health-equity-adjusted quality performance score.[203]

Calculation of shared loss rate.

In determining shared losses, ACOs participating in Level C, D, or E of the BASIC track are subject to a fixed shared loss rate (also referred to as the loss sharing rate) of 30 percent.[204]

For ACOs participating in the ENHANCED track, for performance years beginning on or after January 1, 2023, the shared loss rate is determined as follows.

- If an ENHANCED track ACO meets either the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(5)(i) or achieves the alternative quality performance standard under § 425.512(a)(5)(ii), CMS determines the shared loss rate as follows:

[202] Refer to §§ 425.512(a)(1), 425.605(c) and (d)(1), and 425.610(c) and (d).
[203] Refer to §§ 425.605(d)(1) and 425.605(h). See also discussion in the CY 2023 PFS Final Rule, 87 FR 69948–69949.
[204] Refer to § 425.605(d)(1)(iii)(C), (d)(1)(iv)(C), and (d)(1)(v)(C).

Step 1: Calculate the product of 75 percent and the ACO's health-equity-adjusted quality performance score (refer to Appendix G).

Step 2: Calculate the shared loss rate as 1 minus the product determined in step 1. The shared loss rate may not exceed 75 percent and may not be less than 40 percent.[205]

- If an ENHANCED track ACO fails to meet the quality performance standard or the alternative quality performance standard under § 425.512, the ACO will be accountable for shared losses based on the maximum shared loss rate of 75 percent.[206]

For a summary of the rates used to calculate shared savings and shared losses (if applicable) by track/level of participation, refer to Appendix A.

Step 7: Calculate the shared savings or shared loss amount.

For ACOs eligible for shared savings, CMS multiplies the final sharing rate (Section 4.3, Step 6 within this list) by the ACO's savings (Section 4.3, Step 4). For ACOs liable for shared losses, CMS multiplies the shared loss rate (Section 4.3, Step 6 within this list) by the ACO's losses (Section 4.3, Step 4). Note that the final sharing rate and the shared loss rate are applied on a first dollar basis, not only to savings or losses that exceed the MSR/MLR.[207]

Step 8: Reduce shared savings amount by 2 percent for sequestration.

CMS adjusts the shared savings amount for sequestration by reducing by 2 percent, as required by the Budget Control Act of 2011. This 2 percent reduction is applied after CMS applies the final shared savings rate to the ACO's savings (refer to Section 4.3, Step 7 within this list) and prior to applying the performance payment limit.

Step 9: Apply the performance payment limit or loss recoupment limit.

CMS caps the sequestration adjusted shared savings amount (refer to Section 4.3, Step 8 within this list) at the applicable performance payment limit for the ACO's track.[208] CMS caps the amount of shared losses at the applicable loss recoupment limit for the ACO's track (and the payment model within that track, if applicable).[209] For a summary of the performance payment limit and loss recoupment limit by track or level of participation, refer to Appendix A.

BASIC track.

For ACOs in the BASIC track, the performance payment limit is 10 percent of total updated historical benchmark expenditures.[210] For ACOs in Level C, D, or E of the BASIC track, the loss sharing limit is a percentage of total Medicare Parts A and B FFS revenue of the ACO

[205] Refer to § 425.610(f)(4)(i).
[206] Refer to § 425.610(f)(4)(ii).
[207] Refer to § 425.605(d)(1)(i)(B)(*1*), (d)(1)(ii)(B)(*1*), (d)(1)(iii)(B)(*1*), (d)(1)(iv)(B)(*1*), and (d)(1)(v)(B)(*1*); § 425.610(e)(1).
[208] Refer to § 425.605(d)(1)(i)(B)(*2*), (d)(1)(ii)(B)(*2*), (d)(1)(iii)(B)(*2*), (d)(1)(iv)(B)(*2*), and (d)(1)(v)(B)(*2*); § 425.610(e)(2).
[209] Refer to § 425.605(d)(1)(iii)(D), (d)(1)(iv)(D), and (d)(1)(v)(D); § 425.610(g).
[210] Refer to § 425.605(d)(1)(i)(B)(*2*), (d)(1)(ii)(B)(*2*), (d)(1)(iii)(B)(*2*), (d)(1)(iv)(B)(*2*), and (d)(1)(v)(B)(*2*).

participants in the ACO, not to exceed a percentage of the ACO's updated historical benchmark.[211] The loss sharing limit for BASIC track ACOs is calculated as follows.

Calculate revenue-based loss sharing limit. CMS determines ACO participants' Medicare FFS revenue (refer to *Section 3.3*). CMS applies the applicable percentage to the revenue amount to derive the dollar amount of the revenue-based loss sharing limit.

Calculate benchmark-based loss sharing limit. CMS applies the applicable percentage to an ACO's total updated historical benchmark expenditures to derive the dollar amount of the benchmark-based loss sharing limit.

Compare the revenue-based and benchmark-based loss sharing limits. CMS uses the benchmark-based loss sharing limit instead of the revenue-based loss sharing limit if the dollar amount of the revenue-based loss sharing limit exceeds the dollar amount of the benchmark-based loss sharing limit.

Example: Calculating Loss Sharing Limit for an ACO in Level E of the BASIC Track

- ACO's total updated benchmark expenditures: $93,411,313
- ACO participants' total Medicare FFS revenue: $13,630,983

Calculate revenue-based loss sharing limit.

In this example, it is 8% of the ACO participants' total Medicare FFS revenue.

$$ACO\ participants' total\ Medicare\ FFS\ revenue \times 8\%$$
$$\$13{,}630{,}983 \times 8\% = \$1{,}090{,}479$$

Calculate benchmark-based loss sharing limit.

In this example, it is 4% of the ACO's updated historical benchmark expenditures.

$$ACO's\ updated\ historical\ benchmark\ expenditures \times 4\%$$
$$\$93{,}411{,}313 \times 4\% = \$3{,}736{,}453$$

Determine whether the revenue-based loss sharing limit exceeds the benchmark-based loss sharing limit; in which case the benchmark-based loss sharing limit applies.

In this case, the ACO's revenue-based loss sharing limit does not exceed the benchmark-based loss sharing limit, therefore the ACO's loss sharing limit is $1,090,479.

ENHANCED track.

For ENHANCED track ACOs, the performance payment limit is calculated as 20 percent of the ACO's total updated historical benchmark expenditures[212] and the loss sharing limit is calculated as 15 percent of the ACO's total updated historical benchmark expenditures.[213]

[211] Refer to § 425.605(d)(1)(iii)(D), (d)(1)(iv)(D), and (d)(1)(v)(D).
[212] Refer to § 425.610(e)(2).
[213] Refer to § 425.610(g).

Step 10: Other calculations that may apply.

(a) Reduce shared losses for ACOs affected by extreme and uncontrollable circumstances.

If an ACO's assigned beneficiaries reside in an area affected by extreme and uncontrollable circumstances and the ACO owes shared losses, CMS reduces the amount of the ACO's shared losses calculated for the performance year by an amount determined by multiplying the shared losses by both of the following percentages:[214]

(1) The percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance. To determine this percentage, CMS identifies counties affected by an extreme and uncontrollable circumstance where its assigned beneficiaries reside, then calculates the weighted average share of months in the performance year that these counties were affected. In computing this average, the share of months affected for each affected county is weighted by the number of assigned beneficiaries residing in that county as a share of total assigned beneficiaries residing in all affected counties.

(2) The percentage of the ACO's assigned beneficiaries who reside in a county affected by an extreme and uncontrollable circumstance. CMS determines the percentage of the ACO's performance year assigned beneficiary population that was affected by the extreme and uncontrollable circumstance based on the final list of beneficiaries assigned to the ACO for the performance year. There is no minimum threshold for percentage of an ACO's assigned beneficiaries residing in an affected area for an ACO to receive the adjustment to shared losses.

This adjustment is applied after applying the loss sharing limit (refer to Section 4.3, Step 9 within this list).

(b) Payment consequences of early termination.

Close-out procedures and payment consequences of early termination of an ACO's participation agreement are specified in § 425.221. Termination of an ACO's participation agreement by CMS under § 425.218 or by the ACO under § 425.220 may impact an ACO's eligibility to receive shared savings or the ACO's liability for shared losses.[215]

An ACO that voluntarily terminates its participation agreement under § 425.220 is only eligible to receive shared savings for the given performance year if CMS designates or approves an effective termination date of the last calendar day of the performance year (i.e., December 31), the ACO has completed all close-out procedures by the deadline specified by CMS, and the ACO has satisfied the criteria for sharing in savings during the performance year.[216] An ACO whose participation agreement is terminated by CMS under § 425.218 is not eligible to receive shared savings for the performance year during which the termination becomes effective.[217]

For performance years beginning on July 1, 2019, and subsequent performance years, CMS will impose payment consequences for early termination by holding ACOs in two-sided models

[214] Refer to §§ 425.605(f) and 425.610(i).
[215] Refer to § 425.221.
[216] Refer to § 425.221(b)(1)(i).
[217] Refer to § 425.221(b)(1)(ii).

liable for pro-rated shared losses. This approach will apply to ACOs that voluntarily terminate their participation more than midway through a 12-month performance year (i.e., after June 30) beginning with PY 2020, and all ACOs that are involuntarily terminated by CMS, regardless of the termination date.[218]

An ACO under a two-sided model that voluntarily terminates its participation agreement under § 425.220 with an effective date of termination after June 30 of a 12-month performance year is liable for a pro-rated share of any shared losses determined for the performance year.[219] An ACO under a two-sided model whose participation agreement is terminated by CMS under § 425.218 is similarly liable for a pro-rated share of any losses determined for the performance year during which the termination becomes effective.[220] In both of these cases, the pro-rated amount reflects the number of months during the performance year that the ACO was in the program. In the case of a 12-month performance year, the pro-rated share of losses is calculated as follows: the shared losses incurred during the 12 months of the performance year are multiplied by the quotient equal to the number of months the ACO participated in the program during the performance year, including the month in which the termination was effective, divided by 12.[221] These shared losses take into account the application of the Shared Savings Program's extreme and uncontrollable circumstances policy for mitigating shared losses (described in Section 4.3, Step 10(a) within this list), under which CMS reduces the amount of the ACO's shared losses by an amount of the total months in the performance year affected by an extreme and uncontrollable circumstance and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.[222]

(c) Recoupment of Advance Investment Payments through shared savings earned (if applicable).

Certain eligible ACOs that enter an agreement period beginning on or after January 1, 2024, will receive advance investment payments.[223] CMS will recoup advance investment payments made to an ACO from any shared savings earned by the ACO in any performance year until CMS has recouped in full the amount of advance investment payments made to an ACO. Any remaining balance owed will be carried forward to subsequent performance year(s) in which the ACO achieves shared savings, including in any performance year(s) in a subsequent agreement period for both renewing and re-entering ACOs.[224] CMS will not recover an amount of advance investment payments greater than the shared savings earned by an ACO in that performance year, unless certain exceptions apply.[225]

[218] Refer to § 425.221(b)(2)(ii).
[219] Refer to § 425.221(b)(2)(ii)(A).
[220] Refer to § 425.221(b)(2)(ii)(B).
[221] Refer to § 425.221(b)(2)(iii)(A).
[222] Refer to §§ 425.605(f) and 425.610(i). See also discussion in the December 2018 Final Rule, 83 FR 67940–67944.
[223] Refer to § 425.630. See also, CMS, *Medicare Shared Savings Program, Advance Investment Payments Guidance* (March 2024, version 2), available at https://www.cms.gov/files/document/aip-guidance.pdf.
[224] Refer to § 425.630(g)(1).
[225] Refer to § 425.630(g)(3); see also §§ 425.630(g)(4) and 425.316(e).

At the time of financial reconciliation, CMS will recoup advance investment payments made to an ACO from any shared savings the ACO earns.[226] The recoupment period begins in the first performance year of the agreement period in which the ACO receives advance investment payments.[227] During the financial reconciliation process for an ACO's first performance year, CMS will not recover an amount of advance investment payments greater than the advance investment payments received by the ACO for that first performance year, even though payments for the second performance year would have occurred by the time of financial reconciliation for the first performance year. During financial reconciliation for any performance year, CMS will not recover an amount of advance investment payments greater than the shared savings earned by an ACO in that performance year.[228] CMS will subtract the recouped amount from the ACO's shared savings after reducing the shared savings payment amount for sequestration (refer to Section 4.3, Step 8 within this list) and applying the performance payment limit (refer to Section 4.3, Step 9). If the amount of shared savings is less than the amount available for recoupment, the ACO will not receive an earned performance payment (refer to Section 4.3, Step 11 below) and any remaining advance investment payment balance will be carried forward to future performance years. For both renewing and re-entering ACOs, CMS will carry forward any remaining balance owed to subsequent performance year(s) in which the ACO achieves shared savings, including in any performance year(s) in a subsequent agreement period.[229]

Step 11: CMS determines earned performance payment amount for ACO eligible to share in savings; two-sided model ACO pays losses (if owed).

The amount the ACO receives for shared savings is referred to as the earned performance payment. CMS notifies the ACO in writing regarding whether the ACO qualifies for a shared savings payment, and if so, the amount of the payment due.[230]

If an ACO has shared losses, CMS provides written notification to the ACO of the amount of shared losses it must repay to the program. The ACO must make payment in full to CMS within 90 days of receipt of notification.[231] If CMS does not receive full payment of the debt on or before 90 days from the date of notification, CMS will enforce collection of the debt, including drawing down the repayment mechanism. For more information on the repayment mechanism requirement, refer to § 425.204(f) and the Medicare Shared Savings Program Repayment Mechanism Arrangements Guidance.

[226] Refer to § 425.630(g)(1) and (g)(2).
[227] See for example discussion in the CY 2023 PFS Final Rule, 87 FR 69804–69805.
[228] Refer to § 425.630(g)(3).
[229] Refer to § 425.630(g)(1).
[230] Refer to §§ 425.605(e)(1) and 425.610(h)(1).
[231] Refer to § 425.605(e)(2) and (e)(3); § 425.610(h)(2) and (h)(3).

Example: Calculating shared savings for an ACO in Level A of the BASIC track that did meet the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(5)(i)

- Track: BASIC track; Level A
- Performance-year-assigned beneficiaries: 60,000
- MSR: 2%
- Total updated benchmark expenditures: $500 M
- Total performance year expenditures: $487 M
- Quality performance: ACO met the quality performance standard
- Maximum sharing rate: 40%
- Performance payment limit (percentage): 10%
- Total advance investment payment amount available for recoupment at the time of financial reconciliation: $2,050,000

Steps in this example correspond with the steps described in the body of the text beginning with Section 4.3, Step 4. This example may reflect some, but not all, of the applicable policies described in the steps.

Step 4: Determine difference between total updated benchmark expenditures and total performance year expenditures.

$$Total\ updated\ benchmark\ expenditures - Total\ performance\ year\ expenditures$$
$$\$500M - \$487M = \$13M\ Savings$$

If the difference (*in this example,* $13M) is > 0, then the ACO may share in savings, proceed to next step. If not, the ACO does not share in savings.

Step 5: Determine if savings generated meet or exceed the MSR.

$$Total\ updated\ benchmark\ expenditures \times \text{MSR}$$
$$\$500M \times 2\% = \$10M$$

If savings (*in this example,* $13M) are ≥ the MSR (*in this example,* $10M), proceed to next step. If not, determine whether the ACO may be eligible for reduced shared savings under § 425.605(h). If not, the ACO is not eligible for a shared savings payment.

Step 6: Calculate the final shared savings rate (percentage) based on quality performance.

Since the ACO met the quality performance standard, the sharing rate = maximum sharing rate.

Step 7: Calculate the shared savings amount.

$$Savings\ (Step\ 4) \times Final\ shared\ savings\ rate\ (Step\ 6)$$
$$\$13M \times 40\% = \$5.2M\ Shared\ savings\ amount$$

Step 8: Reduce shared savings amount by 2 percent for sequestration.

$$Shared\ savings\ amount\ (Step\ 7) \times 2\%$$
$$\$5.2M \times 2\% = \$104{,}000\ Sequestration\ amount$$
$$Subtract\ sequestration\ amount\ from\ shared\ savings\ amount$$
$$\$5.2M - \$104{,}000 = \$5{,}096{,}000$$

Step 9: Apply the performance payment limit.

$$Total\ updated\ benchmark\ expenditures\ \times Performance\ payment\ limit\ percentage$$
$$\$500M \times 10\% = \$50M\ Performance\ payment\ limit\ amount$$

If shared savings amount reduced by sequestration amount (*in this example,* $5,096,000) is > the performance payment limit amount (*in this example,* $50M), then apply cap. If not, do not apply cap.

$$\$5{,}096{,}000 < \$50M$$

In this example, the cap is NOT applied.

Step 10(c): Determine amount of advance investment payment recoupment from shared savings.

$$\$5{,}096{,}000 > \$2{,}050{,}000$$

In this example, the ACO's capped performance payment (*in this example,* $5,096,000) is greater than its advance investment payment amount available for recoupment (*in this example,* $2,050,000), and so the full amount is recouped.

Step 11: Determine earned performance payment amount.

$$Total\ capped\ performance\ payment\ (Step\ 9)$$
$$-\ Advance\ investment\ payment\ recoupment\ amount\ (Step\ 10(c))$$
$$\$5{,}096{,}000 - \$2{,}050{,}000 = \$3{,}046{,}000\ earned\ performance\ payment$$

The ACO's earned performance payment = $3,046,000. No outstanding balance for advance investment payments will be carried forward. CMS will recoup any additional advance investment payments received by the ACO, from shared savings earned by the ACO in future performance years.

Example: Calculating shared savings for an ACO in Level A of the BASIC track that did <u>not</u> meet the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(5)(i) but did meet the alternative quality performance standard established in § 425.512(a)(5)(ii)

- Track: BASIC track; Level A
- Performance-year-assigned beneficiaries: 60,000
- MSR: 2%
- Total updated benchmark expenditures: $500M
- Total performance year expenditures: $489M
- Quality performance: ACO did not meet the quality performance standard, but did meet the alternative quality performance standard. For the purposes of this example, we will assume a health-equity-adjusted quality performance score of 45, which is less than the 40th percentile MIPS Quality performance category score.
- Maximum sharing rate: 40%
- Performance payment limit (percentage): 10%
- Total advance investment payment amount available for recoupment at the time of financial reconciliation: $2,050,000

Steps in this example correspond with the steps described in the body of the text beginning with Section 4.3, Step 4. This example may reflect some, but not all, of the applicable policies described in the steps.

Step 4: Determine difference between total updated benchmark expenditures and total performance year expenditures.

$$Total\ updated\ benchmark\ expenditures - Total\ performance\ year\ expenditures$$
$$\$500M - \$489M = \$11M\ Savings$$

If the difference (*in this example,* $11*M*) is > 0, then the ACO may share in savings, proceed to next step. If not, the ACO does not share in savings.

Step 5: Determine if savings generated meet or exceed the MSR.

$$Total\ updated\ benchmark\ expenditures\ \times \text{MSR}$$
$$\$500M \times 2\% = \$10M$$

If savings (*in this example,* $11*M*) are ≥ the MSR (*in this example,* $10*M*), proceed to next step. If not, determine whether the ACO may be eligible for reduced shared savings under § 425.605(h). If not, the ACO is not eligible for a shared savings payment.

Step 6: Calculate the final shared savings rate (percentage) based on quality performance.
Since the ACO failed to meet the quality performance standard, but met the alternative quality performance standard, the sharing rate = the maximum sharing rate for the ACO allowable by track or level multiplied by the ACO's health-equity-adjusted quality performance score (expressed as a percentage).

$$\text{Maximum sharing rate allowable for BASIC track Level A} \times \text{ACO's health-equity-adjusted quality performance score (expressed as a percentage)}$$
$$40\% \times 45\% = 18\%$$

Step 7: Calculate the shared savings amount.

$$Savings\ (Step\ 4) \times Final\ shared\ savings\ rate\ (Step\ 6)$$
$$\$11M\ \times\ 18\% = \$1.98M\ Shared\ savings\ amount$$

Step 8: Reduce shared savings amount by 2 percent for sequestration.

$$Shared\ savings\ amount\ (Step\ 7) \times 2\%$$
$$\$1.98M \times 2\% = \$39{,}600\ Sequestration\ amount$$
$$Subtract\ sequestration\ amount\ from\ shared\ savings\ amount$$
$$\$1.98M - \$39{,}600 = \$1{,}940{,}400$$

Step 9: Apply the performance payment limit.

$$Total\ updated\ benchmark\ expenditures\ \times Performance\ payment\ limit\ percentage$$
$$\$500M \times 10\% = \$50M\ Performance\ payment\ limit\ amount$$

If shared savings amount reduced by sequestration amount (*in this example,* $1,940,400) is > the performance payment limit amount (*in this example,* $50*M*), then apply cap. If not, do not apply cap.

$$\$1{,}940{,}400 < \$50M$$

In this example, the cap is NOT applied.

Step 10(c): Determine amount of advance investment payment recoupment from shared savings.

$$\$1{,}940{,}400 < \$2{,}050{,}000$$

The advance investment payment recoupment may not exceed the total capped performance payment. Thus, in this example the advance investment payment recoupment amount is set to $1,940,400.

Step 11: Determine earned performance payment amount.

$$Total\ capped\ performance\ payment\ (Step\ 9)$$
$$- Advance\ investment\ payment\ recoupment\ amount\ (Step\ 10(c))$$
$$\$1{,}940{,}400 - \$1{,}940{,}400 = \$0\ earned\ performance\ payment$$

The ACO's earned performance payment = $0. In this example, the advance investment payment recoupment amount is set equal to the total performance payment ($1,940,400).

$$Advance\ investment\ payment\ amount\ available\ for\ recoupment$$
$$- advance\ investment\ payment\ recoupment\ amount$$
$$\$2{,}050{,}000 - \$1{,}940{,}400 = \$109{,}600\ outstanding\ advance\ investment\ payment\ balance$$

The ACO still has an outstanding advance investment payment balance of $109,600. CMS will recoup this amount, plus any additional advance investment payments received by the ACO, from shared savings earned by the ACO in future performance years.

Example: Calculating shared savings for an ACO in Level E of the BASIC track that did not meet the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(5)(i) but did meet the alternative quality performance standard established in § 425.512(a)(5)(ii) and qualified for reduced shared savings

- Track: BASIC track; Level E
- Performance-year-assigned beneficiaries: 60,000
- MSR: 2%
- Total updated benchmark expenditures: $500M
- Total performance year expenditures: $493M
- Quality performance: ACO did not meet the quality performance standard, but did meet the alternative quality performance standard. For the purposes of this example, we will assume a health-equity-adjusted quality performance score of 40, which is less than the 40th percentile MIPS Quality performance category score.
- Maximum sharing rate: 50%
- Performance payment limit (percentage): 10%
- Agreement period start date: January 1, 2024
- Revenue status: Low-revenue status

Steps in this example correspond with the steps described in the body of the text beginning with Section 4.3, Step 4. This example may reflect some, but not all, of the applicable policies described in the steps.

Step 4: Determine difference between total updated benchmark expenditures and total performance year expenditures.

$$Total\ updated\ benchmark\ expenditures - Total\ performance\ year\ expenditures$$
$$\$500M - \$493M = \$7M\ Savings$$

If the difference (*in this example,* $7*M*) is > 0, then the ACO may share in savings, proceed to next step. If not, the ACO does not share in savings, and may be liable for shared losses (not included in this example).

Step 5: Determine if savings generated meet or exceed the MSR.

$$Total\ updated\ benchmark\ expenditures \times \text{MSR}$$
$$\$500M \times 2\% = \$10M$$

If savings (*in this example,* $7*M*) are ≥ the MSR (*in this example,* $10*M*), proceed to next step. If not, determine whether the ACO may be eligible for reduced shared savings as established under § 425.605(h).

If the difference determined in Step 4 (*in this example*, $7*M*) is > 0, assigned beneficiaries (*in this example,* 60,000) are > 5,000, the ACO is a low-revenue ACO, and agreement period start date is on or after January 1, 2024, proceed to next step. If not, the ACO is not eligible for a shared savings payment. In this example, the ACO is eligible for reduced shared savings.

Step 6: Calculate the final shared savings rate (percentage) based on quality performance.
Since the ACO failed to meet the quality performance standard but met the alternative quality performance standard, and did not meet the MSR but did meet the criteria to share in reduced shared savings, the final sharing rate = the maximum sharing rate for the ACO allowable by track or level multiplied by the ACO's health-equity-adjusted quality performance score (expressed as a percentage) multiplied by ½.

$$Maximum\ sharing\ rate\ allowable\ for\ BASIC\ track\ Level\ E \times ACO's\ health - equity - adjusted\ quality\ performance\ score \times \frac{1}{2}$$
$$50\% \times 40\% \times \frac{1}{2} = 10\%$$

Step 7: Calculate the shared savings amount.

$$Savings\ (Step\ 4) \times Final\ shared\ savings\ rate\ (Step\ 6)$$
$$\$7M \times 10\% = \$700{,}000\ Shared\ savings\ amount$$

Step 8: Reduce shared savings amount by 2 percent for sequestration.

$$Shared\ savings\ amount\ (Step\ 7) \times 2\%$$
$$\$700{,}000 \times 2\% = \$14{,}000\ Sequestration\ amount$$
$$Subtract\ sequestration\ amount\ from\ shared\ savings\ amount$$
$$\$700{,}000 - \$14{,}000 = \$686{,}000$$

Step 9: Apply the performance payment limit.

$$Total\ updated\ benchmark\ expenditures\ \times Performance\ payment\ limit\ percentage$$
$$\$500M \times 10\% = \$50M\ Performance\ payment\ limit\ amount$$

If shared savings amount reduced by sequestration amount (*in this example,* $686,000) is > the performance payment limit amount (*in this example,* $50*M*), then apply cap. If not, do not apply cap.

$$\$686{,}000 < \$50M$$

In this example, the cap is NOT applied.

Step 10(c): Determine amount of advance investment payment recoupment from shared savings.
In this example, the ACO is not participating in advance investment payment.

Step 11: Determine earned performance payment amount.
The ACO's earned performance payment = $686,000

Example: Calculating shared losses for an ACO in the ENHANCED track that did <u>not</u> meet the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(5)(i) and did not meet the alternative quality performance standard established in § 425.512(a)(5)(ii) (e.g., the ACO did not report any quality measures to CMS)

- Track: ENHANCED track
- MLR: 1%
- Performance-year-assigned beneficiaries: 16,000
- Total updated benchmark expenditures: $130M
- Total performance year expenditures: $132.6M
- Quality performance: ACO failed to meet the quality performance standard and failed to meet the alternative quality performance standard.
- Maximum sharing rate: 75%
- Shared loss rate: between 40% and 75%
- Loss sharing limit (percentage): 15%

Steps in this example correspond with the steps described in the body of the text beginning with Section 4.3, Step 4. This example may reflect some, but not all, of the applicable policies described in the steps.

Step 4: Determine difference between total updated benchmark expenditures and total performance year expenditures.

$$Total\ updated\ benchmark\ expenditures - Total\ performance\ year\ expenditures$$
$$\$130M - \$132.6\text{M} = -\$2.6\text{M}\ Losses$$

If difference (*in this example*, −$2.6M) is < 0, then the ACO may be liable to repay a share of the losses, proceed to next step. If the difference is > 0, then the ACO may share in savings (not included in this example).

Step 5: Determine if losses generated meet or exceed the MLR.

$$Total\ updated\ benchmark\ expenditures \times MLR$$
$$\$130\text{M} \times -1\% = -\$1.3\text{M}$$

If the absolute value of the losses (*in this example*, $2.6M) is ≥ the absolute value of the MLR (*in this example* $1.3M), proceed to the next step, as the ACO is liable for repaying a share of those losses. If not, the ACO is not liable for repaying a share of the losses.

Step 6: Calculate the shared loss rate (percentage).
Since the ACO failed to meet the quality performance standard and failed to meet the alternative quality performance standard (e.g., the ACO did not report any quality measures to CMS):

$$\text{Shared loss rate} = 75\%$$

Step 7: Calculate the shared loss amount.

$$Losses \times shared\ loss\ rate$$
$$-\$2.6M\ \times\ 75\% = -\$1.95M\ Shared\ loss\ amount$$

In this example, **Step 8** does not need to be completed, because there are no shared savings and sequestration does not apply when determining shared losses.

Step 9: Apply the loss sharing limit.

$$Total\ updated\ benchmark\ expenditures \times Loss\ sharing\ limit\ (percentage)$$
$$\$130M \times -15\% = -\$19.5M\ Loss\ sharing\ limit\ amount$$

If the absolute value of the shared losses amount is > the absolute value of the loss sharing limit amount, then apply cap. If the absolute value of the shared losses amount (*in this example,* $1.95*M*) is < the absolute value of the loss sharing limit amount (*in this example,* $19.5*M*), then do not apply cap.

$$\$1.95M < \$19.5M$$

Amount of shared losses the ACO owes CMS = $1.95M

Step 10(a): Reduce shared losses for ACOs affected by extreme and uncontrollable circumstances.
Percentage of year affected by extreme and uncontrollable circumstance: 15%
Percentage of assigned beneficiaries in affected counties: 90%

$$Shared\ losses \times percentage\ of\ year\ affected\ by\ extreme\ and\ uncontrollable\ circumstance$$
$$\times\ percentage\ of\ assigned\ beneficiaries\ in\ affected\ counties$$
$$-\$1.95M\ \times 15\% \times 90\% = -\$263{,}250$$

In this example, shared losses of $1.95M would be reduced by $263,250 to adjust for extreme and uncontrollable circumstances.

Step 11: Pay losses.
In this example, the ACO must pay CMS the shared losses owed, $1,686,750, within 90 days of receiving written notification from CMS.

Example: Calculating shared losses for an ACO in the ENHANCED track that did <u>not</u> meet the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(5)(i) but did meet the alternative quality performance standard established in § 425.512(a)(5)(ii)

- Track: ENHANCED track
- MLR: 1%
- Performance-year-assigned beneficiaries: 16,000
- Total updated benchmark expenditures: $130M
- Total performance year expenditures: $132.6M
- Quality performance: ACO did not meet the quality performance standard, but did meet the alternative quality performance standard. For the purposes of this example, we will assume a health-equity-adjusted quality performance score of 45, which is less than the 40th percentile MIPS Quality performance category score.
- Maximum sharing rate: 75%
- Shared loss rate: between 40% and 75%
- Loss sharing limit (percentage): 15%

Steps in this example correspond with the steps described in the body of the text beginning with Section 4.3, Step 4. This example may reflect some, but not all, of the applicable policies described in the steps.

Step 4: Determine difference between total updated benchmark expenditures and total performance year expenditures.

$$Total\ updated\ benchmark\ expenditures - Total\ performance\ year\ expenditures$$
$$\$130M - \$132.6\text{M} = -\$2.6\text{M}\ Losses$$

If difference (*in this example*, −$2.6M) is < 0, then the ACO may be liable to repay a share of the losses, proceed to next step. If the difference is > 0, then the ACO may share in savings (not included in this example).

Step 5: Determine if losses generated meet or exceed the MLR.

$$Total\ updated\ benchmark\ expenditures \times MLR$$
$$\$130\text{M} \times -1\% = -\$1.3\text{M}$$

If the absolute value of the losses (*in this example*, $2.6M) is ≥ the absolute value of the MLR (*in this example* $1.3M), proceed to the next step, as the ACO is liable for repaying a share of those losses. If not, the ACO is not liable for repaying a share of the losses.

Step 6: Calculate the shared loss rate (percentage).
Since the ACO did not meet the quality performance standard, but met the alternative quality performance standard, CMS determines the shared loss rate as follows (representing the steps described in Section 4.3, Step 6):

$$Loss\ rate = [1 - (ACO's\ health\ equity\ adjusted\ quality\ performance\ score\ (expressed\ as\ a\ percentage) \times 75\ percent)]$$

The shared loss rate may not be less than 40% and may not exceed 75%.

$$[1 - (45\ \text{percent} \times 75\ \text{percent})] = 66.25\ \text{percent}$$

Step 7: Calculate the shared loss amount.

$$Losses \times shared\ loss\ rate$$
$$-\$2.6\text{M} \times 66.25\% = -\$1{,}722{,}500\ Shared\ loss\ amount$$

In this example, **Step 8** does not need to be completed because there are no shared savings and sequestration does not apply when determining shared losses.

Step 9: Apply the loss sharing limit.

$$Total\ updated\ benchmark\ expenditures \times Loss\ sharing\ limit\ (percentage)$$
$$\$130M \times -15\% = -\$19.5\text{M}\ Loss\ sharing\ limit\ amount$$

If the absolute value of the shared losses amount is > the absolute value of the loss sharing limit amount, then apply cap. If the absolute value of the shared losses amount (*in this example,* $1,722,500) is < the absolute value of the loss sharing limit amount (*in this example,* $19.5*M*), then do not apply cap.

$$\$1{,}722{,}500 < \$19.5M$$

Amount of shared losses the ACO owes CMS = $1,722,500.

Step 10(a): Reduce shared losses for ACOs affected by extreme and uncontrollable circumstances.
Percentage of year affected by extreme and uncontrollable circumstance: 15%
Percentage of assigned beneficiaries in affected counties: 90%

$$Shared\ losses \times percentage\ of\ year\ affected\ by\ extreme\ and\ uncontrollable\ circumstance \times percentage\ of\ assigned\ beneficiaries\ in\ affected\ counties$$
$$-\$1{,}722{,}500 \times 15\% \times 90\% = -\$232{,}538$$

In this example, shared losses of $1,722,500 would be reduced by $232,538 to adjust for extreme and uncontrollable circumstances.

Step 11: Pay losses.
In this example, the ACO must pay CMS the shared losses owed, $1,489,962, within 90 days of receiving written notification from CMS.

APPENDIX A: BASIC TRACK AND ENHANCED TRACK CHARACTERISTICS

For a comparison of BASIC track and ENHANCED track characteristics, refer to Medicare Shared Savings Program, Application Reference Manual, available at Shared Savings Program Application Toolkit webpage. See for example, Application Reference Manual (version 7, April 2025), Appendix A: Financial Description of Models, Comparison of BASIC Track and ENHANCED Track Characteristics.

APPENDIX B: ASSIGNMENT WINDOW, EXPANDED WINDOW FOR ASSIGNMENT, AND EXPENDITURES PERIOD DATES

Table 9. *Relevant assignment window, expenditures period dates, and dates for considering beneficiary designations for purposes of voluntary alignment, for ACOs with an agreement period that begins on January 1, 2022, or in subsequent years*

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR OR PERFORMANCE YEAR	PRELIMINARY PROSPECTIVE ASSIGNMENT WITH RETROSPECTIVE RECONCILIATION	PROSPECTIVE ASSIGNMENT	VOLUNTARY ALIGNMENT (considering beneficiary designations until the listed "Through" date)	EXPENDITURES PERIOD (ALL ACOS)
January 1, 2022	PY4: CY 2025	Assignment window: Jan 1, 2025– Dec 31, 2025 Expanded window for assignment: Jan 1, 2024– Dec 31, 2025	Assignment window: Oct 1, 2023– Sep 30, 2024 Expanded window for assignment: Oct 1, 2022– Sep 30, 2024	Through Sep 30, 2024	Jan 1, 2025– Dec 31, 2025
	PY3: CY 2024	Jan 1, 2024– Dec 31, 2024	Oct 1, 2022– Sep 30, 2023	Through Sep 30, 2023	Jan 1, 2024– Dec 31, 2024
	PY2: CY 2023	Jan 1, 2023– Dec 31, 2023	Oct 1, 2021– Sep 30, 2022	Through Sep 30, 2022	Jan 1, 2023– Dec 31, 2023
	PY1: CY 2022	Jan 1, 2022– Dec 31, 2022	Oct 1, 2020– Sep 30, 2021	Through Sep 30, 2021	Jan 1, 2022– Dec 31, 2022
	BY3: CY 2021	Assignment window: Jan 1, 2021– Dec 31, 2021 Expanded window for assignment: Jan 1, 2020– Dec 31, 2021	Assignment window: Oct 1, 2019– Sep 30, 2020 Expanded window for assignment: Oct 1, 2018– Sep 30, 2020	Through Sep 30, 2020	Jan 1, 2021– Dec 31, 2021

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR OR PERFORMANCE YEAR	PRELIMINARY PROSPECTIVE ASSIGNMENT WITH RETROSPECTIVE RECONCILIATION	PROSPECTIVE ASSIGNMENT	VOLUNTARY ALIGNMENT (considering beneficiary designations until the listed "Through" date)	EXPENDITURES PERIOD (ALL ACOS)
January 1, 2022 continued	BY2: CY 2020	Assignment window: Jan 1, 2020– Dec 31, 2020 Expanded window for assignment: Jan 1, 2019– Dec 31, 2020	Assignment window: Oct 1, 2018– Sep 30, 2019 Expanded window for assignment: Oct 1, 2017– Sep 30, 2019	Through Sep 30, 2019	Jan 1, 2020– Dec 31, 2020
	BY1: CY 2019	Assignment window: Jan 1, 2019– Dec 31, 2019 Expanded window for assignment: Jan 1, 2018– Dec 31, 2019	Assignment window: Oct 1, 2017– Sep 30, 2018 Expanded window for assignment: Oct 1, 2016– Sep 30, 2018	Through Oct 31, 2018	Jan 1, 2019– Dec 31, 2019
January 1, 2023	PY3: CY 2025	Assignment window: Jan 1, 2025– Dec 31, 2025 Expanded window for assignment: Jan 1, 2024– Dec 31, 2025	Assignment window: Oct 1, 2023– Sep 30, 2024 Expanded window for assignment: Oct 1, 2022– Sep 30, 2024	Through Sep 30, 2024	Jan 1, 2025– Dec 31, 2025
	PY2: CY 2024	Jan 1, 2024– Dec 31, 2024	Oct 1, 2022– Sep 30, 2023	Through Sep 30, 2023	Jan 1, 2024– Dec 31, 2024
	PY1: CY 2023	Jan 1, 2023– Dec 31, 2023	Oct 1, 2021– Sep 30, 2022	Through Sep 30, 2022	Jan 1, 2023– Dec 31, 2023

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR OR PERFORMANCE YEAR	PRELIMINARY PROSPECTIVE ASSIGNMENT WITH RETROSPECTIVE RECONCILIATION	PROSPECTIVE ASSIGNMENT	VOLUNTARY ALIGNMENT (considering beneficiary designations until the listed "Through" date)	EXPENDITURES PERIOD (ALL ACOS)
January 1, 2023 continued	BY3: CY 2022	Assignment window: Jan 1, 2022– Dec 31, 2022 Expanded window for assignment: Jan 1, 2021– Dec 31, 2022	Assignment window: Oct 1, 2020– Sep 30, 2021 Expanded window for assignment: Oct 1, 2019– Sep 30, 2021	Through Sep 30, 2021	Jan 1, 2022– Dec 31, 2022
	BY2: CY 2021	Assignment window: Jan 1, 2021– Dec 31, 2021 Expanded window for assignment: Jan 1, 2020– Dec 31, 2021	Assignment window: Oct 1, 2019– Sep 30, 2020 Expanded window for assignment: Oct 1, 2018– Sep 30, 2020	Through Sep 30, 2020	Jan 1, 2021– Dec 31, 2021
	BY1: CY 2020	Assignment window: Jan 1, 2020– Dec 31, 2020 Expanded window for assignment: Jan 1, 2019– Dec 31, 2020	Assignment window: Oct 1, 2018– Sep 30, 2019 Expanded window for assignment: Oct 1, 2017– Sep 30, 2019	Through Sep 30, 2019	Jan 1, 2020– Dec 31, 2020
January 1, 2024	PY2: CY 2025	Assignment window: Jan 1, 2025– Dec 31, 2025 Expanded window for assignment: Jan 1, 2024– Dec 31, 2025	Assignment window: Oct 1, 2023– Sep 30, 2024 Expanded window for assignment: Oct 1, 2022– Sep 30, 2024	Through Sep 30, 2024	Jan 1, 2025– Dec 31, 2025
	PY1: CY 2024	Jan 1, 2024– Dec 31, 2024	Oct 1, 2022– Sep 30, 2023	Through Sep 30, 2023	Jan 1, 2024– Dec 31, 2024

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR OR PERFORMANCE YEAR	PRELIMINARY PROSPECTIVE ASSIGNMENT WITH RETROSPECTIVE RECONCILIATION	PROSPECTIVE ASSIGNMENT	VOLUNTARY ALIGNMENT (considering beneficiary designations until the listed "Through" date)	EXPENDITURES PERIOD (ALL ACOS)
January 1, 2024 continued	BY3: CY 2023	Assignment window: Jan 1, 2023– Dec 31, 2023 Expanded window for assignment: Jan 1, 2022– Dec 31, 2023	Assignment window: Oct 1, 2021– Sep 30, 2022 Expanded window for assignment: Oct 1, 2020– Sep 30, 2022	Through Sep 30, 2022	Jan 1, 2023– Dec 31, 2023
	BY2: CY 2022	Assignment window: Jan 1, 2022– Dec 31, 2022 Expanded window for assignment: Jan 1, 2021– Dec 31, 2022	Assignment window: Oct 1, 2020– Sep 30, 2021 Expanded window for assignment: Oct 1, 2019– Sep 30, 2021	Through Sep 30, 2021	Jan 1, 2022– Dec 31, 2022
	BY1: CY 2021	Assignment window: Jan 1, 2021– Dec 31, 2021 Expanded window for assignment: Jan 1, 2020– Dec 31, 2021	Assignment window: Oct 1, 2019– Sep 30, 2020 Expanded window for assignment: Oct 1, 2018– Sep 30, 2020	Through Sep 30, 2020	Jan 1, 2021– Dec 31, 2021

AGREEMENT PERIOD START YEAR	BENCHMARK YEAR OR PERFORMANCE YEAR	PRELIMINARY PROSPECTIVE ASSIGNMENT WITH RETROSPECTIVE RECONCILIATION	PROSPECTIVE ASSIGNMENT	VOLUNTARY ALIGNMENT (considering beneficiary designations until the listed "Through" date)	EXPENDITURES PERIOD (ALL ACOS)
January 1, 2025	PY1: CY 2025	Assignment window: Jan 1, 2025– Dec 31, 2025 Expanded window for assignment: Jan 1, 2024– Dec 31, 2025	Assignment window: Oct 1, 2023– Sep 30, 2024 Expanded window for assignment: Oct 1, 2022– Sep 30, 2024	Through Sep 30, 2024	Jan 1, 2025– Dec 31, 2025
	BY3: CY 2024	Assignment window: Jan 1, 2024– Dec 31, 2024 Expanded window for assignment: Jan 1, 2023– Dec 31, 2024	Assignment window: Oct 1, 2022– Sep 30, 2023 Expanded window for assignment: Oct 1, 2021– Sep 30, 2023	Through Sep 30, 2023	Jan 1, 2024– Dec 31, 2024
	BY2: CY 2023	Assignment window: Jan 1, 2023– Dec 31, 2023 Expanded window for assignment: Jan 1, 2022– Dec 31, 2023	Assignment window: Oct 1, 2021– Sep 30, 2022 Expanded window for assignment: Oct 1, 2020– Sep 30, 2022	Through Sep 30, 2022	Jan 1, 2023– Dec 31, 2023
	BY1: CY 2022	Assignment window: Jan 1, 2022– Dec 31, 2022 Expanded window for assignment: Jan 1, 2021– Dec 31, 2022	Assignment window: Oct 1, 2020– Sep 30, 2021 Expanded window for assignment: Oct 1, 2019– Sep 30, 2021	Through Sep 30, 2021	Jan 1, 2022– Dec 31, 2022

APPENDIX C: PRIMARY CARE AND SPECIALTY CODES USED IN ASSIGNMENT

According to § 425.20, "primary care services" means the set of services identified by the Healthcare Common Procedure Coding System (HCPCS) and revenue center codes designated under § 425.400(c). Table 10 lists the primary care service codes (HCPCS and Current Procedural Terminology (CPT) codes), according to § 425.400(c)(1)(ix), for purposes of assigning beneficiaries for the performance year starting on January 1, 2025, and subsequent performance years. According to § 425.404(b), for performance years starting on January 1, 2019, and subsequent performance years, a service reported on an FQHC or RHC claim is treated as a primary care service performed by a primary care physician. For services billed under the Physician Fee Schedule (including by Method II CAHs, and ETA hospitals), "primary care services" as defined according to § 425.20, include services identified by the HCPCS or CPT codes specified in Table 10.

Table 10. *Primary care service codes for purposes of assigning beneficiaries according to § 425.400(c)(1)(ix)*

PRIMARY CARE SERVICE CODES
96160 Administration of Health Risk Assessment
96161 Administration of Health Risk Assessment
96202 Caregiver Behavior Management Training
96203 Caregiver Behavior Management Training
97550 Caregiver Training Services
97551 Caregiver Training Services
97552 Caregiver Training Services
98016 Virtual Check-in Service
99201 New Patient, brief (office or other outpatient visit for the evaluation and management of a patient)
99202 New Patient, limited (office or other outpatient visit for the evaluation and management of a patient)
99203 New Patient, moderate (office or other outpatient visit for the evaluation and management of a patient)
99204 New Patient, comprehensive (office or other outpatient visit for the evaluation and management of a patient)
99205 New Patient, extensive (office or other outpatient visit for the evaluation and management of a patient)
99211 Established Patient, brief (office or other outpatient visit for the evaluation and management of a patient)
99212 Established Patient, limited (office or other outpatient visit for the evaluation and management of a patient)
99213 Established Patient, moderate (office or other outpatient visit for the evaluation and management of a patient)
99214 Established Patient, comprehensive (office or other outpatient visit for the evaluation and management of a patient)

PRIMARY CARE SERVICE CODES
99215 Established Patient, extensive (office or other outpatient visit for the evaluation and management of a patient)
99304 New or Established Patient, brief (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99305 New or Established Patient, moderate (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99306 New or Established Patient, comprehensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99307 New or Established Patient, brief (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99308 New or Established Patient, limited (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99309 New or Established Patient, comprehensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99310 New or Established Patient, extensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99315 New or Established Patient, brief (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99316 New or Established Patient, comprehensive (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99318 New or Established Patient (professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a SNF)
99341 New Patient, brief (evaluation and management services furnished in a patient's home)
99342 New Patient, limited (evaluation and management services furnished in a patient's home)
99343 New Patient, moderate (evaluation and management services furnished in a patient's home)
99344 New Patient, comprehensive (evaluation and management services furnished in a patient's home)
99345 New Patient, extensive (evaluation and management services furnished in a patient's home)
99347 Established Patient, brief (evaluation and management services furnished in a patient's home)
99348 Established Patient, moderate (evaluation and management services furnished in a patient's home)
99349 Established Patient, comprehensive (evaluation and management services furnished in a patient's home)

PRIMARY CARE SERVICE CODES
99350 Established Patient, extensive (evaluation and management services furnished in a patient's home)
99354 Prolonged Services with Direct Patient Contact (prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure when the base code is also a primary care service code under 425.400(c)(1)(viii))
99355 Prolonged Services with Direct Patient Contact (prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure when the base code is also a primary care service code under 425.400(c)(1)(viii).)
99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99421 Online Digital Evaluation and Management Service, 5–10 minutes (online digital evaluation and management)
99422 Online Digital Evaluation and Management Service, 11–20 minutes (online digital evaluation and management)
99423 Online Digital Evaluation and Management Service, 21 or more minutes (online digital evaluation and management)
99424 Principal Care Management Service
99425 Principal Care Management Service
99426 Principal Care Management Service
99427 Principal Care Management Service
99437 Chronic Care Management Service
99439 Non-Complex Chronic Care Management Service
99441 Telephone Evaluation and Management Service, 5–10 minutes (telephone evaluation and management) – while payable under Medicare Fee for Service payment policies
99442 Telephone Evaluation and Management Service, 11–20 minutes (telephone evaluation and management) – while payable under Medicare Fee for Service payment policies
99443 Telephone Evaluation and Management Service, 21–30 minutes (telephone evaluation and management) – while payable under Medicare Fee for Service payment policies
99452 Interprofessional Consultation Service
99483 Assessment of and Care Planning for Patients with Cognitive Impairment
99484 General Behavioral Health Integration Care Management (behavioral health integration services)
99487 Complex Chronic Care Management Service
99489 Complex Chronic Care Management Service
99490 Non-Complex Chronic Care Management Service
99491 Non-Complex Chronic Care Management Service
99492 Behavioral Health Integration Service
99493 Behavioral Health Integration Service
99494 Behavioral Health Integration Service
99495 Transitional Care Management Services

PRIMARY CARE SERVICE CODES
99496 Transitional Care Management Services
99497 Advance Care Planning (services identified by this code furnished in an inpatient setting are excluded)
99498 Advance Care Planning (services identified by this code furnished in an inpatient setting are excluded)
G0019 Community Health Integration Services
G0022 Community Health Integration Services
G0023 Principal Illness Navigation Services
G0024 Principal Illness Navigation Services
G0101 Cervical or Vaginal Cancer Screening
G0136 Social Determinants of Health Risk Assessment
G0317 Prolonged Nursing Facility Evaluation and Management Service
G0318 Prolonged Home or Residence Evaluation and Management Service
G0402 Welcome to Medicare Visit
G0438 Annual Wellness Visit
G0439 Annual Wellness Visit
G0442 Annual Alcohol Misuse Screening Service
G0443 Annual Alcohol Misuse Counseling Service
G0444 Annual Depression Screening Service
G0463 Hospital Outpatient Clinic Visit (for services furnished in ETA hospitals; refer to note below)
G0506 Chronic Care Management
G0537 Cardiovascular Risk Assessment
G0538 Cardiovascular Risk Management Services
G0539 Individual Behavior Management Caregiver Training Services
G0540 Individual Behavior Modification Caregiver Training Services
G0541 Direct Care Caregiver Training Services
G0542 Direct Care Caregiver Training Services
G0543 Direct Care Caregiver Training Services
G0544 Post-Discharge Telephonic Follow-Up Contacts Intervention
G0556 Advanced Primary Care Management Services
G0557 Advanced Primary Care Management Services
G0558 Advanced Primary Care Management Services
G0560 Safety Planning Interventions
G2010 Remote Evaluation of Patient Video/Images
G2012 Virtual Check-In
G2058 Non-Complex Chronic Care Management Service
G2064 Principal Care Management Service

PRIMARY CARE SERVICE CODES
G2065 Principal Care Management Service
G2086 Office-Based Opioid Use Disorder Services, at least 70 minutes in the first calendar month
G2087 Office-Based Opioid Use Disorder Services, at least 60 minutes in a subsequent calendar month
G2088 Office-Based Opioid Use Disorder Services, each additional 30 minutes above 120 minutes
G2211 Complex Evaluation and Management Services Add-on
G2212 Prolonged Office or other Outpatient Evaluation and Management (E/M) Service
G2214 Psychiatric Collaborative Care Model
G2252 Communication Technology-Based Service (CTBS)
G3002 Chronic Pain Management and Treatment
G3003 Chronic Pain Management and Treatment (additional 15 minutes)

NOTE: Table 10 contains all codes in ranges specified in § 425.400(c)(1)(ix) that are currently in use. G0463 has been used by hospital outpatient departments covered by Outpatient Prospective Payment System (OPPS) (bill type 13X) since January 1, 2014; for Shared Savings Program assignment purposes, it is used only for ETA hospitals.

According to § 425.400(c)(1)(v)–(ix), for the performance year starting on January 1, 2021, and subsequent performance years, professional services or services reported on an FQHC or RHC claim identified by CPT codes 99304–99318 are excluded for purposes of assigning beneficiaries when furnished in a SNF. See for example § 425.400(c)(1)(viii)(A)(5) applicable for the performance year starting on January 1, 2024, and subsequent performance years. Operationally, the exclusion occurs when the following conditions are met (85 FR 84755 and 84756):

> *(1) Either a professional service is billed under CPT codes 99304–99318, or an FQHC/RHC submits a claim including a qualifier CPT code 99304–99318; and*
>
> *(2) A SNF facility claim is in our claims files with dates of service that overlap with the date of service for the professional service or FQHC or RHC service.*

According to § 425.400(c)(1)(v)–(ix), for the performance year starting on January 1, 2021, and subsequent performance years, CMS excludes from use in the assignment methodology advance care planning services claims billed under CPT codes 99497 and 99498 when such services identified by these codes are furnished in an inpatient care setting. See for example § 425.400(c)(1)(viii)(A)(17) applicable for the performance year starting on January 1, 2024, and subsequent performance years. Operationally, CMS will exclude advance care planning services claims billed under CPT codes 99497 and 99498 from use in the assignment methodology when there is an inpatient facility claim in CMS claims files with dates of service that overlap with the date of service for the professional service billed under CPT code 99497 or add-on code 99498 (85 FR 84754).

In the CY 2021 PFS Final Rule (85 FR 84748–84755), CMS updated the definition of primary care services under § 425.400(c) permanently for purposes of determining beneficiary assignment under § 425.402 for the performance year starting on January 1, 2021, and subsequent performance years, so that the following codes would not be linked to the duration of the PHE for COVID-19: (1) HCPCS code G2010 (remote evaluation of patient video/images) and HCPCS code G2012 (virtual check-in); (2) CPT codes 99421, 99422, and 99423 (online digital evaluation and management service [e-visit]). According to § 425.400(c)(2)(i)(A)(2), for the performance year starting on January 1, 2022, and subsequent performance years, CMS will include an exception to the applicability of the expanded definition of primary care services, to extend the timeframe for use of CPT codes 99441, 99442, and 99443 until they are no longer payable under the Medicare FFS payment policies as specified under section 1834(m) of the Act and § 410.78 and § 414.65.

Table 11 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 identify primary care physicians and physicians with other specialty designations, for purposes of identifying primary care services furnished to beneficiaries used in assignment operations. This table includes the primary care specialty designations specified in the definition of "primary care physician" according to § 425.20,[232] and the primary specialty designations according to § 425.402(c). Note that the definition of "physician," for purposes of the Shared Savings Program according to § 425.20, is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

Table 11. *Physician specialty codes used in assignment*

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

NOTE: For FQHCs and RHCs participating in an ACO, CMS will use all claims for services furnished by all FQHC and RHC practitioners submitted by the FQHC or RHC for assignment operations.

[232] For PY 2019 and subsequent years, a physician who has a primary care specialty designation of internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine.

Table 12 lists specialty codes for non-physician practitioners included in Step 1 of claims-based assignment.

Table 12. *Specialty codes for non-physician practitioners included in the definition of an ACO professional (according to § 425.20) used in Step 1 of assignment*

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

APPENDIX D: OUTPATIENT FACILITY CLAIMS USED IN BENEFICIARY ASSIGNMENT

Beneficiary assignment includes services provided in FQHCs, RHCs, Method II CAHs, and ETA hospitals. The claims data used for assignment for these four provider types are limited to outpatient facility claims. As described in this appendix, additional steps are used to identify data on outpatient facility claims. Table 13 summarizes the bill types used in assignment for these providers.

METHOD II CAH CLAIMS FOR PROFESSIONAL SERVICES

In general, ACO participants are identified by TINs. However, the TINs for Method II CAHs are not included in the NCH and Integrated Data Repository (IDR) claims files. Instead, these CAHs submit line item bills using HCPCS. 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. The rendering physician or practitioner is not reported for each line item in these institutional claims. For purposes of the Shared Savings Program, CMS has developed operational procedures that allow these claims to be considered in the claims-based assignment process (80 FR 32756–32757):

- CMS uses the CCN as the unique identifier for an individual Method II CAH.
- To obtain the rendering physician/practitioner for Method II CAH claims, CMS uses the "rendering" National Provider Identifier (NPI) field. In the event the "rendering" NPI field is blank, CMS uses the "other provider" NPI field. If the "other provider" NPI field is also blank on a claim, CMS uses the "attending" NPI field.
- CMS uses PECOS to obtain the CMS specialty for Method II CAH claims.

FQHC AND RHC CLAIMS

FQHC and RHC services are billed on an institutional claim form. FQHC and RHC services require special handling to be incorporated into the beneficiary assignment process. The TINs for FQHCs and RHCs are not included in the NCH and IDR claims files.

For purposes of the Shared Savings Program, CMS has developed operational procedures that allow these claims to be considered in the claims-based assignment process:

- For FQHCs and RHCs, CMS treats all services reported on an FQHC or RHC claim as a primary care service performed by a primary care physician.[233] If a beneficiary is eligible for assignment to an ACO, then CMS uses all claims for services furnished by all FQHC and RHC practitioners 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 claims-based assignment Step 1.
- CMS uses the CCN as the unique identifier for an individual FQHC or RHC.

[233] Refer to § 425.20 (definitions of "primary care services" and "primary care physician"); § 425.404(b).

ETA HOSPITAL 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. According to § 425.402(d), CMS uses an estimated amount, based on the amounts payable under the PFS for similar services in the geographic location of the teaching hospital, as a proxy for the amount of the allowed charges for the service.[234]

ETA hospital institutional claims are identified with a claim type code equal to 40 and a 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 identification method is that physician services provided at ETA hospitals do not otherwise appear in either outpatient or physician claims.[235] ETA hospitals, however, do bill CMS to recover facility costs incurred when ETA hospital physicians provide services. Therefore, the HCPCS code will identify that a primary care service was provided to a beneficiary. Appendix C, Table 10 lists the HCPCS codes that will be used to identify primary care services for ETA institutional claims. However, two codes, G0438 and G0439, were not included in the list of HCPCS codes for ETA hospitals in 2009 and 2010, and are therefore not included for those years. For purposes of the Shared Savings Program, CMS has developed operational procedures that allow these claims to be considered in the claims-based assignment process:

- To obtain the rendering physician/practitioner for ETA institutional claims, CMS uses 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 institutional claims are imputed using the formula used by Medicare's PFS for calculating allowed charges for each HCPCS code.

[234] Refer to 80 FR 32757 and 80 FR 71272–71273.
[235] The physician services, per se, are reimbursed during settlement of the annual Medicare Cost Report for ETA hospitals.

Table 13. Bill types used for identifying Method II CAH, FQHC or RHC, and ETA institutional claims

PROVIDER TYPE	BILL TYPE	USE IN ASSIGNMENT STEPS	REFERENCE
Method II CAH	85X bill type with the presence of one or more of the following revenue center codes: 096X, 097X, and/or 098X	Specialty of rendering physician/practitioner ("rendering" NPI field on claim, or if blank then the "other provider" NPI field, or "attending" NPI field) determines use in assignment operations (pre-step, assignment Step 1, assignment Step 2, or assignment Step 3).	80 FR 32756–32757
ETA Hospital	13X bill types	Specialty of rendering physician/practitioner ("other provider" NPI field on claim, or if blank then "attending" NPI field) determines use in assignment operations (pre-step, assignment Step 1, assignment Step 2, or assignment Step 3).	§ 425.402(d), 80 FR 71272–71273
FQHC	73X bill type (for dates of service prior to 4/1/2010) and 77X bill type (for dates of service on or after 4/1/2010)	A service reported on an FQHC claim is treated as a primary care service performed by a primary care physician for use in assignment operations (pre-step and assignment Step 1 or assignment Step 3).	§ 425.404(b)
RHC	71X bill types	A service reported on an RHC claim is treated as a primary care service performed by a primary care physician for use in assignment operations (pre-step and assignment Step 1 or assignment Step 3).	§ 425.404(b)

NOTE: Refer to Appendix C, Table 11 for physician specialty codes used in claims-based assignment (indicating use in assignment Step 1 or assignment Step 2), and Appendix C, Table 12 for specialty codes for non-physician practitioners used in assignment Step 1.

APPENDIX E: IDENTIFYING MEDICARE ENROLLMENT TYPE

The Shared Savings Program categorizes beneficiaries by four Medicare enrollment types on a monthly basis: ESRD, disabled, aged/dual eligible, aged/non-dual eligible. In this appendix, we describe operational processes for identifying a beneficiary's Medicare enrollment type.

ESRD

The Shared Savings Program categorizes beneficiaries in the ESRD enrollment type for a particular month based on Medicare enrollment and eligibility files. Beneficiaries meet the Medicare ESRD entitlement definition based on long-term dialysis or transplant status. Diagnoses 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 3 months post-graft are not categorized as ESRD beneficiaries under the Shared Savings Program. They have risk scores calculated using the post-graft segment of the ESRD model, which aligns with how MA defines post-graft beneficiaries for purposes of HCC risk adjustment. 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).[236] 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.

DISABLED

Individuals ages 18–64 years can qualify for Medicare benefits on the basis of disability. The Shared Savings Program categorizes beneficiaries in the disabled enrollment type for a particular month if they are not identified in ESRD status for that month and are under age 65.

DUAL ELIGIBLE FOR MEDICARE AND MEDICAID

The Shared Savings Program categorizes beneficiaries in the dual eligible enrollment type according to CMS' definitions of Medicare-Medicaid enrollees,[237] including the following:

- Qualified Medicare Beneficiaries (QMBs; referred to as having "partial-benefits") and Qualified Medicare Beneficiaries plus full Medicaid (QMB-plus; referred to as having "full benefits"), identified in CMS data systems by dual status codes 01 and 02, respectively.
- Specified Low-Income Medicare Beneficiaries (SLMBs) plus full Medicaid or SLMB-plus, identified by dual status code 04.

[236] Refer to CMS Form 2728.
[237] Refer to CMS, "Technical Instructions to Utilize CMS Data on Dually Enrolled Beneficiaries" (Version date: October 2024), available at https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/mmco_dualeligibledefinition.pdf.

- Other full benefit dual eligible/Medicaid-only dual eligible beneficiaries, identified by dual status code 08.

Individuals qualify for Medicare based on age, specifically if they are age 65 years or older. CMS distinguishes between the aged/dual eligible and aged/non-dual eligible populations because CMS modeling suggests these populations have significantly different expenditures. However, the ESRD and disabled categories include both dual eligible and non-dual eligible beneficiaries because CMS modeling suggests expenditures are less divergent for these populations.

APPENDIX F: REPORT DESCRIPTIONS

CMS will provide ACOs with information on their assigned populations and financial performance at the start of the agreement period and routinely throughout the performance year, according to the provisions on data sharing with ACOs specified in 42 CFR part 425, subpart H. Following the conclusion of the performance year, CMS provides ACOs with financial and quality performance results. CMS provides this information in reports, including the following.

The Assignment List Report provides ACOs with beneficiary identifiable information on each one's assigned population:

- *ACOs with preliminary prospective beneficiary assignment with retrospective reconciliation*: ACOs receive an initial preliminary prospective assignment list near 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. These reports also identify beneficiaries who received a primary care service from an ACO participant upon whom assignment is based during the most recent 12-month or 24-month period according to § 425.704(d)(1)(i).
- *ACOs with prospective beneficiary assignment*: ACOs receive a prospective assignment list near the start of each performance year, prospective assignment lists for each benchmark year, quarterly reports 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 prospectively assigned beneficiaries used for financial reconciliation (similarly indicating beneficiaries determined to be excluded from assignment based on select criteria).

The Assignment Summary Report provides summary information on the ACO's assigned beneficiary population including demographic and eligibility characteristics, proportion and number of primary care services provided to assigned beneficiaries, disease categories, and distribution of assigned beneficiary residence by county.

- *ACOs with preliminary prospective assignment with retrospective reconciliation*: ACOs receive a report based on their initial preliminary prospective assignment list near the start of each performance year, a report based on retrospective assignment lists for each benchmark year, a report based on preliminary prospectively assigned population for each quarter, and a year-end report on beneficiaries retrospectively assigned for financial reconciliation.
- *ACOs with prospective beneficiary assignment*: ACOs receive a report based on their prospective assignment list near 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 that also indicate exclusions made in the year-to-date period, and a year-end report on prospectively assigned beneficiaries for the performance year that also indicate beneficiaries determined to be excluded from assignment at the end of the performance year.

The Aggregate Expenditure/Utilization Report provides ACOs with expenditures and utilization rates for their assigned beneficiaries compared to other ACOs, and national means to assist with identifying trends and outliers. Reports are provided each quarter during the agreement period, provided for each benchmark year, and provided annually with financial reconciliation for each performance year. Note that data used for the quarterly reports are not risk-adjusted.

The Beneficiary Expenditure Utilization Report provides beneficiary-level expenditure and utilization data on the ACO's assigned population. Reports are provided each quarter during the agreement period, provided for each benchmark year, and provided annually for each performance year.

The Quarterly List of Beneficiaries Eligible for Medicare CQMs contains beneficiaries eligible for Medicare CQM reporting, including beneficiary-level age, sex, diagnosis, encounter, and measure exclusion information. These files are cumulative (data are year-to-date) and updated quarterly to reflect the most recent quarter's data. For example, Medicare CQM eligible beneficiaries based on available claims data for encounters with dates of service January 1–March 31, 2025, are included in the 2025 Quarter 1 list.. The Quarter 4 data file will be the full list of ACO beneficiaries, based on the available claims data for encounters with dates of service January 1–December 31, 2025. ACOs must determine eligibility for each Medicare CQM by applying the measure specifications to the Quarter 4 List, if they choose to use it, to ensure measure inclusion and exclusion criteria are captured accurately. The Quarterly List is intended to be a tool or resource for identifying beneficiaries eligible for Medicare CQM reporting.

The Medicare CQM collection type will allow for the use of multiple sources of data (e.g., multiple EHRs, paper records, registries, patient management systems) to compile a measure's numerator and denominator. ACOs may find the following data sources valuable to identify beneficiaries that meet the Medicare CQM collection type:

- Quarterly List of Beneficiaries Eligible for Medicare CQMs
- ACO participants clinical data system files
- Claim and Claim Line Feed (CCLF) files
- Beneficiary Claims Data Application Programming Interface (BCDA) files

For more information on reporting via Medicare CQMs, ACOs can refer to the QPP Resource Library for the 2025 Medicare CQMs for Shared Savings Program Accountable Care Organizations Checklist, which provides steps that ACOs may take to prepare for and successfully complete quality reporting via the Medicare CQM collection type, as well as the Medicare CQM Reporting by Shared Savings Program ACOs: Frequently Asked Questions.

The Non-Claims-Based Payment File provides beneficiary-level data on non-claims-based payments for the ACO's assigned population. Non-claims-based payments include, but are not limited to, individually beneficiary identifiable payments made under a demonstration, pilot or time limited program. Files are provided for each quarter during the agreement period, provided for each benchmark year, and provided annually with financial reconciliation for each performance year. ACOs without Non-Claims-Based Payments during the report period will not receive the Non-Claims-Based Payment file.

The Historical Benchmark Report specifies the calculation of the ACO's 3-year average per capita benchmark value. A preliminary Historical Benchmark Report is typically provided within

3 months of the ACO's agreement start date. ACOs that are new starters or renewals will also receive a final Historical Benchmark Report in the first performance year of their new agreement period, based on finalized data for BY3.

An ACO's historical benchmark is adjusted annually to account for certain changes during the ACO's agreement period, as described in Section 4.1.3. In these circumstances, CMS provides the ACO with a Historical Benchmark Report that includes all applicable adjustments.

An updated historical benchmark, showing the adjustment to the historical benchmark to account for changes in severity and case mix for the ACO's assigned beneficiary population between BY3 and the performance year, and updated using a two-way blend of national and regional growth rates or a three-way blend of the ACPT and blended national-regional growth rates (as applicable), is provided to all ACOs as part of the financial reconciliation report.

CMS provides the preliminary, adjusted and final Historical Benchmark Report as part of a Benchmark Report package which include informational reports and files: Assignment List Report, Assignment Summary Report, Aggregate Expenditure/Utilization Report and Non-Claims-Based Payment File for the assigned population for each benchmark year.

The Quality Performance Report provides information on whether ACOs meet the Shared Savings Program quality performance standard or alternative quality performance standard and the ACO's health equity adjusted quality performance score used in financial reconciliation.

The Financial Reconciliation Report specifies the ACO's historical benchmark, updated historical benchmark, and determination of shared savings or losses.

There are differences between reports produced on a quarterly basis and reports produced on an annual basis, in terms of the amount of claims run-out available, and the expenditure completion factors used. In order to provide timely data to the ACOs during each quarter, a shorter claims run-out period must be used. Consequently, the expenditure completion factors must be larger for quarterly data to account for this shorter claims run-out period. There are also differences between the assignment dates of services used for (1) ACOs under prospective assignment and (2) ACOs under preliminary prospective assignment with retrospective reconciliation (refer to Appendix B, Table 9). Table 14 below provides a comparison of select characteristics for some of the above-mentioned ACO reports for ACOs under preliminary prospective assignment with retrospective reconciliation. Table 15 provides a comparison of the same characteristics for ACOs under prospective assignment.

The Advance Investment Payment Summary Report (AIPSR) specifies the calculation of the quarterly payment amount using beneficiary data summarized to the ACO-level resulting in the ACO's aggregate quarterly advance investment payment dollar amount. Only ACOs eligible for advance investment payments will receive the AIPSR.

The Beneficiary Advance Investment Payment Report is a beneficiary-level CSV file that will accompany each AIPSR. This file will include the beneficiary-level data that underlies the ACO's aggregate advance investment payment calculation for the current quarter. Only ACOs eligible for advance investment payments will receive the Beneficiary Advance Investment Payment Report.

Table 14. *Selected characteristics of Shared Savings Program ACO reports for ACOs under preliminary prospective assignment with retrospective reconciliation*

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 (refer to Appendix B, Table 9)	Most recent 12 or 24 months	Most recent 12 or 24 months	Most recent 12 or 24 months	Most recent 12 or 24 months	Most recent 12 or 24 months
Expenditure Completion Factors	N/A	N/A	1.072	1.013	1.013
Medicare Enrollment Type Determined	Monthly	Monthly	Monthly	Monthly	Monthly

NOTE: Preliminary Historical Benchmark Reports use less than 3 months of run-out for the third benchmark year. Depending on the run-out time, CMS uses a completion factor of 1.013 or 1.072.

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

Table 15. *Selected characteristics of Shared Savings Program ACO reports for ACOs under prospective assignment*

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 (refer to Appendix B, Table 9)	Prospective assignment window	Prospective assignment window	Prospective assignment window	Prospective assignment window	Prospective assignment window
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	Refer to parameters in relevant quarterly EXPU report	Refer to parameters in relevant Annual EXPU report	Refer to parameters in relevant Historical Benchmark EXPU report
Medicare Enrollment Type Determined	Monthly	Monthly	Monthly	Monthly	Monthly

NOTE: Beneficiaries are excluded from the prospective assignment lists on a quarterly basis and annually prior to financial reconciliation based on select assignment exclusion criteria (refer to Section 2.3.2.2). The 3 months claims run-out is used for prospective ACOs when determining financial reconciliation and historical benchmark expenditures, eligibility, and utilization, whereas assignment for prospective ACOs is based on the latest data available at the time of the assignment run prior to the start of the performance year.

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

APPENDIX G: CALCULATION OF THE HEALTH EQUITY ADJUSTED QUALITY PERFORMANCE SCORE

The provisions of the Shared Savings Program regulations on determining the ACO quality performance standard for performance years beginning on or after January 1, 2021, are specified in § 425.512. Beginning in PY 2025, Shared Savings Program ACOs are required to report quality data on the APP Plus (refer to § 425.510 and § 425.512). As part of meeting the Shared Savings Program quality reporting requirements in PY 2025:

- ACOs are required to report the 4 eCQMs/MIPS CQMs/Medicare CQMs (using one collection type or a combination of the collection types) in the APP Plus quality measure set;
- ACOs are required to administer the CAHPS for MIPS Survey; and
- CMS will also calculate one measure using administrative claims data: Quality ID: 479 All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups.

Where there are unscored measures or measures without a benchmark, the Shared Savings Program will use the higher of a) the ACO's health equity adjusted quality performance score or b) the 40th percentile MIPS Quality performance category score value used for the quality performance standard when either of the following occur:

- The ACO's total available measure achievement points used to calculate the ACO's quality performance score is reduced due to measure suppression; or
- At least one of the eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set does not have a benchmark

ACOs will qualify for this policy provided that they report all quality data on the APP Plus quality measure set via the eCQM, MIPS CQM, or Medicare CQM collection types, or a combination of these 3 collection types, meet data completeness requirements for each measure, and receive a MIPS Quality performance category score. Measures not meeting case minimum are not addressed by this policy.[238] For MIPS scoring polices applicable to Shared Savings Program ACOs, including the Complex Organization Adjustment and Flat Benchmarks for Medicare CQMs, please refer to the 2025 APP Toolkit.

For performance years beginning on or after January 1, 2023, the Shared Savings Program uses the health equity adjusted quality performance score in determining whether an ACO meets the quality performance standard and for performing certain financial reconciliation calculations (refer to Section 4.3, Step 6).[239] An ACO's health equity adjusted quality performance score is the sum of the ACO's MIPS Quality performance category score, received from the Quality Payment Program (QPP), and the calculated health equity adjustment bonus

[238] Refer to § 425.512(a)(7)(ii)
[239] Refer to § 425.512(b)(4).

points (if any).[240] This appendix provides an overview of the uses for and calculation of the health equity adjusted quality performance score, along with some sample calculations.[241]

To be eligible to receive health equity adjustment bonus points for PY 2025, an ACO must meet the following criteria:

- Report the four eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set and administer the CAHPS for MIPS Survey;[242]
- Meet the data completeness requirement for the four eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set; and
- Have an underserved multiplier of 20% or greater.[243]

HOW CMS USES THE HEALTH EQUITY ADJUSTED QUALITY PERFORMANCE SCORE

CMS uses the health equity adjusted quality performance score in several Shared Savings Program determinations, including the following:[244]

- Determining whether the ACO meets the quality performance standard for PY 2025[245] by achieving a health equity adjusted quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities and providers eligible for facility-based scoring.
- Determining the final sharing rate for calculating shared savings payments for an ACO that meets the alternative quality performance standard and therefore receives scaled shared savings (described in Section 4.3, Step 6).
- Determining the shared losses rate for calculating shared losses for an ENHANCED track ACO that meets the quality performance standard or meets the alternative quality performance standard (described in Section 4.3, Step 6).

ACOs that report eCQMs, MIPS CQMs, or a combination of these two collection types can also meet the quality performance standard for PY 2025 by meeting the criteria for the eCQM/MIPS CQM reporting incentive as described at § 425.512(a)(5)(i)(B)(*2*). The eCQM/MIPS CQM reporting incentive does not use the ACO's health equity adjusted quality performance category

[240] Refer to § 425.512(b)(2). Not all ACOs are eligible to receive health equity adjustment bonus points. For consistency, we use the term health equity adjusted quality performance score to refer to any quality performance score used to determine whether an ACO met the Shared Savings Program quality performance standard and calculate shared savings or losses, if applicable.
[241] Health equity adjustment bonus points are only applied to Shared Savings Program ACOs for purposes of the Shared Savings Program. Therefore, for ACOs that receive health equity adjustment bonus points, their health equity adjusted quality performance score and MIPS Quality performance category score may differ.
[242] An ACO that does not administer a CAHPS for MIPS Survey due to insufficient sample size will still be eligible to receive a health equity adjustment if it meets the other eligibility requirements. Refer to § 425.512(b)(2).
[243] Refer to 42 CFR § 425.512(b)(3)(iv) for details on how CMS determines the underserved multiplier for the ACO.
[244] Refer to § 425.512(b)(4).
[245] Refer to § 425.512(a)(5)(i)(A)(*1*).

score and instead uses measure-level performance relative to the 10th and 40th percentile benchmarks for the four eCQMs/MIPS CQMs in the APP Plus quality measure set. For PY 2025, ACOs can qualify for the eCQM/MIPS CQM reporting incentive if a) they report the four eCQMs/MIPS CQMs in the APP Plus quality measure set, b) meet the data completeness requirement at § 414.1340 for all four eCQMs/MIPS CQMs, and c) achieve a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the three outcome measures in the APP Plus quality measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP Plus quality measure set. Performance benchmarks for PY 2025 used to determine the 10th and 40th percentiles for purposes of evaluating the eCQM/MIPS CQM reporting incentive will be posted on the QPP Resource Library website.

STEPS FOR CALCULATING THE HEALTH EQUITY ADJUSTED QUALITY PERFORMANCE SCORE

CMS calculates the ACO's health equity adjusted quality performance score as the sum of the ACO's MIPS Quality performance category score and the ACO's health equity adjustment bonus points, with the sum of these values not to exceed 100 percent. CMS calculates these bonus points using the ACO's quality performance on the measures[246] in the APP Plus quality measure set relative to other ACOs and the proportion of the ACO's assigned beneficiary population that is underserved. An ACO can receive a maximum of 10 bonus points, and the health equity adjusted quality performance score cannot exceed 100 percent. As noted above, not all ACOs are eligible to receive health equity adjustment bonus points.

CMS will perform the following four steps to calculate an eligible ACO's health equity adjusted quality performance score.

Step 1: Calculate the ACO's measure performance scaler.

For each measure in the APP Plus quality measure set, CMS groups an ACO's performance into the top, middle, or bottom third of ACO measure performance by reporting mechanism (collection type).[247] For example, ACOs that report an eCQM would have that measure grouped based on the performance of other ACOs that report that same eCQM. ACOs that report the MIPS CQM or Medicare CQM versions of that measure would similarly be considered separate. After grouping the ACO by measure performance, CMS assigns values to each ACO for its performance on each measure as follows:

- Values of 4, 2, or 0 for each measure for which the ACO's performance places it in the top, middle, or bottom third of ACO measure performers, respectively.
- Values of 0 for each measure that CMS does not evaluate because the ACO does not meet the case minimum or minimum sample size for the measure.

[246] In the event that an APP Plus quality measure is excluded or an APP Plus quality measure lacks a benchmark, the policy described at § 425.512(a)(7)(ii) will apply.
[247] Refer to § 425.512(b)(3)(ii).

CMS then sums the values assigned to the ACO across the six measures in the APP Plus quality measure set to calculate the ACO's measure performance scaler.[248] The ACO measure performance scaler can range from 0 (meaning that for all six measures in the APP Plus quality measure set the ACO either performs in the bottom third or CMS cannot evaluate the ACO's performance for the measure[s]) to 24 (meaning that for all six measures in the APP Plus quality measure set the ACO performs in the top third). Table 16 illustrates how the measure performance scaler is calculated for six hypothetical ACOs with MIPS Quality performance category scores based on eCQMs, MIPS CQMs, or Medicare CQMs: two with high measure performance (ACOs 1 and 2), two with middle measure performance (ACOs 3 and 4), and two with low measure performance (ACOs 5 and 6).

Table 16. *Hypothetical data on the measure performance scaler*

MEASURE #	ACO 1 & 2 PERFORMANCE GROUP	ACO 1 & 2 VALUE	ACO 3 & 4 PERFORMANCE GROUP	ACO 3 & 4 VALUE	ACO 5 & 6 PERFORMANCE GROUP	ACO 5 & 6 VALUE
321	Top third	4	Top third	4	Middle third	2
479	Top third	4	Middle third	2	Bottom third	0
001	Top third	4	Top third	4	Bottom third	0
134	Top third	4	Top third	4	Middle third	2
236	Top third	4	Middle third	2	Middle third	2
112	Top third	4	Middle third	2	Bottom third	0
Total assigned value per ACO		24		18		6

Measure numbers and names: 321 = CAHPS for MIPS; 479 = Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups; 001= Diabetes: Glycemic Status Assessment Greater Than 9%; 134 = Preventive Care and Screening: Screening for Depression and Follow-up Plan; 236 = Controlling High Blood Pressure 112 = Breast Cancer Screening.

Step 2: Calculate the ACO's underserved multiplier.

CMS determines the proportion of the ACO's assigned beneficiary population that is considered underserved for the performance year, ranging from 0 to 1, based on the higher of the two proportions below:

- The proportion of the ACO's assigned beneficiaries residing in a census block group with an Area Deprivation Index (ADI)[249] national percentile rank of at least 85; or
- The proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) or are dual eligible for Medicare and Medicaid. [250]

[248] Refer to § 425.512(b)(3)(iii).
[249] The ADI was developed by researchers at the National Institutes of Health with the goal of quantifying and comparing social disadvantage across geographic neighborhoods. It is a composite measure derived through a combination of 17 input variables from census data. Refer to the CY 2023 PFS Final Rule, 87 FR 69794.
[250] Refer to § 425.512(b)(3)(iv).

If the underserved multiplier is lower than 0.2 (or 20 percent), the ACO is ineligible for health equity adjustment bonus points.[251]

In calculating the underserved multiplier, CMS will use the ADI national percentile rank of the census block group associated with a beneficiary's most recent address during the performance year. ADI national percentile rank may be unavailable for some assigned beneficiaries, for a number of circumstances, including if they could not be matched to a census block group due to missing or insufficient mailing address data, or because they lived in a U.S. census block group without a national percentile rank due to data suppression criteria. CMS will exclude such beneficiaries from both the numerator and denominator when calculating the proportion of beneficiaries residing in a census block group with ADI national percentile rank of at least 85.[252] Separately, in calculating the underserved multiplier, CMS uses the number of beneficiaries for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D LIS or who are dual eligible for Medicare and Medicaid.[253]

Example: Calculation of the proportion of assigned beneficiaries residing in a census block group with ADI national percentile rank of 85 or higher

The following is based on a hypothetical ACO.

Total assigned beneficiaries: 6,500

Assigned beneficiaries with ADI national percentile rank of 85 or higher: 1,400

Assigned beneficiaries with ADI national percentile rank of 1 to 84: 5,030

Assigned beneficiaries missing ADI national percentile rank value: 70

Calculate the proportion, including only beneficiaries with ADI data:

$$\frac{Number\ of\ ACO\ assigned\ beneficiaries\ with\ ADI\ national\ percentile\ rank\ \geq 85}{Total\ number\ of\ ACO\ assigned\ beneficiaries\ with\ ADI\ data}$$

$$\frac{1{,}400}{1{,}400+5{,}030} = 0.218$$

Thus, the ACO's proportion of assigned beneficiaries residing in a census block group with ADI national percentile rank of at least 85 is 0.218 or 21.8% of its assigned population.

CMS computes the proportion of the ACO's assigned beneficiaries with any months enrolled in Medicare Part D LIS or dual eligible for Medicare and Medicaid, divided by the total number of the ACO's assigned beneficiaries. Specifically, the calculation of the proportion uses the number of beneficiaries flagged as having at least one month of LIS enrollment or dual eligibility as the numerator and the total number of beneficiaries assigned to the ACO as the denominator.[254]

In determining whether a beneficiary is enrolled in LIS for a given month for purposes of calculating the underserved multiplier, CMS will consider beneficiaries who qualify for either a

[251] Refer to § 425.512(b)(3)(iv)(B).
[252] Refer to § 425.512(b)(3)(iv)(A)(*1*)(*i*); see also the CY 2024 PFS Final Rule, 88 FR 79114–79117, for discussion of "Modifications to the Health Equity Adjustment Underserved Multiplier," including to remove beneficiaries who do not have a numeric national percentile rank available for the ADI from the health equity adjustment calculation for PY 2023 and subsequent performance years.
[253] Refer to § 425.512(b)(3)(iv)(A)(*2*); see also the CY 2024 PFS Final Rule, 88 FR 79114–79117.
[254] Refer to § 425.512(b)(3)(iv)(A)(*1*)(*ii*) and (b)(3)(iv)(A)(*2*)(*ii*); see also 88 FR 79115.

full or partial subsidy. To identify whether a beneficiary is dual eligible for Medicare and Medicaid for a given month, CMS will use the criteria described in Appendix E. Dual eligible months will include both (1) months that a beneficiary is allocated to the aged/dual eligible Medicare enrollment type and (2) months that a beneficiary is allocated to the ESRD or disabled enrollment type and also meets the criteria for dual eligibility.

Example: Calculation of the proportion of beneficiaries enrolled in Medicare Part D LIS or dual eligible for Medicare and Medicaid

The following is based on a hypothetical ACO.

Total assigned beneficiaries: 6,500

Assigned beneficiaries who were enrolled in LIS or dual eligible for at least one month during the performance year: 1,750

Calculate the proportion:

$$\frac{Number\ of\ ACO\ assigned\ beneficiaries\ who\ were\ enrolled\ in\ LIS\ or\ dually\ eligible\ for\ at\ least\ one\ month}{Total\ number\ of\ ACO\ assigned\ beneficiaries}$$

$$\frac{1{,}750}{6{,}500} = 0.269$$

Thus, this ACO's proportion of assigned beneficiaries enrolled in LIS or dual eligible for Medicare and Medicaid for at least one month during the performance year is 0.269 or 26.9% of its assigned population.

Table 17 illustrates how the underserved multiplier would be determined for six hypothetical ACOs. Among these ACOs, ACO 4 provides an example of an ACO that is ineligible for health equity adjustment bonus points because its underserved multiplier is lower than 20 percent.

Table 17. *Hypothetical data on the underserved multiplier*

HYPOTHETICAL ACO	PROPORTION OF PY ASSIGNED BENEFICIARIES WITH ADI NATIONAL PERCENTILE RANK OF AT LEAST 85 [A]	PROPORTION OF PY ASSIGNED BENEFICIARIES ENROLLED IN LIS OR DUAL ELIGIBLE [B]	UNDERSERVED MULTIPLIER ([C] = HIGHER OF [A] OR [B])
ACO 1	0.4	0.6	0.6
ACO 2	0.1	0.2	0.2
ACO 3	0.3	0.3	0.3
ACO 4	0.1	0.1	0.1
ACO 5	0.8	0.6	0.8
ACO 6	0.2	0.1	0.2

Step 3: Calculate the ACO's health equity adjustment bonus points.

For an ACO that has an underserved multiplier greater than or equal to 0.2 (20 percent), CMS calculates the ACO's health equity adjustment bonus points as the product of the measure performance scaler from Step 1 and the underserved multiplier from Step 2. If the product of

these values is greater than 10, CMS will set the ACO's health equity adjustment bonus points equal to 10.[255] Table 18 illustrates this calculation for six hypothetical ACOs.

Table 18. *Hypothetical data on the health equity adjustment bonus points*

HYPOTHETICAL ACO	MEASURE PERFORMANCE SCALER [A]	UNDERSERVED MULTIPLIER [B]	HEALTH EQUITY ADJUSTMENT BONUS POINTS ([C] = LOWER OF [A] × [B] OR 10)
ACO 1	24	0.6	10.0
ACO 2	24	0.2	4.8
ACO 3	18	0.3	5.4
ACO 4	18	0.1	N/A
ACO 5	6	0.8	4.8
ACO 6	6	0.2	1.2

Step 4: Calculate the ACO's health equity adjusted quality performance score.

CMS then adds the calculated bonus points to the ACO's MIPS Quality performance category score to obtain the ACO's health equity adjusted quality performance score. Table 19 illustrates this calculation for six hypothetical ACOs. If the sum is greater than 100, CMS will set the score equal to 100 as shown for ACO 1 below.[256]

Table 19. *Hypothetical data on the health equity adjusted quality performance score*

HYPOTHETICAL ACO	MIPS QUALITY PERFORMANCE CATEGORY SCORE (%) [A]	HEALTH EQUITY ADJUSTMENT BONUS POINTS [B]	HEALTH-EQUITY-ADJUSTED QUALTY PERFORMANCE SCORE ([C] = LOWER OF [A] + [B] OR 100)
ACO 1	92.0	10.0	100.0
ACO 2	92.0	4.8	96.8
ACO 3	85.0	5.4	90.4
ACO 4	85.0	N/A	85.0
ACO 5	60.0	4.8	64.8
ACO 6	60.0	1.2	61.2

The health equity adjusted quality performance score will be provided to ACOs in their Shared Savings Program quality performance reports.

[255] Refer to § 425.512(b)(3)(v).
[256] Refer to § 425.512(b)(2).

LIST OF ABBREVIATIONS

Abbreviation	Definition
ACO	Accountable Care Organization
ACPT	Accountable Care Prospective Trend
The Act	The Social Security Act
ADI	Area Deprivation Index
AIPSR	Advance Investment Payment Summary Report
APM	Alternative Payment Model
APP	Alternative Payment Model Performance Pathway
BY	Benchmark Year
CAH	Critical Access Hospital
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCN	Centers for Medicare and Medicaid Services Certification Number
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT©	Current Procedural Terminology
CQM	Clinical Quality Measure
CY	Calendar Year
DSH	Disproportionate Share Hospital
eCQM	Electronic Clinical Quality Measure
ESRD	End-Stage Renal Disease
ETA	Electing Teaching Amendment
EXPU	Aggregate Expenditure and Utilization Report
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FR	Federal Register
HCC (or CMS-HCC)	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System
HEBA	Health Equity Benchmark Adjustment
IFC	Interim Final Rule with Comment Period
IHS	Indian Health Service
IME	Indirect Medical Education
LIS	Low-Income Subsidy
MA	Medicare Advantage
Medicare CQM	Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program
MIPS	Merit-Based Incentive Payment System
MLR	Minimum Loss Rate

Abbreviation	Definition
MSR	Minimum Savings Rate
NCH	National Claims History
NPI	National Provider Identifier
OACT	Office of the Actuary
PECOS	Provider Enrollment, Chain, and Ownership System
PFS	Physician Fee Schedule
PHE	Public Health Emergency
PY	Performance Year
QMB	Qualified Medicare Beneficiary
QPP	Quality Payment Program
RHC	Rural Health Clinic
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
TIN	Taxpayer Identification Number